House of Commons
CANADA

Standing Committee on the Status of Women

FEWO • NUMBER 018 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Wednesday, May 12, 2010

Chair

The Honourable Hedy Fry

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● (1530)

[*English*]

The Chair (Hon. Hedy Fry (Vancouver Centre, Lib.)): I'm going to call the meeting to order.

Pursuant to Standing Order 108(2), this committee is studying maternal and child health.

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

> 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 would be hosting, as long as this is done before the end of May.

We are doing four hearings, and you are our third set of hearings.

Today we have four sets of witnesses. I will begin with the video conference witness, Pamela Fuselli from Safe Kids Canada, and then I will move on to the others in order.

Let me tell you that each group has 10 minutes to present. I will give you a warning when you have two minutes left. You don't have to take 10 minutes, by the way. Then we will have a question and answer set of rounds.

I'm going to begin with Pamela Fuselli, executive director for Safe Kids Canada.

Ms. Fuselli, your 10 minutes begins.

Ms. Pamela Fuselli (Executive Director, Safe Kids Canada): Thank you very much.

Good afternoon, and thank you for the invitation to speak to the House of Commons Standing Committee on the Status of Women. The focus on maternal and children's health is an important issue, and the discussions about children's health would not be complete without the inclusion of preventable injuries, an indicator of health and the leading cause of death for children in Canada and around the world.

Let me first tell you a little bit about Safe Kids Canada, the national injury prevention program of the Hospital for Sick Children. Our organization was founded in 1992 by Dr. David Wesson, a trauma surgeon at SickKids who saw the results of injuries and looked for a way to address the fact that they were largely predictable and therefore preventable. Safe Kids Canada is a leader in Canada, acting as a knowledge broker, bridging research to inform action through evidence-based strategies, information, and resources.

Through a stakeholder network across Canada, we have partners at the federal, provincial, territorial, and local levels. With industry, corporations, and community organizations, we are endeavouring to achieve our vision: fewer injuries, healthier children, a safer Canada.

Safe Kids Canada is encouraged to see the Canadian government's commitment to championing a major initiative to improve the health of women and children in the world's poorest regions. We congratulate the government for striving to make a tangible difference in maternal and child health by making this the top priority in June. As well, we were pleased to see that the government is looking to mobilize governments, non-governmental organizations, and private foundations alike.

In the recent Speech from the Throne, it was announced that:

> To prevent accidents that harm our children and youth, our Government will also work in partnership with non-governmental organizations to launch a national strategy on childhood injury prevention.

Safe Kids Canada agrees with Canada's G8 agenda to focus on human welfare:

> It is incumbent upon the leaders of the world's most developed economies to assist those in the most vulnerable positions.

In his statement laying out the G8 agenda focusing on human welfare, Prime Minister Harper pointed out that "an astonishing 9 million children die before their 5th birthday". This number is too high, and unacceptable. Equally so is the number of children's lives lost to injuries around the world. As a national injury prevention program, we understand the high value and strong effects that prevention can have on the health and welfare of children.

Also in his statement outlining Canada's G8 agenda, Prime Minister Harper pointed out that the vast majority, as much as 80% of deaths during pregnancy, are easily preventable. Furthermore, the Prime Minister expressed that far too many lives and unexplored futures have already been lost for want of relatively simple and inexpensive health care solutions.

Injuries are preventable. Prevention is a relatively simple and inexpensive solution to the loss of too many lives and the detrimental effects that injuries can have on a child's quality of life, as well as the lives of their families and communities.

According to the 2008 World Health Organization and UNICEF's *World report on child injury prevention*, 60% of all child deaths were the result of road traffic collisions, drowning, fire-related burns, falls, and poisoning. Other unintentional deaths accounted for 30%, including smothering, asphyxiation, choking, etc. In comparison, war accounted for 2.4% of deaths, and homicide for 5.7%. This is not unlike the picture we see in Canada.

Injuries are the leading cause of death and disability in the world, responsible for more than five million deaths each year. Approximately 830,000 children under 18 years of age die every year as a result of an unintentional injury. More than 95% of all injury deaths in children around the world occur in low-income and middle-income countries, although child injuries remain a problem in high-income countries, accounting for 40% of all child deaths.

