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# Standing Committee on the Status of Women

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**EVIDENCE**

## Monday, May 10, 2010

## Chair

**The Honourable Hedy Fry**

# Standing Committee on the Status of Women

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● (1530)

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC)):** It's 3:30 and I'd like to call the committee to order.

On April 12, 2010, the Standing Committee on the Status of Women unanimously adopted the following motion to study maternal and child health:

> That the Committee study maternal and child health following the government's announcement to make maternal and child health a priority at the G8 in June that Canada will be hosting, as long as this is done before the end of May.

The committee will hold four meetings on this question. The first two meetings brought together non-governmental organizations and coalitions specializing in development issues as well as maternal and child health. Witnesses specializing in maternal and sexual health are appearing at today's meeting.

We are very pleased to have here with us today Jolanta Scott-Parker from the Canadian Federation for Sexual Health. We also have Ainsley Jenicek from the Fédération du Québec pour le planning des naissances; and Bridget Lynch from the International Confederation of Midwives. Joining the Canadian Federation for Sexual Health, just to provide support here, is Pierre La Ramée. Finally, we have Regroupement Naissance-Renaissance.

We will start, and each witness will have 10 minutes. We are pleased to start now with Jolanta Scott-Parker.

**Ms. Jolanta Scott-Parker (Executive Director, Canadian Federation for Sexual Health):** Thank you.

I'd first like to thank the committee for the opportunity to appear here today as a witness to address the important topic of maternal and child health. We're certainly very humbled to appear alongside the variety of esteemed organizations that have appeared both today and on the other two days of hearings dedicated to this topic.

The Canadian Federation of Sexual Health, formerly Planned Parenthood Federation of Canada, is a national network dedicated to supporting access to comprehensive sexual health information, education, and services in every community. 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 with dedication 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. In fact, as Madam Chair pointed out, I'm joined here today by my colleague, Pierre La Ramée, from the IPPF's western hemisphere region office in New York—although, I might add, he's actually a Canadian. He'll be pleased to participate in the question and answer period along with me.

IPPF is the world's leading organization in sexual and reproductive health, with an unparalleled network of health providers in 171 countries. IPPF and its member organizations implement grassroots service delivery programs that meet the reproductive health needs of the poor, marginalized, socially excluded, and underserved.

All of those in the IPPF network welcomed the Canadian government's announcement that it would focus on maternal, newborn, and child health as part of its G8 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.

There is strong evidence to show that family planning saves lives. The World Bank estimates that 40% of maternal deaths could be prevented by a wider uptake of reliable contraceptive methods.

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 to this issue in the last 12 months, we have a tremendous opportunity to move forward with new momentum.

To review quickly some of the facts that you've been presented with in recent days, 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.

I know that Sharon Camp was here last week to speak to the new research from the Guttmacher Institute, which suggests that if we met 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 is also estimated that unsafe abortions would decrease from 20 million to 5.5 million.

So the study suggests that meeting the combined need would actually be less expensive than meeting the need for maternal and newborn care alone. This cost saving would be a result of the dramatic reduction in the need for pregnancy-related care due to unintended pregnancies.

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

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, as well as a variety of other factors. In cases where abortion is legal, women must be offered access to this procedure safely.

At the 2009 G8 summit, Canada committed to "accelerating progress on maternal health, through sexual and reproductive health care and services and voluntary family planning". Furthermore, all of the G8 leaders signed on to 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, which must also include emergency obstetrical care; safe abortion services where abortions are legal; and improved child nutrition and prevention and treatment of major childhood diseases.

● (1535)

The upcoming G8 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 millennium development goals. MDG 5 and MDG 5.B are the goals toward which the least progress has been made, and this G8 meeting provides a tremendous opportunity to change that. Strong and effective civil society organizations are critical to ensuring the effective implementation of the government's 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 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 are a critical component of the maternal health architecture, working in the world's least developed countries to build capacity to deliver high-quality services from a rights-based perspective. The evidence is overwhelming, and the global consensus is clear with respect to what action is required.

In just over one month, 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 hospital I will go to has 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 threaten my life or the long-term well-being of my family. I am choosing to have my second child almost exactly three years after my first and I have had the privilege of a variety of forms of modern contraception to assist me in making this choice. I also have fairly readily available access to abortion services, had this not been a pregnancy that I was able to continue, for whatever reason.

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. Let us lead by example by investing in an integrated maternal, newborn, and child health strategy that is built on evidence and that maximizes its investment by providing comprehensive sexual and reproductive health services.

Thank you very much.

● (1540)

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you very much.

Next we will hear from the Fédération du Québec pour le planning des naissances.

**Ms. Ainsley Jenicek (Project Manager, Fédération du Québec pour le planning des naissances):** Thank you very much. I too am very humbled by the co-presenters I have the honour to present alongside.

[*Translation*]

Thank you very much for inviting our federation to make a presentation today. We really appreciate the opportunity to deliver our point of view. In my presentation, I will address the topic of abortion in the context of the recent confirmation of the fact that the Government of Canada will not be financing such services as part of its maternal and child health initiative at the G8 Summit.

I will first explain why abortion services are inseparable from maternal and child health in general. I will close by explaining why the strategy of refusing funding for abortion services is ineffective.

First, abortion is a fundamental component of maternal health. A false distinction is often made between abortion and maternal health. It is as if the women who chose abortion and mothers were different women. But we forget that mothers are often the ones who need abortion services. There is also a lack of understanding of the link between abortion and child health. In reality, more than 220,000 children lose their mothers each year due to unsafe abortions. So it is a lot more likely that, without their mothers, those children will die.

In addition to children who suffer as a result of losing their mothers, it would be inhuman to deny women in poorer countries those essential services. The majority of the 42 million abortions performed around the world annually take place in developing countries. Approximately 70,000 women die each year due to unsafe abortions.

[*English*]

That means seven women die per hour every year from unsafe abortions.

[*Translation*]

Five million women are hospitalized because of complications resulting from unsafe abortion and this number does not even include the other three million women who do not have access to a hospital. The complications those women are experiencing can have short-term and long-term consequences that would cost their governments more money than funding safe abortion services.

In Canada, and in most developed or rich countries, we have access to safe abortion services. These services, in addition to being essential health care services, meet women's need to be in control of their bodies and, therefore, of their lives. Refusing to recognize that fundamental need perpetuates not only a flagrant injustice between women from the south and women from the north, but also denies women their universal rights.

Canadian and Quebec women have fought for these rights. We must not allow our government to dictate to women from poorer countries what they can and cannot do with their own bodies.

[*English*]

I'll move on to my second point, which is simply that refusing to finance abortions abroad does not actually reduce the rate of abortions.

We can learn a number of key lessons from former President George Bush's reinstatement of the Mexico City policy, also commonly called the “global gag rule”, the policy that denied U.S. aid funding to NGOs that performed abortions, provided counsel and references related to such services, or lobbied for the legalization of abortion in their country. U.S. aid was even cut off from organizations that used non-U.S. funding for these activities.

Its main lesson is, to repeat, that refusing to finance abortion services abroad does not actually reduce their frequency. When legal and safe abortion services become less available, the only thing that changes is that women seek out unsafe procedures or try to self-abort, and these procedures often occur under unsanitary and dangerous conditions. Refusing to fund safe abortion procedures therefore bolsters the rate of maternal death, infection, and long-term consequences, such as infertility. Let us remember that 13% of maternal deaths across the world are due to unsafe abortions. The most effective way to reduce abortions is to reduce the number of unintended pregnancies. The way to achieve this is to increase the availability of family planning initiatives that include abortion services.

Why include these services?

It's because contraception alone is not enough. It often takes decades for contraception to be broadly introduced and accepted, meaning that abortion continue to be an important recourse. Reliable access to contraception is also nearly impossible for some of the world's poorest women, including adolescents, refugees, victims of sexual coercion or violence, or those suffering from chronic illnesses, such as HIV/AIDS. Even where contraception is broadly available, abortion services continue to be needed, because no contraceptive method is 100% effective.

The global gag rule also teaches us that refusing to finance NGOs that provide abortion-related services only interrupts, complicates, or even shuts down family planning programs. In other words, cutting off funding from abortion-related services weakens maternal health initiatives. Faced with restrictions placed on funding during the global gag rule, numerous NGOs concluded that it would be unethical for them to cut any mention of abortion out of their family planning programs. They were therefore cut off from U.S. aid, causing many to reduce their staff power and their services and to even close clinics.

We should note that the global gag rule even applied in countries where abortion was legal, meaning that the global gag represented an affront on poorer countries' sovereignty. It also undermined the promotion of democracy abroad, notably the fundamental democratic principle of free speech and open public debate.

Finally, while the global gag rule affected women on the international stage, it was part of a broader strategy to diminish the rights of women domestically and abroad, sometimes called “Bush's other war”, the war on women's reproductive and sexual rights.

In conclusion, a maternal heath initiative that includes contraception but not abortion will be insufficient in helping women.