It's essential that injuries are seen as an indicator of overall child health, as the WHO and UNICEF report points out:

> ...preventing child injury is closely connected to other issues related to children's health. Tackling child injury must be a central part of all initiatives to improve the situation of child mortality and morbidity and the general well-being of children.

So how does Canada compare to the rest of the world? Canada ranks 18th out of 26 OECD nations for deaths from unintentional injuries. Had we enjoyed the rate achieved by Sweden, 2,665 more children would be alive today. Many experts believe that 90% of childhood injuries are preventable and that there are best-practice strategies, such as the use of bike helmets and car seats, that could be implemented immediately and make an impact on children's lives.

The annual burden that injury places on Canadians overall, our health care system and Canadian society, looks like this: over 13,000 deaths, 300 of which are children under the age of 14; over 211,000 Canadians who are hospitalized, 21,000 of them being children under 14; over three million emergency room visits; and over 67,000 Canadians permanently disabled.

We're looking at over $10 billion in health care costs and $19.8 billion in total economic costs, which is the same as the amount spent annually on pharmaceuticals across Canada. An estimated $4 billion is the economic burden of injury among children in Canada.

So why are these injuries the leading causes of death in Canada for children between one and 14 years of age? The vast majority of health care dollars are focused on treating disease, not prevention.

● (1535)

Given that preventable injuries are the leading cause of death to Canadian children, the amount of dollars spent are inverse to the scope of the problem. There's a misperception or misunderstanding that injuries are accidents that can neither be anticipated nor prevented. In reality, most injuries follow a distinct pattern and are therefore predictable and preventable.

Children live in a world built for adults and they have developing cognitive and physical abilities that put them at risk for injuries. The WHO and UNICEF report states that:

> Over fifty years ago, one child injury expert declared that: "it is now generally recognized that accidents constitute a major problem in public health".

Unfortunately, this statement remains true today.

As a part of a global movement of Safe Kids countries around the world, Safe Kids Canada supports the conclusion of the WHO and UNICEF report, which states:

> Evidence demonstrates the dramatic successes in child injury prevention in countries which have made a concerted effort. These results make a case for increasing investments in human resources and institutional capacities. This would permit the development, implementation and evaluation of programmes to stem the tide of child injury and enhance the health and well-being of children and their families the world over. Implementing proven interventions could save more than a thousand children's lives a day.

We think it's indisputable that injuries need to be a part of the overall child health strategy, both in Canada and worldwide. Currently Canada has the opportunity to be a leader in maternal and children's health by adopting certain strategies. In the area of injury prevention, this can begin by instituting the national injury prevention strategy, as outlined in the Speech from the Throne, and by adopting consumer products safety legislation that will allow mothers to know that the toys their children play with are safe.

Thank you for allowing me to speak with you today about the importance of injury prevention related to maternal and child health.

● (1540)

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

Now we'll go to Anne Snowdon, researcher, AUTO21.

Dr. Anne Snowdon (Researcher, AUTO21): Thank you so much for the opportunity to speak with you today. I represent AUTO21, Canada's network of centres of excellence team of researchers that focus on the automotive sector.

I am a nurse by training. I bring today to my comments background as a pediatric critical care nurse. I spent a number of years looking after critically ill children, 50% of whom are admitted to our ICUs—only very few of those actually survive—as a result of severe road crashes.

I currently lead a national team of researchers that includes not only academia—members from computer science, business, engineering, nursing and medicine—but also engages private sector partners and public sector partners to leverage both their experience and technologies in this area of injury prevention.

As you've just heard from Pam Fuselli, road crashes are the leading cause of death of children in Canada and are a substantial threat to children globally. In Canada alone we lose approximately three classrooms-full of children every year who will not see grade six because of road crashes.

As you have also just heard, we have a substantial number of very severe injuries in the neighbourhood of about 11,000 annually. Most of those injuries are lifelong, including head, neck, and spinal cord, so prevention could play a significant role if we were able to achieve that.

If today I was able to get every child in this country correctly seated in a car seat, we would be able to reduce the child deaths in our country by 74% and reduce the severe injuries by 67%. Once again, a prevention strategy has tremendous value if we're able to achieve that.

In Canada, the majority of parents I work with and have researched do attempt to keep their children safe in vehicles—about 85% of us. The sad story is that about 15% to 20% do so accurately enough so those children can benefit from protective strategies such as car seats. Some 75% of the children in the most recent Transport Canada data who died in road crashes were actually wearing seat belts.

The issue is not that we're not attempting to keep our children safe: it's the accuracy and the correct strategy for keeping them safe that is so important.

My most recent national child seat survey, which I conducted with Transport Canada, was in 2006, and I will be conducting it again this summer, in 2010. We had only 19% of children ages four to eight using booster seats in the back seats of our vehicles—the lowest and clearly the highest-risk group. We do have legislation for booster seats in five Canadian provinces at the moment. However, the impact of that legislation has not achieved the numbers of children correctly seated in that age group that we would like to see.

The question is what we can do about it? Let me share some of the lessons we have learned and the achievements I think we have been able to contribute. Education programs are—no question—important, for children particularly and the entire family. Mothers tend to be the most knowledgeable member of a family to keep children safe in vehicles, but we also engage children in our education as well, because they're a very important influence in families. We do not have a national strategy—as was already pointed out by my colleague at Safe Kids—around the education and awareness issue for these families, which I think would benefit them.

With regard to parent information, when I talk to parents in Canada, I ask them where they seek information, because it is important to try to help them find correct information. They tell me two things. They look at the pictures on the box and they go to speak with their family friends.

We've actually engaged our colleagues in computer science to use artificial intelligence technology. We've created a virtual community that is able to demonstrate the very important influence of social networks. Families tend to learn from other families, so influencing our social networks is a very important strategy that I don't believe is unique to Canada, but in fact I think perhaps could allow Canada to play an important role worldwide.

You also have to look at the impact of culture. Families do practice particular health behaviours based on cultural beliefs. We have done some studies with new Canadians in our country that suggest that there are cultural values in place. The role of the mother as protector often leads to the family's decision to actually hold their child on their knee rather than safely seat them in a vehicle in a car seat.

So again, the use of artificial intelligence has been important in helping me map and helping us conceptualize how we need to shift from just straight education materials for families, to actually social marketing, which we have done, by engaging our business school colleagues who have expertise in that.

● (1545)

The lessons learned, I think, can be very valuable in moving forward to a more global agenda. I won't review the number of statistics shared with you already, except to say that injury is a growing health concern, as identified by the World Health Organization. Low-income and middle-income countries particularly spend more than they receive in international aid on the outcomes of injury. So if we're able to help them prevent injury through a multi-sector and a multi-disciplined approach, we would actually be supporting them globally, I believe, in meeting some of their other needs for aid.

On networks of key stakeholders, I can't say enough about how important that lesson has been in terms of engaging key stakeholders on the ground, the people in communities who help us understand the influence of those social networks so that we can help them transmit information, knowledge, and awareness on keeping children safe in vehicles through a network approach.

National coordination, I believe, has already been identified by my colleague as a very important strategy. We have lots of data, lots of strategies, and lots of educational tools, but if we can't get them to every family in Canada, we cannot achieve the reduction in the mortality and severe injury rates that are so very high in this country, and are growing in other countries.

The rates of road crashes are expected to climb from being the ninth-leading cause of death to the fifth-leading cause of death worldwide by 2030. WHO suggests a multi-sector approach. It has also been my experience with the multi-sector approach that it is very important having families, community members, and key stakeholders from different parts of the public sector and private sector bringing technologies and different approaches to the table, in addition to researchers and academia.

I believe Canada has the ability and the capacity to achieve global leadership in the area of coordinating efforts across sectors by engaging key stakeholders; leveraging technologies like information technologies to measure and monitor our outcomes and the impacts of various initiatives worldwide; and engaging private sector, government, and academic partnerships to build the capacity we need for child health in the area of injury prevention and to start to reduce this growing challenge that we have with injury rates that have such lifelong effects for Canada's children, but also for children globally.