● (1545)

[*Translation*]

We must remember that the principles of free choice and self-determination are shared by most Canadians. In April 2010, an EKOS poll showed that the majority of Canadians are pro-choice. They know that, even if we do not want to use abortion services ourselves, these services must be available to women who need them.

I urge you to use your privileged status and influence to encourage the Conservative government to change its position on funding for abortion services abroad.

Thank you very much.

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you very much.

We will now move on to the International Confederation of Midwives and Bridget Lynch, who is the president.

You have 10 minutes.

**Ms. Bridget Lynch (President, International Confederation of Midwives):** Thank you, Cathy.

It's a pleasure and a privilege for me to be here to speak on behalf of midwifery and the role that midwifery has to play in the reduction of maternal and newborn morbidity and mortality globally.

I want to start off by talking about this at an international level. Then I'd like to come back to look at what we're doing here in Canada as well, in terms of the potential recommendations coming out of your committee.

In *The Lancet* , in 2005, midwives were identified as the key health care providers for reducing maternal and infant morbidity and mortality globally. In 2008, the World Health Organization identified that among the 1.2 million health care workers needed to improve health systems globally, we needed 350,000 more midwives to attend to the issue of the high levels of morbidity and mortality.

When we look at the role of midwives in sub-Saharan Africa and in South Asia, where they have the highest incidence of maternal and newborn morbidity and mortality, we see a virtual invisibility of midwives in those countries. Midwives are often lost, in terms of their identity, within the ranks of those covered by the overarching term “health care workers”.

One of the issues that's really being highlighted this year is the issue of the female health care workforce and the low level of support and recruitment into the female health care workforce, especially in the low-resource countries where women and their infants are dying.

One issue that has been identified, and this is extremely important when we're looking at addressing maternal and infant mortality and morbidity, is the role of midwives in normal newborn and normal birth care. The facts are that 85% of all births in healthy women are normal. In most of our countries, in our own reference points, we have become very used to physicians and obstetricians taking on the greater part of care for maternal and newborn care.

In looking at the best health care providers for the continuum of care that has been identified, it is really important, in addressing human as well as economic resources, that if a mother survives, then, as you've said, her newborn and her older children have a much higher rate of survival as well. The continuum of care is basic to midwife care. Our scope of practice covers antenatal care through childbirth care, through looking after the mother in the postpartum as well as looking after her newborn.

In terms of the best use of resources, we should be working with countries and encouraging the G8 to identify the specific role of the midwife. Currently, and in most of the literature that's out there, we're still talking in vague, overarching terms and addressing this as a health care workforce issue. The problem is, unless we start to identify midwives and the need to develop a midwifery workforce, we will not accomplish the education, the regulation, and the professional development that midwives need at a global level.

The International Confederation of Midwives represents 250,000 midwives in 95 countries globally. One of the biggest issues that has been identified in the low-resource countries is the lack of good education for midwives, lack of standards of education, lack of regulation, lack of full integration into multidisciplinary teams of health care workers, lack of recognition by pediatricians, lack of recognition by obstetricians, and lack of recognition by governments of the important role that midwives can play in determining maternal and newborn health policy.

Midwives provide family planning, and in some countries are attending at first trimester abortions. We provide sexual and reproductive health care. We prevent mother-to-child transmission of HIV. We provide treatment for malaria. We provide bed nets. Most importantly, we provide women-centred care. Finally, coming onto the international agenda has been very important. It's not just important that a mother and her newborn survive, but that a mother survives with dignity and is treated with dignity.

● (1550)

It's very important in Canada that we recognize the role of midwives here in this country; we have developed one of the strongest models of midwifery care in the world.

The three pillars of any strong health care profession are a good education system, a strong regulatory system, and a strong professional association that can contribute to policy development and can work as colleagues and in conjunction with our other health care professionals.

Canada has developed a profession of midwifery that recognizes and respects the right of a woman to choose her place of care. This is the only jurisdiction in the world where women are supported in choosing their place of birth. We are required to provide women with informed choice in all decision-making, putting them at the centre of their care, and we are required to provide a continuity of care provider for women so that they are not seeing multiple health care providers during the course of their pregnancies and their childbirths.

Quebec has the only four-year undergraduate degree program in French for midwives in the world. The Maison de naissance is located in Quebec, the only jurisdiction in the world where midwife-led, out-of-hospital maternity facilities have existed for 10 years. It's a tremendous model that is being talked about globally. Nobody knows, not even here in Canada, if we really recognize this particular model and its success and the fact that many women in Quebec have chosen this model.

In fact, when they did a survey of women in the 1990s as to their preferred place of birth, the women of Canada chose an out-of-hospital birthing facility.

I want to come back to Canada before I end. The unanimous all-party resolution that went through our Parliament last June 5 called for the Canadian government to renew its commitment to reducing maternal and infant mortality and morbidity globally and to improve maternal and newborn health here in Canada.

I do want to make a plea that Canada join the ranks of Holland and Great Britain and develop a national strategy for maternal, newborn, and child health. It's so important to take this opportunity not only to look outside our country but also to look at the ways we can improve what's taking place here in Canada.

We need to improve our perinatal surveillance system. We still don't have all provinces on board with a cohesive national perinatal surveillance system. We don't really even know what's taking place at many demographic levels here in our own country. In strengthening the demographic components of the perinatal surveillance system, we need to look at health indicators, including diabetes, tuberculosis, and hypertensive disorders. We need to look at proximity to care. We need to address the social determinants of health and access to fresh food in our inner cities and in our remote communities. We need to address clean water and sanitation as we look at improving maternal, newborn, and child health in our own country. We need to address issues of safety and security at the personal and community levels.

We need to strengthen the continuum of care approach to maternal, newborn, and child health in our own country. We need to encourage our professional associations, pediatrics, obstetricians, nurses, and midwives to work together. They need to be invited to the table by the federal government to also identify maternal, newborn, and child health areas of research.

● (1555)

We need to have coordinated research efforts in this country to look at improving maternal, newborn, and child health—

**The Vice-Chair (Mrs. Cathy McLeod):** Could you quickly wrap it up? You're over time.

**Ms. Bridget Lynch:** The last piece I want to identify—and this is extremely important—is adolescent health. It's not thought of when we look at maternal and child health. The largest reason for death among adolescent females globally is pregnancy and childbirth. We need to identify this as an at-risk population. We need to look at the influence of drugs and alcohol. We need to pay specific attention to our inner-city, native, and immigrant adolescent populations.

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you so much.

We'll now move on to Lorraine Fontaine. She's with the Regroupement Naissance-Renaissance.

Welcome.

[*Translation*]

**Ms. Lorraine Fontaine (Coordinator, Political Issues, Regroupement Naissance-Renaissance):** Good afternoon. As a mother, grandmother and childbirth advocate, I am honoured to have been invited to speak to you on behalf of my organization, Regroupement Naissance-Renaissance, which has been a part of the movement for the humanization of childbirth and the perinatal period—pregnancy to one year after birth—for the past 30 years in Quebec.

This afternoon, I would like to present a woman's perspective on maternal and infant health and bring to your attention an innovative initiative that addresses our concerns about women's autonomy in decision-making regarding childbirth, and focuses on the importance of treating women with respect and dignity. All local and international policies, programs and initiatives must respect the fundamental rights of women to self-determination regarding their own and their children's health.

● (1600)

[*English*]

You have been passed a copy of this document. I'd ask you to read it when I'm done. There are many details, but I want to draw your attention to four of the details in it.

The International mother-baby child birth initiative, or IMBCI, as I will call it, has already garnered widespread support and is modelled after the World Health Organization/UNICEF baby-friendly hospital initiative, with its 10 steps to successful breastfeeding. I quote:

> The purpose of the IMBC...is to improve care throughout the childbearing continuum...in order to save lives, prevent illness and harm from the overuse of obstetric technologies, and promote health for mothers and babies around the world.

It includes and builds upon an already widely accepted and implemented program that has saved millions of lives.

So these four steps that I'd like to draw your attention to are steps that we have identified in our organization, but they are also steps that the most active nations that are in support of IMBCI have chosen.

The first reads:

> Treat every woman with respect and dignity, fully informing and involving her in decision-making about care for herself and her baby in language that she understands, and providing her the right to informed consent and refusal.

The most important principle that we must hold to, all of us, in our work is that women must be treated with respect and dignity regardless of their economic status, country or culture of origin, physical abilities or disabilities, and any other recognized rights status. Women must be at the heart of all decisions regarding their reproductive health. The women who choose motherhood must be the ones to decide where, how, and with whom they give birth.

Step six reads, “Avoid potentially harmful procedures and practices that have no scientific support for routine or frequent use in normal labour and birth.” Caesareans are a good example of an intervention that has the potential to help, but also to harm. According to the World Health Organization, optimum Caesarian rates should be within 5% to 15%. This means in countries where the rate is 2%, women are dying from lack of obstetrical care. Conversely, in countries where the rates exceed 15%, we begin to see what borders on dangerous overuse of obstetrical intervention, manifested by increasing maternal mortality rates. Examples of C-section rates... Canada goes up to 26%; in the U.S.A., 30% to 40%; in Puerto Rico, 60%. We're beginning to see third-generation women who are having Caesareans. In Brazil, the rates are even higher.

We cannot just export the model we have put in place in North America and think we will save lives. According to the national birthing initiative for Canada in 2008, data released by the OECD in June 2006 indicates that we have slipped in rank from sixth to 21st regarding infant mortality, from 12th to 14th with regard to maternal perinatal mortality, and from second to 11th in maternal morbidity rates. I quote: “When it comes to maternity care in Canada, we must not assume that everything is OK.”

The third step I would like to point out to you is this:

> Possess and routinely apply midwifery knowledge and skills that enhance and optimize the normal physiology of pregnancy, labour, birth, breastfeeding, and the postpartum period.

You said it all, my dear. Thank you very much. But I would add that a very recent survey that was published on May 5, on international midwifery day, states that in Quebec, 26% of women of childbearing age would prefer to give birth with a midwife, but only 2% have access. So midwifery is a practice rooted, according to us, in the respect of women and their capacity to give birth, and it promotes a physiological birth and well-being in a culturally appropriate manner. We see all over the world midwifery practices and more traditional practices of midwifery disappearing. We need to do something about that as well.

The tenth step is the baby-friendly hospital initiative. It is part of the mother-friendly or the mother-baby initiative. They are connected. I particularly want to point out something about breastfeeding that all of you would know. The commercialization of breast milk substitutes in the seventies and eighties wreaked havoc on the lives of mothers and newborns in developing nations. Likewise, in the 21st century we must be vigilant so that childbirth does not become the stage for similar misplaced interests and consequent mistreatment.

● (1605)

The BFHI, or baby-friendly hospital initiative, is reinstating breast feeding to its proper place, not only as a life-saving and low-cost form of nourishment, but also—and this is also important—as a means of strengthening psychological and emotional mother-child bonds, notably through skin-to-skin contact immediately after birth.

A requisite for becoming a baby-friendly maternity service is adhering to the code of commercialization of breast milk substitutes. The IMBCI, the initiative that I proposed to you, is taking this a step further in filling an important gap by ensuring that childbirth and the mother's experience be included and seen as essential.

All of what I am saying to you today is also backed up by the UN Human Rights Council's resolution of November 2008, entitled “Preventable maternal mortality and morbidity and human rights”, which reaffirms the links between maternity and human rights.

When you separate women from their support networks and you separate mothers from their newborns, you break bonds that save lives. Like the baby-friendly hospital initiative, the international mother-baby childbirth initiative, when adhered to, will ensure maternal and infant health, reduce mortality and morbidity, and bring health to many babies and mothers.

However—and I conclude with this—we must not delude ourselves that these issues are problems only in developing nations. There is ample evidence of failures in our own system towards mothers and infants. From immigrant and northern communities to disabled and handicapped populations to young mothers, we are too often usurping women's individual and collective rights.

Health is more than the absence of death and disease. With respect to maternal and infant health, we must have a holistic vision that includes the social and economic environment in which mother and infant live. You all wished a happy Mother's Day to your own mothers yesterday, so you know well that motherhood is a long-term commitment. If we are not going to follow up on the BFHI and the IMBCI and all the other good initiatives out there with a commitment to continued improvement of the socio-economic well-being of women, children, and families throughout their lives, then we're creating a false hope and a potentially disastrous disservice to those whose lives would be saved.

Whatever actions we take to reduce maternal and infant mortality and morbidity must be done by and for women and with the support of a variety of organizations, including community-based ones. Funding for these community-based organizations needs to be strong and sustained, because we cannot improve maternal health without women and without those who are listening closely to women and working side by side with them.

[*Translation*]

So we recommend that the Government of Canada through its representatives, present the IMBCI to the participants of the upcoming G8 Summit as a means of both improving women and children’s health and promoting practices that will ensure their well being. Thank you very much.

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you very much to everyone for sharing their perspectives on this very important initiative.

We're going to go into our rounds. The first round is seven minutes for both questions and answers. As we get towards the end, I usually cut in to make sure everyone has a fair opportunity both for questions and for answers.

To begin, we have Ms. Neville for the Liberals.

**Hon. Anita Neville (Winnipeg South Centre, Lib.):** Thank you, Madam Chair.

Thank you all for being here.

This is our third panel, and there's again a great diversity of opinion.

My colleague asked whether Pierre would get a chance to speak. I assume he'll have the opportunity during the questions.

I have three thrusts to my questions. They all relate to the upcoming G8. I'm going to put all three out there and then ask you to respond.

First, Ainsley, I think you referred to this in your presentation. During question period in the House on Friday, the minister responsible for the status of women referenced at least four times the fact that, as we sit here, 24,000 children under the age of five die in the developing world every day. I think we all know that.

My concern or my question is to those of you who are actively engaged internationally. I would like to know about the mothers who die from abortions. Can you tell us about that? I've heard various statistics. Can you tell us about the impact it has on children, both in terms of their own mortality and their long-term well-being should they survive? That's question number one.

My second question is this. My colleague from Toronto Centre, Bob Rae, asked a question in the House last week in terms of abortion as it relates to rape. He particularly used the Congo as a reference because of what's going on there.

I was astounded by statistics that my office and my staff provided me with today. The information is from an organization called Solidarity Helping Hand. It says that one child is raped every three minutes in South Africa and 45% of rape victims in South Africa are children. I would ask for comments from those of you who do international work. What are the impacts on those children, and what is Canada's role?

My third question relates to the Canadian government and *The Lancet* editorial that we heard about last week. They said the Canadian government does not deprive women living in Canada. I don't want to read it all. It said that "bans on the procedure, which are detrimental to public health, should be challenged by the G8, not tacitly supported." Further:

> Canada and the other G8 nations could show real leadership with a final maternal health plan that is based on sound scientific evidence and not prejudice.

Again, my question to all of you is this. How do you see Canada's role in providing leadership to the G8, given their limited response to women's productive rights?

Those are my three thrusts, to whoever wants to go first.

● (1610)

**The Vice-Chair (Mrs. Cathy McLeod):** We have about three and a half minutes left to try to tackle a number of issues. Who would like to try to tackle any one of the three questions that have been put forward?

**Ms. Jolanta Scott-Parker:** I can start with the last one.

In response to the question on the G8, I think the important thing is that we move forward with an integrated and comprehensive approach. I think it's perhaps what *The Lancet* article suggested in terms of not leaving out pieces of it. The evidence shows that a comprehensive strategy that addresses sexual and reproductive health and rights as part of a strategy for maternal and child health is critical. All the evidence supports that.

We also know that a menu-based approach to funding, where we have different countries picking different pieces of it, doesn't provide the type of cohesive joint strategy that is called for under these circumstances.

I guess that would be my response to the third question.

Do you want to try answering one of the other ones?

**Mr. Pierre La Ramée (Director, Development and Public Affairs, Western Hemisphere Region, International Planned Parenthood Federation):** Picking up also on the third question, as a Canadian living in the United States for quite a number of years I have often found myself feeling rather smug vis-à-vis my American colleagues, given many of the issues and conflicts around sexual and reproductive health in that country, issues like the global gag rule that has already been mentioned, for example. I find myself now in the very peculiar position of having to defend my own country when people approach me with some of the same questions about what's happening with Canadian policy: "Why are these positions being taken by your country?"

My personal embarrassment at this is very small in comparison with the potential consequences of this backsliding in Canada's vaunted and well-deserved leadership role on all of these issues for quite a number of years, and I think Canada should regain a leadership role in the G8, along with the rest of our G8 colleagues, and basically show the wider community of nations the direction in which we should be going on maternal mortality.

**The Vice-Chair (Mrs. Cathy McLeod):** We have a minute left. Does anyone want to tackle that?

Ms. Fontaine.

**Ms. Lorraine Fontaine:** Regarding reproductive rights and the backsliding and what not, I'm thinking of two changes that were recently made, which I read about. I think you would probably know better than I would. In the charter of rights in Iran, they decided to change the word "rights" to "protecting women". What did that represent? I was reading an article about that. When we see women as victims—victims of violence, victims of disease, victims of poverty, and all of that—then we want to go in with compassion, and that's a good reason to want to go in, but my main point is that women are not just victims. They are actors within their situation. They are the principal actors within their situation, and they have to be involved in the decision-making.

So when there is talk in Canada about being afraid of the words "rights" and "defending our rights", we shouldn't be afraid of those, because empowering women is part of democracy.

● (1615)

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you.

We now move to Madame Deschamps.

[*Translation*]

**Ms. Johanne Deschamps (Laurentides—Labelle, BQ):** Thank you, Madam Chair. I will try to be quick, but this is an important issue. I am surprised to see that we are still discussing the right to abortion in 2010. Thank you for your testimonies. They were very stunning.

Mr. La Ramée, the Secretary of State, Hillary Clinton, recently paid us a visit. She made a rather sensational statement. We can assume that the U.S. is now showing a degree of openness to abortion and contraception.