Thank you.

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

I'll now go to Christina Dendys, executive director of Results Canada.

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

Results is a national grassroots advocacy organization. We are committed to creating the political will to end poverty and needless suffering. We champion cost-effective, proven, tangible, and impactful solutions that will benefit the world's poorest and, we believe, by extension, the world as a whole. Our volunteers across the country are parents who think that no other parent's child should die for lack of immunizations that cost pennies. They're neighbours who think that nobody around the block or around the world should die for lack of drugs or access to drugs that cost dimes or dollars. They're everyday citizens, and they're your constituents.

So I'm honoured to be here today to represent their views, but also I'm honoured to present some recommendations outlined in the brief that was developed by a coalition that includes results in partnership with some of Canada's largest and most respected development organizations, including Unicef Canada, World Vision Canada, Care Canada, Plan Canada, and Save the Children, whom you'll hear from as well.

About a year ago, our organizations came together to push for child, newborn, and maternal health to be the signature development theme at the G8 initiative. We certainly weren't alone in that effort. Many partners in the room are part of that and very focused on that. So we were all very glad in January when that came to fruition.

In terms of the numbers, in the world's poorest regions, close to nine million women watch their children succumb to painful yet mostly preventable disease and illness, illnesses that, as I said, cost dimes—not dollars—to treat, illnesses like diarrheal disease, malaria, pneumonia, measles, and malnutrition. At the same time, at least 350,000 mothers die annually in childbirth due to complications during delivery.

I'm not going to run through all the statistics at this point, because I think you're very well versed in those at this point, after hearing from a number of very informed witnesses. Perhaps just to paint a picture, I'll tell this very brief story.

Last year I had the opportunity to go to Bangladesh to lead a parliamentary delegation there. We were looking at the challenges associated with global poverty but also very much focused on the hope and solutions. One day we went to a hospital called the ICDDR,B hospital in Dhaka. We were there in March, and it was just before rainy season. At that point, waters are stagnant, and babies get sick primarily of diarrheal disease and other diseases as well.

We went to that hospital that receives about 700 to 800 patients a day, children with diarrheal disease, moms and babies coming in for treatment. It's such a busy time of year that they don't have enough wards or beds, so they construct giant white tents outside, next to the hospital. I think there were two or three of them, and row upon row of kids getting oral rehydration therapies and intravenous therapies. While they're there being treated for other leading causes of death, kids who are malnourished are getting therapeutic feeding and other access to treatments that are again very inexpensive.

That scenario was poignant for a mom like me, but it's played out throughout the world. Diarrheal disease alone kills about 1.5 million children every single year. Most of those children who made it to that hospital will survive, actually, and that was the story of hope, because they had access to health services. However, many more in the most impoverished pockets of the world unfortunately will not, because they do not have access to dependable health care close to home.

This brings me to our brief. What we've focused on in our brief—I think you have it in your packages—is very much not about the global initiative as a whole, although we have some thoughts on that, but very much about where Canada's value-added contribution can be. So we've been focusing on where Canada's contribution to the G8 initiative should go.

What we're calling on is for Canadian investments in a cadre of front line health workers who have the support and training necessary to deliver an integrated bundle of high-impact interventions targeted at the poorest people, where they live, and all of that with the commitment to monitor results and measure impact.

I'm going to go over those four core elements very quickly here.

Number one, as I said: ramp up the number of front line health workers who are supported, trained, equipped, and motivated to deliver essential services to mothers and children at the community level close to home. As I'm sure you've heard, skilled and motivated health workers in the right place at the right time with the necessary infrastructure, drugs, and equipment are an essential part of the solution. That's from the Partnership for Maternal, Newborn and Child Health. There's a consensus around that. It's important because evidence shows that up to 80% of deaths of children under five years of age around the world may occur at home with little or no contact with health providers and that one in four women experience childbirth without skilled assistance.

Two, provide those front line workers with the capacity to deliver an integrated package or a bundle of interventions to get at the leading causes of death. Kids don't just die of one thing. They're susceptible to a whole gamut of illness and disease.