**Mr. Pierre La Ramée:** I will answer in English since that will be a lot faster. It is a lot easier for me.

[*English*]

There already has been a substantial reopening of discussion on both abortion and of course sexual and reproductive health in general in the United States under the Obama administration. Certainly, as Secretary of State, Hillary Clinton plays a very important leadership role in that respect, but we can see in the appropriations for foreign assistance, for example, that the largest amount ever appropriated in U.S. history for reproductive health—or family planning, as they tend to call it—was passed.

In terms of the issue of abortion, there are a number of issues that will, I think, restrain progress. First of all, there's the difficulty of dealing with the Congress, where in spite of having a large majority, as we saw in the debate on health care, there are a number of Democrats who have anti-choice views, so that puts certain limits on the administration's ability to move forward.

Nevertheless, one of the first things President Obama did was to rescind the global gag rule, and there are currently some very strong initiatives to try to get a permanent rescinding of the global gag rule so that no future administration can re-implement it.

[*Translation*]

**Ms. Johanne Deschamps:** It is said that we are furthest behind on goal 5, which deals with maternal health but also with child health. Last year, countries agreed to make it a priority and move forward with it. In June 2009, Canada co-sponsored a resolution of the United Nations Human Rights Council that recognizes maternal mortality and morbidity as a pressing human rights issue.

This year, we are celebrating the 15th anniversary of the Beijing Platform for Action, in the context of which governments from around the world, including Canada, reaffirmed that reproductive rights are based on the recognition of the fundamental right of all couples and individuals to freely and responsibly decide the number, the spacing and the moment of births, the right to have access to information and means to decide, and the right to receive the highest level of sexual and reproductive health.

We earned that fundamental right here in Canada. We fought and now it is written: women have a right to abortion. How is it that having control over our own bodies is part of our fundamental right but we do not promote it abroad although we want to move ahead with the goal we are furthest behind with? How is it that we do not promote this right in the poorest countries where women have no choice and where, often, their husbands dictate their choices? I do not understand, and if there is no global consensus on all services, including abortion and contraception, we will completely miss the target. I think we will have to forget about achieving the goal for the year 2015.

● (1620)

**Ms. Ainsley Jenicek:** It is precisely why we cannot say that we do not want to address divisive topics for the Canadian population, since the majority of Canadians are pro-choice. Also, maternal health is not a neutral subject. It is impossible to be neutral on this topic; it is always a very politicized topic because we are talking about women's bodies and lives. So I am pleased we agree.

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** Ms. Fontaine.

[*Translation*]

**Ms. Lorraine Fontaine:** I have made a point about the marketing of breast milk substitutes and its corollary to birth. What also worries me is what is going on with women's bodies. This attack on abortion is an attack on women's reproductive health; I get the impression that a woman's body is a territory occupied by pharmaceutical companies, corporations and economic interests. I am very concerned about the fact that abortion is being proposed as a topic for a great dialogue and a source of conflicts and obstacles, and I suspect that we are going to have to "slip one by" because there are other interests. I hope not.

I hope we are not trying to make money at the expense of women, as is the case in the south, in the US where 66% of hospital revenue comes from mothers and newborns.These questions must be asked.

**Ms. Johanne Deschamps:** Ms. Lynch?

[*English*]

**Ms. Bridget Lynch:** Yes.

You asked how we can achieve MDG 5 with this as an issue. We have to be very careful here. There are women who don't have access to basic maternal, newborn, and sexual reproductive health care, and in Canada we risk having this discussion turn completely to one of abortion.

We have to be careful that we don't get sidelined into this trap. We have to be very strategic as women. We need essential health care delivered at the household and community levels so that women and their newborns and children are not dying. The discussion on abortion needs to happen as well, but we can't forsake one for the other.

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you.

Ms. Brown is next, please.

**Ms. Lois Brown (Newmarket—Aurora, CPC):** Thank you very much, Madam Chair.

I think it's very important that we set the record straight here and say that there are many places where abortion is illegal. The Republic of Congo is one of those countries. Canada must respect the sovereignty of these nations, and if other discussions need to go on, that's for another debate.

Canada has chosen to take a leadership position on the issue of child and mother health because we know that as a millennium development goal it has received the least recognition and the least amount of money has been put toward it. So Canada is taking a leadership role on this. It's a very complex and difficult issue, but we know that we have services, we have expertise, and we can make a difference.

I want to refer you to an article that was in today's *Globe and Mail*. I understand that Bob Geldof and Bono were given the opportunity to be editors-in-chief for a day, given their long interest in Africa, which I think is quite remarkable, and they're outlining some of the things that are really changing in Africa. They talk about a growing middle class. "Africans are subscribing to mobile phones at an astounding pace, an increase from 54 million to 350 million, or 550 per cent", and it goes on to say afterwards that this alone is changing how Africa is responding to different areas. It talks about merchants and farmers texting to find out latest market prices. It talks about "Africans can now find out when a medical professional might be available, saving an hours-long walk to town." So we're seeing some considerable differences.

I pose my question to Ms. Lynch, if I may.

I happened to spend some time last year in Bangladesh. I was introduced there to women in the villages. Sasthya Sabika is the term they use for them, but essentially it's the women who were being given the basic training to become midwives and to give basic medical care. You talked about the need for 350,000 more midwives internationally, I think.

What do we need to do to encourage young people to engage in this? Are there opportunities for men in this field? Do we call them mid-husbands? I don't know. What recommendations can you or your association make to the Canadian government to ensure that we put the incentives forward for young people to choose this as a profession?

I know that for years Canadian women used to have to go overseas to get their midwifery licences, particularly to Scotland, I think, where there was a very excellent course. But how do we create exposure for this profession, and encourage that, because we know Canada has expertise in this area?

● (1625)

**Ms. Bridget Lynch:** We do thank you for your question. It's a very important question: how do we move forward?

As we speak today, there's no global standard for midwifery education. What this means is that various countries have invented programs to educate midwives. The International Confederation of Midwives, along with the World Health Organization, as we speak, has a global task force that is developing an international standard for midwifery education for governments to use as reference points for educating midwives. This will allow governments to also create a career path for midwifery. In too many countries midwives have an 18-month training period, a two-year training period, and there's no opportunity to complete an undergraduate degree program and go on into master's, post-graduate work, etc., to get into policy development and research.

Upholding and supporting the development of education programs as a way to build a midwifery workforce globally is one of the most fundamental and essential pieces of work that Canada can contribute to in terms of its actual contribution to workforce development. The other is to help countries develop regulations and standards of practice for not only midwives... In many countries, such as Haiti, there are no regulations and standards of practice for any health care profession in that country.

In terms of Bangladesh, I was there as well. When you have the community health workers who are being trained to attend normal childbirth, they must be supervised and trained by a cadre of midwives. That cadre is missing right now, so the countries are developing tens of thousands of community health workers, doing normal birth, but they're not paying attention to who is supervising and training them over the long term.

**Ms. Lois Brown:** Is that expertise Canada can assist with?

**Ms. Bridget Lynch:** Absolutely.

**Ms. Lois Brown:** Do we have people at that level who could create the education and the curriculum?

**Ms. Bridget Lynch:** The Canadian midwifery education program is being used as one of the stellar models for midwifery education globally.

**Ms. Lois Brown:** You talked earlier about the continuum of care they provide. You're talking about helping them learn about nutrition and clean water—that was one of the problems we observed in Bangladesh.

**Ms. Bridget Lynch:** Yes. Midwives work from the household through to the hospital setting. So that's the most vulnerable service delivery area. That's where the midwifery competencies really have the highest advantage in providing antenatal care, intrapartum care, making sure women have clean water, making sure there's good nutrition, and getting involved at that community health level. That's where midwifery services work.

What we want is that a midwife is a midwife is a midwife. Whether they're male or female—and there are many countries that have male midwives—in Bangladesh, Argentina, or Canada, we need to have a global understanding that they've been educated to the same level, that they are regulated, and that they have standards of practice at the same level.

**Ms. Lois Brown:** If I have time, Madam Chair, could I just pose a question to Ms. Fontaine?

You spoke about breastfeeding and encouraging women to breastfeed because it is the most appropriate way to nurture a child. However, one of my observations when I was in Bangladesh was that three, four, and five crops were being taken off the same piece of land without any nutrients going back into the soil. So the value of the nutrients is limited. And what we're saying, as the Canadian opportunity or contribution—

● (1630)

**The Vice-Chair (Mrs. Cathy McLeod):** She didn't leave you any time for an answer.

Ms. Mathyssen.

**Ms. Irene Mathyssen (London—Fanshawe, NDP):** Thank you, Madam Chair.

Thank you for being here. Thank you for this expertise.

I have a number of questions.

I want to start with you, Ms. Fontaine, because you've touched on something that I explored at length with my students. It is the whole issue of the multinationals intervening in countries and providing short-term milk products to new mothers, which interfered with their ability to breastfeed. That led to incredible disruption, baby deaths, and all kinds of quite horrendous things.