● (1550)

Among children, just four diseases—pneumonia, diarrhea, malaria, and measles—account for close to half of all under-five deaths in the developing world. The majority of these lives, experts say, could be saved by increasing the use of low-cost, effective prevention and treatment measures.

This is a UNICEF pack of oral rehydration salts, which many of you who have travelled have seen. This is what could save the life one of those children who ended up at ICDDR,B hospital. It costs, we've determined, something like 20¢ to 40¢ a package.

For mothers, there is clear evidence to show that the availability of skilled attendants at birth and immediately after, with the capacity for timely referral to access to other care facilities, is the critical factor in addressing the major causes of maternal mortality such as hemorrhage, infections, and hypertensive disorders. But also, these front line health workers have a very important role to play in addressing maternal health, which is also absolutely integral to healthy pregnancies and deliveries.

Number three, focus on the poorest people, again where they live, close to home, in rural areas or urban slums. The poorest people actually live, get sick, and die alone, far away from the nearest hospital. So focusing on the poorest people in terms of what kills them or what makes them sick will help us go a long way.

Number four, commit to accountability and tracking results, which allows for appropriate mid-course correction and measurable results on mortality impact, coverage of services, etc. In other words, any effective aid program should have a commitment to ensuring that we're getting it right and then having the capacity to improve practice along the way.

Those are the four legs of the table, as I call them, that we have been advocating for. You can read more in the brief.

Again, just to tell the story of how that plays out on the ground, this year I had the opportunity to lead another parliamentary delegation, this time to Ethiopia. We did a real focus on child and maternal health.

In Ethiopia, with the commitment of the ministry of health there and with partners like CIDA, UNICEF and NGOs, and the Global Fund, they've created a system that's very focused on community care front line workers. They've trained 30,000 young women who have about a grade 10 education. They have given them a year of training in the leading causes of death and illness and intervention—training on malaria diagnostic tests or how to deliver ACTs, which costs about a buck. A baby or a child who gets malaria can die within 24 hours. If you're far away from a hospital setting, you need to have people close by who can diagnose and treat that quickly, or that child is gone. There are 30,000 of them. They made a conscious decision that they would all be women, too. Talk about empowering women within communities; it was very powerful.

They've also created 15,000 health posts in rural areas in Ethiopia, health posts about the size of your living room, that have the equipment to address all these leading causes of death. They call them the “16 packages”. They get at malaria, therapeutic feeding, ORTs for diarrheal disease, but also immunizations. We saw babies getting measles vaccinations and polio vaccines.

So with 15,000 health posts and 30,000 health workers, that is about health system strengthening and transformative change in that country. That is the model we're talking about that could be a solution for the challenges that we face globally.

I want to talk about the money thing before we get through the two minutes.

The G8 acknowledges that the international financing gap to save 10 million women's and children's lives, between now and 2015, is estimated at approximately $30 billion globally. We feel that Canada's fair share contribution should be $1.4 billion in new—and I'll repeat, “new”, not reassigned, not repackaged, not reallocated—money. Over the next five years, that could have tremendous impact.

Thank you for this. I think it's time to focus on hope and opportunity, and we welcome the fact that you're studying this issue and helping us do that.

● (1555)

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

Finally, we have Ms. Cicely McWilliam, coordinator for the Every One campaign, Save the Children Canada.

Ms. Cicely McWilliam (Coordinator, Every One Campaign, Save the Children Canada): Thank you, Chair.

Thank you, committee members, for giving Save the Children the opportunity to present today.

Save the Children works in Canada and 120 countries overseas to bring immediate and lasting improvements to children's lives. Save the Children focuses on the issues of health and nutrition, education, HIV/AIDS, child protection, emergency relief, and child rights. My specific focus, as the chair mentioned, is the Every One campaign, which is our newborn and child survival initiative.

My colleague Chris has spoken of the shocking number of children and mothers who are dying annually of preventable and treatable causes, and she has outlined the brief presented to the Canadian government by our group of six, a coalition of international aid agencies and advocates working on this issue. Like our coalition partners, Save the Children believes there should be a real drive to expand the coverage of proven integrated interventions that reduce maternal, newborn, and child mortality. These include: skilled personnel available during pregnancy, childbirth, and after delivery; preventive and curative treatment of pneumonia, malaria, and diarrhea; and support for nutrition, including breastfeeding, complementary feeding, cash transfers, and wider social protection programs.