I know Nestlé was one of the companies that was targeted. There was a 10-year boycott, and they eventually got the message. But you've indicated that it's still going on. Can you describe what is happening and how these multinationals are continuing to operate in a reprehensible way?

**Ms. Lorraine Fontaine:** In Quebec we put together a premise on how to support breastfeeding. We have many baby-friendly hospitals in Quebec, and breastfeeding is taking on a kind of new renaissance. Part of the code of commercialization does not allow hospitals to receive gifts from companies that make substitutes for breast milk. So if you can't receive the gift, the companies can't send their ads, and if they can't send their ads, they have to find someplace else. So they find the Internet and all kinds of other ways to get their message out. Of course, they're really good and have lots of money to advertise about that. That's one of the things.

Another example of what's been happening recently is in Haiti. I was at the Coalition for Improving Maternity Services in February, and we had a midwife who worked in Malaysia speak to us about Haiti. She said one of the first things that happened was that Nestlé dropped off their milk and said, “Aren't we good? We're bringing all these substitutes for milk.” But they didn't have clean water and the circumstances under which to sterilize bottles. She told the mothers to give it to their babies if they were walking. It has stuff in it and it isn't all bad, but it's not the kind of milk infants need.

The other issue you raised has to do with the environment. She was telling us about Malaysia and the women there. The rice they were eating 10 years ago had all the nutrients they needed, but now that we have GMOs and things that are denuded of all the nutrients, they have to give vitamin supplements to the mothers in order to allow them to have healthy babies and not hemorrhage after childbirth. So the commercial interests are sort of sneaking in all over the place, and we need to be vigilant.

**Ms. Irene Mathyssen:** Thank you.

Ms. Jenicek, you made mention of the Bush gag rule, and I think you described the impact of it very well. You called it Bush's other war. Ms. Fontaine, you made reference to it too: Bush's other war, that other agenda.

What hidden agenda are you fearful of?

**Ms. Ainsley Jenicek:** That's referring to a document produced by the International Women's Health Coalition. I believe it's called “Bush's Other War”, his war on reproductive and sexual health of women. It has to do with the repealing of all progress made over the last few decades in these areas to advance the rights of women. To emphasize it, 60% of the world's 1.55 billion women of reproductive age live in countries where abortion is broadly legal. That is why there is a reluctance about our government repeating such mistakes.

To come back to the fact that where abortion is illegal within Africa and Latin America, these laws tend to be holdovers of the colonial era, where European colonizers imposed these laws; they have since liberalized their own abortion laws, but these laws continue on in their former colonies. Hopefully that'll give you a sense of that.

Bush's other war is very much connected to the cutting of financing of women's groups domestically at the same time as these abortion services are denied internationally, in preparation for the repeal of abortion rights within the domestic borders.

● (1635)

**Ms. Irene Mathyssen:** It's cutting funding to women's groups for research, or advocacy, or...?

**Ms. Ainsley Jenicek:** Yes. I mean a broad range of activities. There are no specific activities that stand out in my mind. Their document is so thorough that I would be hesitant to try to summarize it here. They have pages and pages of different assaults on women's rights, reproductive and sexual rights, domestically and internationally, on their website.

**Ms. Irene Mathyssen:** I'd like to have that document.

**Ms. Ainsley Jenicek:** Yes, absolutely.

**Ms. Irene Mathyssen:** I appreciate that very much.

This reference, in terms of this colonial attitude, underscores the Maputo plan. We heard about that in our committee work a few days ago. It does makes sense and it does sort of begin to blend together.

Is there anyone else who would like to comment?

Mr. La Ramée.

**Mr. Pierre La Ramée:** I'd like to say a little bit about abortion in Africa and Latin America. It would be a misrepresentation to say that abortion is illegal in Africa and Latin America. The fact is that in the majority of countries in Africa and Latin America it's legal under some circumstances. In countries where it is not legal, the Democratic Republic of the Congo being a case in point, Canada's concern shouldn't be to try to impose its laws or its values on the Democratic Republic of the Congo. Rather, I would hope that Canada would be concerned with rape as a weapon of war and the large number of women who die from unsafe abortion, because in a circumstance where abortion is not legal, this becomes a major contributor to maternal mortality.

**Ms. Irene Mathyssen:** Ms. Fontaine, you talked about slippage in terms of Canada's child and maternal health and infant deaths. That astounds me. Why on earth are we going backwards in our own country?

**Ms. Lorraine Fontaine:** You know what? I'm just going to say it's the threshold of intervention.

**The Vice-Chair (Mrs. Cathy McLeod):** Very good.

We're now onto our next round. It's five minutes each, and we'll start with Mrs. Simson.

**Mrs. Michelle Simson (Scarborough Southwest, Lib.):** Thank you, Chair.

I'd like to thank the witnesses. This has been very interesting and informative.

I'd like to start by asking you all a question. I'd just like a one-word response. I only have five minutes, so I'm going to keep it short.

We've heard testimony from witnesses during the course of this study that access to full reproductive and sexual health care is not just a health issue, but it's a basic human right. Would you agree with this view or not?

**Mr. Pierre La Ramée:** Yes.

**Ms. Jolanta Scott-Parker:** Yes, absolutely.

**Ms. Ainsley Jenicek:** Yes.

**Ms. Bridget Lynch:** Yes.

**Ms. Lorraine Fontaine:** Yes.

**Mrs. Michelle Simson:** Thank you.

I'd like to also pick up on a few things that Ms. Brown had to say with respect to how Canada should be viewed as not interfering in terms of countries like the Congo, where abortion is illegal. Would you not think that the flip side of that is where it is legal, and our failure to provide full family planning, which we do in our own country...could that not be viewed very much as a significant foreign policy shift, because it's not domestic policy, and that it is also, to some degree, some form of political interference from our country by trying to impose our values in some of these developing countries?

**Ms. Jolanta Scott-Parker:** I have a couple of comments.

It's important to refer back to the many consensus documents that exist in the international context in terms of what is required. I also think it's important to refer back to the Paris declaration on aid effectiveness, whereby we agree to be directed by individual countries in terms of what they need for their health systems and for their development dollars. In both of those cases we would be deferring to those countries themselves. And then it's important to refer back to the international agreements, where we've outlined a broad spectrum of needed interventions.

We've heard today about even more diversity than what we'd heard about in some of the other days of testimony, in terms of skilled attendants, family planning, as well as safe abortion, where abortion is legal. It's all laid out there. They are effective health systems. The evidence is all there.

● (1640)

**Mrs. Michelle Simson:** Would you not agree, though, that it's rather bizarre that we're trying to impose certain restrictions that we don't even have within our own country?

**Ms. Jolanta Scott-Parker:** Sure. Absolutely. I think we need to follow what's there internationally and not try to export our own values, but rather—

**Mrs. Michelle Simson:** But this, obviously, isn't our own value, because we don't restrict the women here.

**Ms. Jolanta Scott-Parker:** Fair enough.

**Mrs. Michelle Simson:** That's the part I find bizarre, but in any event...

Ms. Jenicek, would you like to answer?

**Ms. Ainsley Jenicek:** I would just like to wholeheartedly agree that we should not try to impose present government values on a foreign country.

But I just want to come back to the fact that we must really remember that when it comes to abortion services... As Bridget Lynch mentioned, there is a whole host of issues. That's why I'm so glad there are such diverse voices on the panel today. Abortion services are linked to infant and child health. The children who lose their mothers, worldwide, are ten times more likely to die within two years. Those under a year old have an 80% chance of dying in childhood. For those under five, more than half will not reach adulthood. I would just come back to that.

**Mrs. Michelle Simson:** Thank you.

**The Vice-Chair (Mrs. Cathy McLeod):** You have one minute.

**Mrs. Michelle Simson:** There are so many aspects to this. Again, do you not see this as a shift in foreign policy, a really significant shift in Canada's foreign policy abroad?

**Ms. Lorraine Fontaine:** Is this a one-word thing again?

**Voices:** Yes.

**Mrs. Michelle Simson:** Yes, certainly.

**Ms. Bridget Lynch:** Yes.

I just wanted to speak to the democratic piece of this as well. We fought so hard and long in this country for women to be respected, for their voices to be respected. This isn't just about abortion; this is about not respecting women's voices. It's much larger than an abortion issue. It's silencing, taking the voice away and taking the choice away from other people. And hypocrisy doesn't even begin to address the significance of this.

But my fear is that we're getting sidelined in another debate, and we're using an international arena to have a debate. There's a lot of politics at play here, and we have to be careful about what rabbit hole we might fall down.

**The Vice-Chair (Mrs. Cathy McLeod):** We're now on to Ms. Wong.

**Mrs. Alice Wong (Richmond, CPC):** Thank you, Madam Chair.

And thank you, all of you, for coming.

I want to set the record straight. On May 4, Margaret Biggs, the president of CIDA, clearly stated that this is not a policy change, that this government did not change any policy on abortion, and it is not imposing ideology. I just want to make that straight.

I think my colleagues have been quoting a lot from *The Lancet* report, and I would like to quote as well:

> In fact, researchers and health leaders in the field of child and maternity health in developing nations say that the rough outline for a Canadian strategy unveiled at the G8 meeting of development ministers in Halifax, Nova Scotia, amounts to a highly promising boost for evidence-based international health programs.

That was from Paul Christopher Webster, in the *Canadian Medical Association Journal*. In fact he is also the author of *The Lancet* report.

I would like to quote another person and then pose my question. Jean Chamberlain, executive director of Save the Mothers, a medical education program focused on maternity and child survival in Mukono, Uganda, concurs, and I quote:

> I applaud the focus on child and maternal health, which are inseparable.

All of these quotes are from the *Canadian Medical Association Journal*.

Honourable officers can just cherry-pick the quotes that justify their political tactics. I agree 100% that this should not be used as a political agenda. This should be focused on people who are in need in developing countries—for example, the children who are dying because of insufficient food and the mother who cannot have good milk for the baby because of malnutrition.

I actually agree with what Ms. Lynch just said. Let's focus not just on the destructive and other things that are strictly political but on the actual needs of the mothers and the children.

Can you further comment on the real needs of the mothers and the children in these countries, please?

● (1645)

**Ms. Bridget Lynch:** Yes, and not to misquote Ms. Lynch... because Ms. Lynch wants to be really, really clear that Canada is playing horrific politics right now.

And when I'm saying it's politics, it's going to cost women's lives. Now we're put in a position of having to compromise what we do instead of doing the best job and giving the best leadership we possibly can.

As a Canadian and as a woman, I want to identify that I am horrifically embarrassed by what my country is saying. That voice of my country is as much my voice as it is the government's voice. I really wish that the voices of women in this country could be heard loud and clear internationally, that we disagree with this aspect of this Canadian proposal.

Having said that, we have to do the best job we can to get money at the table at the G8. We have to have commitments, not just verbal commitments, and this is where the rubber hits the road. We have to put money into maternal, newborn, and child health. We have to get it into the health systems. We have to be building health systems. We have to be developing workforces. We have to do the real work on the ground, beyond the talk.

**Mrs. Alice Wong:** Yes, I agree. However, at the moment if you want the mothers and the children to live, we have to pay attention to clean water, good food, good medical support, and also access to medical support staff like you. I think these are some of the practical issues we should bring to the table.

I think this aspect has been applauded by those who are at the table as well. Yes, women's voices should be heard, and I think we should not just focus on one issue that doesn't really help in those areas.

**The Vice-Chair (Mrs. Cathy McLeod):** We have 20 seconds and lots of people who would like to respond.

Mr. La Ramée.

**Mr. Pierre La Ramée:** I think all of the issues you mentioned are critically important. But when you're talking about maternal mortality, the continuum of care is very well understood. There's a global consensus on it. What ultimately will save women's lives is providing universal access to sexual and reproductive health.

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you.

Now we're on to Madame Demers.

[*Translation*]

**Ms. Nicole Demers (Laval, BQ):** Thank you, Madam Chair.

Thank you very much for being here this afternoon. My first question is for Mr. La Ramée and it is will be quick.

You are waiting for funding. Have you received it?

[*English*]

**Mr. Pierre La Ramée:** Ah, no.

[*Translation*]

**Ms. Nicole Demers:** Thank you.

I understand what you mean, Ms. Lynch. It is very political right now.

Is it not a little ironic that, in order to support an initiative that will save 300,000 women in the long run, we must let 70,000 die because we do not want to talk about abortion and we do not want to include that procedure in the initiative? Does that not seem a little unhealthy?

Personally, I only see the number of women dying, regardless of how they die. I also see the children who are left behind and die as a result. Could you give me an answer?

**Ms. Lorraine Fontaine:** Yes, we agree. I think it is a one-word answer, as Ms. Simpson asked us earlier.

[*English*]

**Mr. Pierre La Ramée:** I'd like to respond a little bit, though, to your first question.

Our understanding is that the application for funding is still being reviewed. It is still pending. We have not yet received a response, either affirmative or negative.

[*Translation*]

**Ms. Nicole Demers:** Since when have you been receiving funding?

**Mr. Pierre La Ramée:** Since around 1960, I think.

**Ms. Nicole Demers:** Since 1960? Has the work of your organization always been recognized?

**Mr. Pierre La Ramée:** Yes, it certainly has. It is the largest international and non-governmental organization in the world in the field of reproductive and sexual health.

● (1650)

**Ms. Nicole Demers:** And did CIDA provide you with the funding?

**Mr. Pierre La Ramée:** Yes, it has always been CIDA.

**Ms. Nicole Demers:** Are there any reasons for the current delay?

**Mr. Pierre La Ramée:** It may be because of the process adopted by CIDA.

**Ms. Nicole Demers:** But CIDA gave quite considerable amounts of money to two religious organizations in western Canada. Does it not concern you that you have received no news?

[*English*]

**Mr. Pierre La Ramée:** Well, let me answer in English, and it will go a little bit more quickly.

In our previous review, there was in fact a delay, so we are trying to be optimistic and we are hoping that the delay is basically because of bureaucratic procedures, as occurred in the past. But the funding has always been renewed. And in fact it was renewed basically by this same government, at least prior to the last election.

[*Translation*]

**Ms. Nicole Demers:** Would you please keep the committee up to date?

**Mr. Pierre La Ramée:** Sorry?

**Ms. Nicole Demers:** Would you please keep the committee up to date on the situation of your organization?

**Mr. Pierre La Ramée:** Yes, of course.

**Ms. Nicole Demers:** Thank you very much.

Madam Chair?

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** You still have two minutes.

[*Translation*]

**Ms. Nicole Demers:** Very good. Thank you very much.

Ms. Fontaine, you mentioned that Canada slipped in rank from sixth to twenty-first regarding infant mortality. You started talking about it earlier.

Could you tell me why infant mortality has increased so much in Canada?

**Ms. Lorraine Fontaine:** I was talking about the threshold of intervention. Something is happening in terms of obstetrical procedures. They can be good for us, like a C-section for example. They can also produce the so-called “iatrogenic effect”, when procedures lead to other procedures. When 98% of women who go to the hospital are healthy, and when 26%, or 30 to 40% in the United States, and 60% in Puerto Rico, come out after undergoing a major surgery, which could have been avoided, we must ask ourselves about the system in which birth takes place. It is not a medical condition, but a human condition; the majority of women could live under normal circumstances with the support of people who know what they are doing. Doctors are losing their knowledge, on things like breech births, for example. So there is loss of knowledge, and our hospitals and our health care system are structured in a way that gives priority to medical approaches. There is even a cultural fear of birth in our society. We need to work on that.

I would like to add that some women's groups are excluded from this debate: aboriginal women, disabled women, refugees, and undocumented women. They live in Canada, so we should also include them.

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you.

We'll go to Ms. Mathyssen.

**Ms. Irene Mathyssen:** Thank you, Madam Chair.

I want to put a human face on what we've been saying. Ms. Jenicek, you said that the complications of unsafe abortions cost governments more than the cost of offering the safe option. I'd like you to tell me about those complications. What happens to these women? What is the reality they face? And please, I'd like to hear from all of you, if possible.

**Ms. Ainsley Jenicek:** It greatly depends on the kinds of unsafe abortion procedures used. I mean, some unsafe abortion procedures used around the world in developing countries include drinking bleach or putting excessive pressure on the abdominal area, which can rupture certain organs inside. Going septic, hemorrhaging, and perforation of the uterus are the kinds of complications that can arise. Some of them lead to death. Some of them lead to infection that can be long term. Some lead to long-term disabilities, such as infertility, for instance.

Does that sort of give you a better sense of the complications that might arise?

The number I found in terms of the cost of hospitalizing those five million women each year due to unsafe abortions is about $460 million.

**Ms. Irene Mathyssen:** That is if there is a hospital.

**Ms. Ainsley Jenicek:** Yes. Having sat in just a few weeks ago on a few abortions, prior to 15 weeks, in a feminist clinic in Quebec... These procedures are so fast and so cost-effective. If we can just get behind it and not do a menu—sort of picking and choosing from above—and trust the people on the ground, on what the women in these communities need, and sort of listen to them and respond based on their needs, that would be a much stronger, unified response.

● (1655)

**Ms. Irene Mathyssen:** Talking about the response on the ground, one of the things we heard last week, from Katherine McDonald, in response to my question.... We have Canadian aid dollars. We have the G8. And Canada is saying that we're not going to support abortion services and that the others will do it. Who is monitoring that? The reality is that if you have a clinic that is receiving Canadian aid dollars, what happens when a young woman comes in and needs the procedure? What happens to that woman? Does that clinic tell her she's risking their dollars, so go away?

**Ms. Bridget Lynch:** I can speak to that a little bit. Even under the gag rule, if you're a health care worker in the field, whether there are dollars coming in or not—and it will be very difficult to describe dollars going in—it will be more at the level of who among the NGOs gets moneys than about the actual provision of care in the clinic on the ground.