Given the recent global economic crisis, it would be easy to be pessimistic about the prospects of achieving MDGs 4 and 5; yet we know that a really dramatic reduction in the number of child deaths is achievable. We know it because many low- and middle-income countries have cut mortality significantly over the last few decades. Many have done so more rapidly than today's developed nations have managed to do in the last century. Although further progress is of course needed, since 1990 more than 60 countries have reduced their child mortality rate by 50%.

One of Save the Children's programmatic approaches to reduce maternal child mortality is the household-to-hospital continuum of care, which strengthens the capacity of caregivers. Whether in the household, the community, health facility, or hospital, this approach helps to address major causes of death before, during, and after childbirth for the mother, as well as the causes of newborn mortality. The approach is outlined on the slide that was presented and that is in your package. You can certainly ask any questions on it during the Q and A afterwards.

Building health workforce care capacity should be a priority, particularly the recruitment and training of front line female health care providers to serve in their communities or in clinics close to their homes. Save the Children has also prioritized community case management as a global child health initiative to address the health needs of children under five. CCM is a strategy in which trained community health workers deliver curative interventions for potential life-threatening childhood infections in remote communities that lack access to health facilities, similar to what Chris outlined in Ethiopia.

For 11 years, Save the Children has reported on the state of the world's mothers. Pregnancy and childbirth is a very risky time, as we know, for mothers in the developing world. Approximately 50 million women give birth each year at home with no professional help whatsoever. This year's report examines how investments in training and deploying female health workers have paid off in terms of lives saved and illnesses averted. It points to low-cost, low-tech solutions that could save millions more lives if only they were more widely available and used.

If we want to solve the interconnected problems of maternal and newborn mortality, we must do a better job of reaching these mothers and babies. Studies show that women prefer female health workers, particularly for uniquely female health issues such as pregnancy and family planning. In some countries, women choose not to vaccinate themselves or their children when the vaccine is administered by a male health worker because they fear the perception of sexual infidelity, or, in the case of some Muslim countries, when modesty precludes women, for example, from lifting up their garments for the vaccine itself.

The report, which is an international report by Save the Children international, dovetails nicely with the Canadian recommendations. We call for training and deploying more health care workers. The number we've put on it internationally at Save the Children is 4.3 million health workers, if we are to meet the millennium development goals by the target date. We also recommend providing better incentive to attract and retain female workers, particularly those working in remote or under-served areas, and that would certainly include better pay and training, support and protection, and opportunities for career growth and professional recognition.

● (1600)

We also believe, of course, that an increased investment in girls' education is essential. If we are to enlarge the pool of young women who are qualified to be health care workers, we must invest in education, obviously. But also, by investing in education we empower future mothers to be stronger and wiser advocates, not only for their own health, but for the health of their children.

Finally, we recommend strengthening basic health systems and designing health care programs to better target the poorest and most marginalized women and children. As we all know, health systems in many developing countries are grossly underfunded and cannot meet the needs of their communities. More funding is needed for staffing, transport, equipment, medicine, health worker training, and supportive supervision, not to mention the day-to-day costs of operating these systems.

Today's developed countries have already cut their mortality rates dramatically over the course of the last century. Many developing countries have made huge strides, often in difficult circumstances. We do not need a major technological breakthrough to dramatically reduce newborn and child mortality; we only need to learn from other countries' successes. We don't need innovation, per se; we simply need the dedication of the adults of the world.

It must become intolerable to all of us here in this room and outside it that a child could die of a preventable or treatable cause, or indeed that a woman should die simply because she's too far away from a hospital or can't afford to have access to health care before, during, or after birth.

The deaths of millions of young children and mothers every year is a moral outrage and comparable to the worst abuses and social evils of the past. Every one of us has a role to play in tackling this problem. Further delay or inaction is simply inexcusable.

Thank you.