You will have health care providers, in some cases, when there is capacity, who will provide appropriate care. If it's an NGO that isn't receiving funding to provide abortions, then there will be areas where there won't be care.

Women will die, and women will die if there aren't functioning health care systems. Ultimately, this is not our decision about who receives and who does not receive an abortion. We should not be involved in this discussion as a nation. That is up to the individual woman and her health care providers. I don't even want to say that it's up to the law in the country, because it is not. We all, as women and as people, have to get past this. It's ridiculous.

I'm seeing what is going on with the politicization of this committee. We're wasting this opportunity to support Canada taking a leadership role, including the provision of.... I've been sitting here for an hour and a half now, somewhat aghast, as I realize the division within this committee. What is going on here?

Being so absolutely, humanly... I'm asking the question. What is happening here politically? Are you really saying that in 2010 a woman should die because Canada said, based on politics, that we wouldn't be providing funding for her, when we ourselves, and our daughters, have that choice?

**The Vice-Chair (Mrs. Cathy McLeod):** I'm sorry. We're on to our next one.

Madame Boucher.

[*Translation*]

**Mrs. Sylvie Boucher (Beauport—Limoilou, CPC):** Good afternoon, ladies. Good afternoon, sir. Welcome to our committee. It really is very interesting to hear you, but it is especially troubling to see the extent to which we are divided, as you said.

We are not really divided. We must understand that, even if we play politics, we are here for all women.

I would like to understand one thing. We know that, often, at G8 meetings, countries have major joint projects for which they give great speeches accompanied by great selling points, but we lack the willingness to see these projects through. In fact, for one reason or another, these projects fall by the wayside. Our joint projects fall by the wayside, which is not what we would like to see happen right now.

There is a consensus that transparency and accountability are issues when G8 countries make promises. When this initiative was launched, we also wanted to improve transparency and accountability to ensure that the G8 members would make smart promises in June so that countries would be able to keep them and could see them through together.

Are you in favour of Canada taking measures to increase transparency and accountability?

● (1700)

**Ms. Lorraine Fontaine:** Yes.

[*English*]

**Ms. Bridget Lynch:** I think this is one of Canada's strengths. The call for accountability must take place. We must be accountable.

The G8 has made promises. At the University of Toronto, they did a phenomenal review by country and by category of G8 promises made and G8 promises kept. Canada actually comes across pretty well. We were at the 70% level on living up to our G8 promises.

There has not been a system of accountability. This is where Canada is again taking a leadership role.

On the accountability piece, yes, government should be held accountable for their promises. There should be evaluations. There should be ongoing feedback to the people of the countries as well. This is one of the strengths.

[*Translation*]

**Mrs. Sylvie Boucher:** Good.

You talked about evaluations. Do you think that Canada should take a leadership role and ensure that the evaluations of promises made at G8 are transparent, but also that the promises are kept?

If we all make a commitment, it will not be an empty or fuzzy promise, but something that we want to see through. Do you think that the G8 members can reach a consensus?

[*English*]

**Mr. Pierre La Ramée:** The idea of a consensus and then accountability for a consensus is an interesting one, because it's precisely what was reached at the G8 last year when Canada committed itself to the consensus for maternal and child health.

On the basis of Canada being part of that consensus and then launching a major G8 initiative on maternal mortality, one would have expected transparency and accountability would dictate that there would not immediately have been questions and doubts about what a commitment to maternal mortality would include, in this case whether it would be reproductive health, or whether it would be abortion, or whether it would be reproductive health but not abortion. As of this point, in terms of transparency and accountability, it's still actually not clear what the position of the Canadian government is and how it defines its maternal mortality initiative.

[*Translation*]

**Mrs. Sylvie Boucher:** I had another quick question.

Ms. Fontaine, you said that, even here, in Canada, we are falling behind medically despite new technologies. I am one of the statistics since I had bleeding, eclampsia and anemia. You are saying that we have fallen behind in maternal health despite the new technologies we have.

**Ms. Lorraine Fontaine:** Technology is available and it is important for you and the women who need it, but if we overuse the procedures and treat them as the norm, we start using them when it is not necessary. We do one procedure, which leads to another one and that can lead to death.

**Mrs. Sylvie Boucher:** Thank you.

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** That finishes our second round. We do have time for a three-minute round, and then we will have to go in camera for about five minutes.

So to start off for three minutes, really quick questions and answers, Mr. Garneau.

[*Translation*]

**Mr. Marc Garneau (Westmount—Ville-Marie, Lib.):** Thank you, Madam Chair.

I am not sure if this will take three minutes, but I have two specific questions for Mr. La Ramée, along the same lines as Ms. Demers' questions.

[*English*]

Normally, at this time of the year, it seems to me that the IPPF would have received its financing from Canada based on past performance. If I understood you correctly, you have not received it yet. It's an important question, because if you had received it, it would indicate that the government supported International Planned Parenthood abroad and had not changed its position. That would, of course, be at odds with the discourse they are holding in the House of Commons at the moment, about not wanting to talk about it or deal with it. So that preoccupies me. Is this a shift in policy? Now, I think you are trying to be diplomatic here about not having received it, and there may be some bureaucratic holdups for it, but my first question is this. When would you normally, based on past years, have received your financing? I don't know your financial cycle.

**Mr. Pierre La Ramée:** Normally we should have received the funding by now—if not be in receipt of the funding, at least have received a response on our proposal.

**Mr. Marc Garneau:** And you have not heard anything?

● (1705)

**Mr. Pierre La Ramée:** No.

**Mr. Marc Garneau:** If you do receive your funding but it is some time after the G8 summit, that will say a great deal about whether or not this was really a bureaucratic holdup or not, or whether it was just something people didn't want to deal with until after the G8 summit. So like Madame Demers, I would very much like to hear if and when you do receive your funding.

**Mr. Pierre La Ramée:** I will keep you apprised.

**Hon. Anita Neville:** Is there a little bit of time? One minute.

My question is following up on Ms. Boucher's comments or questions. How can Canada push for accountability when its credibility is suspect among its G8 partners? Do you have any comment on that?

**Ms. Lorraine Fontaine:** Canada is all of us; we can all speak out. We can still have credibility. I think we have a responsibility. I think Bridget called out very passionately to it. As citizens groups and as other organizations...and as members of Parliament, you can speak out, and you are doing so. I think we need to remember all the voices of women—all the voices of women—and that reproductive health is all our lives. I said earlier that I think women's bodies are an occupied territory, but I think, unfortunately, it's the case from our childhood all the way until menopause and on. It's a territory for testing and all kinds of things.

**Hon. Anita Neville:** What I am hearing is a call for action.

**The Vice-Chair (Mrs. Cathy McLeod):** It will now be Mr. Calandra for three minutes.

**Mr. Paul Calandra (Oak Ridges—Markham, CPC):** Sorry, they will be quick questions because I only have three minutes,

Mr. La Ramée, are you entitled to funding forever, at the exclusion of everyone else?

**Mr. Pierre La Ramée:** No, of course not. We are not entitled to funding forever.

**Mr. Paul Calandra:** Is there any problem with your funding being reviewed from time to time, in fact every year?

**Mr. Pierre La Ramée:** Our funding has to be reviewed every time it is renewed.

**Mr. Paul Calandra:** Thank you.

Ms. Mathyssen referenced clinics earlier. Are those clinics not currently funded by CIDA? Can anybody mention anything on that?

Ms. Lynch, are those clinics that Ms. Mathyssen referred to earlier funded by CIDA currently?

**Ms. Bridget Lynch:** We weren't referring to any particular clinic.

**Mr. Paul Calandra:** She mentioned that funding would be removed as part of this new strategy.

**Ms. Bridget Lynch:** To NGOs.

**Mr. Paul Calandra:** Is it not currently funded by CIDA, though? Can anybody answer that?

**Ms. Jolanta Scott-Parker:** I would just echo what Bridget said. I think she is talking generally about clinics that might be providing sexual and reproductive health services—

**Mr. Paul Calandra:** Are they currently funded by CIDA?

**Ms. Jolanta Scott-Parker:** Some may be, yes, which would potentially put them in a different position—

**Mr. Paul Calandra:** We've mentioned that CIDA hasn't changed how it is funding. The G8 initiative is much different, so it stands to reason that any clinics that are being funded right now, because our foreign policy has not changed, are still going to be funded post the G8 initiative.

Let me ask you this, Ms. Lynch. With respect to midwives, is Canada better than everybody else in the G8? Are we equal to everybody else in the G8? Are our midwives better trained? Do we have better rules?

**Ms. Bridget Lynch:** Our midwives within the G8 probably have, consistently, one of the highest levels of education, regulation, and provision of services.

**Mr. Paul Calandra:** As part of the G8 initiative, should we then hold back funding or should we insist that our G8 partners reach our levels before we actually help women and children in other countries, or can we somehow look at best practices in the G8 and ask that perhaps, potentially, when it comes to midwifery, Canada, being a recognized leader, should take the leadership role on this initiative with respect to the G8?

Would that be a safe assessment, yes or no?

**Ms. Bridget Lynch:** I don't give a yes or no to a question like that, thank you.

What I would have to answer is that various G8 nations might have various levels of expertise that they can actually contribute to addressing this entire issue.

**Mr. Paul Calandra:** So they should be focusing also on their expertise. So a wholesale approach using best practices is another way that we can actually achieve this millennium development goal, predominantly for Africa and South Asia, basically for women and children. Is that right?

● (1710)

**Ms. Bridget Lynch:** Yes, but not by withholding service. It's by contributing service.

**Mr. Paul Calandra:** But we can all do it with respect to best practices, right?

**Ms. Bridget Lynch:** Yes, and there could be choices around the best practices.

**Mr. Paul Calandra:** What we have, then, if I can summarize, is the ability for the G8 nations to look over and above what their current foreign aid practices are. Canada is committed to its current foreign aid practice of funding. We have the G8 initiative looking at—

**The Vice-Chair (Mrs. Cathy McLeod):** Sorry, I'm going to have to cut you off, Mr. Calandra. Your three minutes have expired.

Madame Deschamps.

[*Translation*]

**Ms. Johanne Deschamps:** Thank you, Madam Chair.

Let us talk about your funding issue. Do you know of any organizations in your network that have received the bad news that they will not be funded? If so, which ones are they?

**Ms. Ainsley Jenicek:** Unfortunately, I did not bring the list with me. I know that CIAFT is one of them. It is not part of our network, but it is in our building. It is part of the Quebec women's rights network.

**Ms. Johanne Deschamps:** Could you provide it to the committee?

**Ms. Ainsley Jenicek:** Yes, absolutely.

**Ms. Lorraine Fontaine:** There is also AFEAS and other groups, including the Table des groupes de femmes. He is right to say that we cannot expect long-term and ongoing funding all the time.

**Ms. Johanne Deschamps:** And what is happening at the international level?

**Ms. Lorraine Fontaine:** Yes, it would be better to talk about the international component.

**Ms. Johanne Deschamps:** Ms. Parker, what do you have to say about that?

[*English*]

**Ms. Jolanta Scott-Parker:** I was just going to comment that I think there are several examples that have been very public in the media where organizations involved in development have had their funding revoked, including KAIROS, which was one of the first examples that we understood.

That has been in the news. It's quite a prevalent example.

[*Translation*]

**Ms. Johanne Deschamps:** I still find it strange. The government lays the foundations, designs its policies and implements them too. It is unfortunate, because it must be said that all groups that have been defending human rights for a number of years have seen their funding cut off or reduced. You talked about KAIROS, but we must also recall the women's program at Status of Women Canada, where groups defending women's rights had their funding cut off. It is very disturbing.

When I hear the government speak for Canada, I do not feel included in its policies. I was born in Quebec. I live in Quebec, a province within this Canada that has made great strides socially. It is as if they pulled the rug from under my feet. This is not a menu from which you can pick and choose.

**Ms. Lorraine Fontaine:** As to funding in Quebec, we should still point out that we are ready to provide $85 million for in vitro fertilization on an ongoing basis, but we are not ready to give $1 million for a new birthing centre. There are issues and priorities to be studied. We have not addressed the questions about new technologies, in vitro fertilization and screening. I urge you to please ask yourselves these questions at some other time.

[*English*]

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you.

Ms. Mathyssen, please.

**Ms. Irene Mathyssen:** Thank you very much, Chair.

I want to get back to the issue of funding.

Monsieur La Ramée and Madame Scott-Parker, you indicated that you have existed since 1960, and we have a description of what you do. And of course funding is reviewed from time to time. The fact that your funding hasn't been renewed at this point: are you doing something differently now than you have in the past that might negatively affect your funding? What's changed?

**Mr. Pierre La Ramée:** We would have to answer this separately. I will answer for IPPF.

I think what has changed for us, in fact, is that we are providing more services.

And actually, we've been in existence since 1952. Our funding from Canada has been since 1960.

We continue to expand the number and range of services we provide. We also have taken great strides—the question of accountability came up—to really monitor and evaluate the quality of our services, to give an indication of the value of the investment our donors are making in IPPF in terms of what happens on the ground.

So while no organization expects to receive funding in perpetuity, and certainly not without review and evaluation, we actually go out of our way to make sure that more and more information is available by which Canada or any other donor can evaluate the quality of our work.

I am led to wonder, in the event that our funding is not renewed, in the context of a major initiative on maternal mortality, whether that would not constitute a major shift in policy rather than a judgment on the quality of IPPF's work.

● (1715)

**Ms. Jolanta Scott-Parker:** If I could just clarify, the Canadian Federation for Sexual Health, which is the Canadian member of IPPF, does not actually receive funding from IPPF. We're accredited by them as an international organization, and we're certainly very proud to be associated with them, but because the majority of IPPF funding is comprised of dollars from donor governments that is really directed to the global south, we're not actually a recipient member organization, but rather considered a donor country.

**Ms. Irene Mathyssen:** Okay.

Now we've heard a great deal, and it's been very public, about the 14 organizations whose funding was revoked. Is there a common thread among those groups in terms of the services they deliver that would explain why their funding has been revoked?

**Mr. Paul Calandra:** Madam Chair, on a point of order, last week I was told by the chair that we had to focus on what we were talking about with respect to the G8 initiative to maternal care. I'm not sure how the relevance of—

**Ms. Irene Mathyssen:** Madam Chair, this is about maternal health.

**Mr. Paul Calandra:** Sorry, I'm just actually on my point of order, if that's okay.

At that point I was speaking about nutrition and food and the need for mothers and their children to receive proper food and how that would help offset a lot of this. I was told that was off topic.

I'm wondering how this relates to millennium development goal number 5, which is what I was told we were supposed to be focusing on at the last meeting. I wonder if this still falls within that mandate.

**The Vice-Chair (Mrs. Cathy McLeod):** Madam Mathyssen.

**Ms. Irene Mathyssen:** Madam Chair, I'd like to point out that it was indeed Mr. Calandra who introduced this, and I'm simply following through and expanding on the information that was provided.

**The Vice-Chair (Mrs. Cathy McLeod):** Okay, well, let's—

**Mr. Paul Calandra:** Sorry, on a point of order, then, out of that, and not to belabour the silliness of the intervention opposite, but it was actually Madam Mathyssen who introduced that.

I'd ask you to talk about the relevance.

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you, Mr. Calandra.

Certainly I've been informed by the clerk, being that I'm fairly new to this role, that it doesn't actually qualify as a point of order.

There are seven seconds left. We did stop the clock during the question period, and you have seven seconds left in which to—

**Ms. Irene Mathyssen:** Is there a commonality with the groups?

**Ms. Lorraine Fontaine:** I think Madame Deschamps brought it up. It has to do with the defence of rights and women's rights and it has to do with that kind of thing. But I—

**The Vice-Chair (Mrs. Cathy McLeod):** Thank you.

Our last speaker is Ms. Brown for three minutes.

**Ms. Lois Brown:** Thank you, Madam Chair.

I've done a little bit of travelling. One of my observations is that many of the issues we're dealing with are in countries where culture is different from what we perceive. What we would consider to be child brides constitute a real problem, which I'm sure poses difficulties for the midwives. I think all of that has to be taken into consideration in the discussion we're having today.

But I wonder whether I could change the focus a little bit and talk about the other diseases that children are encountering. When I was in Botswana and Zambia three months ago, the discussion centred around the issue of AIDS and the transfer of AIDS from mother to child, mother to baby, and the number of children who are being lost because they've lost parents to the terrible AIDS epidemic that exists there. When I was in Bangladesh last year, there was a terrible prevalence of tuberculosis.

These are other issues that we have said demand our attention, because through such initiatives as inoculations for malaria, providing bed nets—which, I think, Ms. Jenicek, you said the midwives provide—there is real opportunity for us to save children's lives.

Can any of you comment on the success of those kinds of initiatives as well? What are your organizations doing to address these other situations?

● (1720)

**Mr. Pierre La Ramée:** I think there has been a great deal of success, especially with prevention and treatment of HIV and AIDS. One of the things we try to work on with our member associations is the provision of a comprehensive package of sexual and reproductive health services, which means working on prevention for HIV and AIDS, helping women to get treatment when they are diagnosed with HIV, which they might otherwise not be able to get, and in turn helping by basically intervening in the cases of mother-to-child transmission by providing the appropriate countermeasures.

**Ms. Lois Brown:** Is there anyone else?

**Ms. Lorraine Fontaine:** One of the steps of the international mother-baby childbirth initiative is providing evidence-based care and avoiding harmful procedures, but it's also implementing measures that enhance wellness. That includes a lot of things. You have something here that might be worth examining, which could be a tool for consensus amongst all of you.

**The Vice-Chair (Mrs. Cathy McLeod):** That wraps up our last round. I would like to thank the witnesses so much for joining us and focusing your lens on this important issue.

We will take a two-minute break and go in camera.

[*Proceedings continue in camera*]

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