The Chair: Thank you.

Now we're going to move to the first round of questions. These rounds are of seven minutes each, but that includes both questions and answers, so I would really like everyone to be as crisp and succinct as possible in both asking questions and answering them.

We will begin with the Liberals, with Ms. Neville.

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

I thank all of you for being here, in person and by video.

We've certainly heard diverse presentations today. You've all offered very helpful testimony, certainly concerning the child component of the maternal and health initiative. I know that as we get into developing the report, all of your presentations will be considered.

But if you've been following the committee reports, I think you will note that we have been focusing fairly substantially on the maternal health component of the initiative. The testimony of the witnesses of the previous committees talked about the need to reconcile the current proposals by the government with Canada's international commitments and obligations on maternal and child health.

I'm going to put my questions out and then let the time run away with them.

For all of the witnesses, I would ask, given that the G8 has previously committed to a comprehensive approach to maternal and child health in Italy in 2009, and secondly, that the Secretary-General of the UN just today here in Ottawa called on the G8 leaders to honour their previous commitments and promises, would you be supportive of a comprehensive Canadian foreign policy on maternal and child health?

I'll hear your responses, and then I have individual questions for each of the groups.

● (1605)

The Chair: We'll begin with Ms. Snowdon.

Dr. Anne Snowdon: Would I be supportive of a comprehensive strategy for maternal and child health? Of course I would be supportive of that. I would encourage a focus on collaboration with the various target countries. One size does not fit all, in my experience, so the population and the specific community needs have to be addressed at every system level in a very collaborative approach.

Hon. Anita Neville: Thank you.

Ms. Christina Dendys: Yes, of course I'm supportive of a comprehensive approach for the G8 initiative, and a value-added approach for Canada where we can have the most impact as part of that comprehensive approach.

The Chair: Ms. McWilliam.

Ms. Cicely McWilliam: I feel like I should essentially just say "ditto". Of course we support a comprehensive approach. We have been a participant in the creation of the brief, which talks about what we feel is Canada's value added.

I think the brief speaks for itself in that regard.

Hon. Anita Neville: We haven't had a chance to look at it. We just got it, so I haven't read your brief yet.

The Chair: Ms. Fuselli.

Ms. Pamela Fuselli: I would echo the opinions that have been expressed and add my support to Dr. Snowdon's comments about involving those who are going to be impacted by any of the policy outcomes.

Hon. Anita Neville: I'm assuming, then, from your remarks, that you would believe that full access to all reproductive services would be included as a basic human right; correct me if I'm wrong.

I have some other questions as well.

For Results Canada, from your perspective, what are the top three evidence-based interventions for women's reproductive health and for maternal health and for child survival?

For Save the Children, you referenced substantially the training of health care professionals. I would be interested to know how your organization trains and works with other countries to train and build capacity of health care professionals.

For Ms. Snowdon and for Ms. Fuselli, is it your understanding that injury prevention is part of the G8 commitment to maternal and child health that was made in Italy last year?

Ms. Christina Dendys: In terms of where we are, in our brief, I think we've identified that we think the top intervention in terms of addressing maternal and child health both—this, I think, is echoed in the brief of the Partnership for Maternal, Newborn and Child Health—is access to health services and skilled health attendants along the continuum of care, including front line health workers, but all along the continuum of care.

We've highlighted front line health workers as an entry point for Canada, and that certainly is highlighted within the partnership's manifesto as well. In fact, I think they call for a million skilled and trained front line health workers as an actual numeric target.

In terms of the interventions that address child survival and child mortality, the four leading killers of children are pneumonia, malaria, diarrhea, and an underlying cause in malnutrition. What we're suggesting is that you can't really isolate what the interventions are. We've been advocating for an integrated bundle of interventions that would be delivered to treat the whole patient.

The Chair: Thank you.

Ms. McWilliam.

Ms. Cicely McWilliam: Save The Children obviously works predominantly with children. When we do work on maternal health issues, it is often through the work we do with children. For example, we do a great deal of work around breastfeeding and we do a great deal of work around prenatal support and vitamins and postnatal care. That is our focus. Save The Children as an organization does not perform abortion services, just to be clear.

In terms of what we believe is the focus—I'm sorry, I thought you might have had the brief earlier, but I can clarify—as Chris was saying, we do believe that the focus for the Canadian value-add is front line workers. As I said, at Save the Children we actually call for a greater number of front line workers than the partnership does. We call for 4.3 million health care workers in general, but a lion's share of those in the field.

As for the training we provide, for example with the community health workers in the CCM project, we ensure that they can diagnose malnutrition, can diagnose pneumonia, diagnose malaria; that they can provide treatments for those illnesses. We do kangaroo care, which is essentially teaching women—

● (1610)

The Chair: Could you please finish?

Ms. Cicely McWilliam: Wrap it up? Okay.

So that is the kind of work we do when we work with community health workers, and that's who we train.

The Chair: Thank you.

That ends Ms. Neville's round.

Now we go to the Bloc Québécois and Madame Deschamps.

[*Translation*]

Ms. Johanne Deschamps (Laurentides—Labelle, BQ): Thank you, Madam Chair.

Welcome. I am going to speak to you in French.

It is interesting to see from your presentations what each of your organizations is doing to improve health.

I have a question for Ms. Fuselli, Ms. Snowdon and perhaps also Ms. McWilliam, because I may not have grasped in what context you work. At Save the Children Canada, do you work here Canada? Do you work with partners internationally?

[*English*]

Ms. Cicely McWilliam: *C'est international.*

[*Translation*]

Ms. Johanne Deschamps: Ms. Snowdon and Ms. Fuselli, do you work in Canada, or do you have expertise that you export internationally?

[*English*]

The Chair: I'll begin with Ms. Fuselli.

Ms. Pamela Fuselli: Safe Kids Canada is part of a global movement called Safe Kids Worldwide. Our mandate is to address injuries in Canada itself, but we certainly work within the global context with our partners that have Safe Kids organizations in countries such as Germany, New Zealand, Uganda, Vietnam, Mexico, and Brazil. We come together face to face once a year, but we communicate more often than that, to share ideas and exchange opinions and solutions to issues. And certainly we build on the work of others working in other countries, taking pieces of information and successes that can be used in our own.

More recently, Safe Kids Canada is partnering with the Canadian Public Health Association in applying for a European Union grant to help support and build capacity in four countries: Uganda, South Africa, Tanzania, and Romania. So our mandate is specifically Canada but we do have outreach in terms of the international community.

Ms. Cicely McWilliam: As I said earlier, at Save the Children Canada we have some projects in Canada, but the majority of the work we do is overseas. We're in 120 countries.

[*Translation*]

The Chair: Ms. Deschamps, you may continue.

Ms. Johanne Deschamps: I asked Ms. Snowdon the question.

[*English*]

Dr. Anne Snowdon: *Merci beaucoup.*

My work is predominantly in Canada; however, I have worked with the World Health Organization around the training of health professionals and the looming shortage of nurses, particularly. For example, in 2020 the U.S. will be short one million nurses, and whenever a large, economically developed country is short of nurses, it tends to recruit from many other countries, developing countries being one of them.

So we do face a tremendous challenge in our delivery system of children's and women's health intervention programs around the health professional capacity. And further to my earlier comments, that's where collaboration among countries will become very central to manage that shortage of health workers.

● (1615)

[*Translation*]

Ms. Johanne Deschamps: For several sessions, we on the Standing Committee on the Status of Women have been holding discussions. The Standing Committee on Foreign Affairs and International Development has been doing the same thing. We have been meeting with civil society organizations to discuss major priorities.

The fifth millennium development goal is said to be the one on which the least progress has been made in developing countries. On the eve of the G8 meeting that will be held in Canada in June, we are trying to show, through the testimony of our guests who come to share their expertise with us, that 2015 is not very far away. It is just five years from now. Most of the people who have come here are calling on Canada and other donor countries to increase their aid envelope by 50% to achieve the goals countries have set for themselves. Representatives of the Global Fund to Fight AIDS, Tuberculosis and Malaria came to tell the Standing Committee on Foreign Affairs and International Development this week. Canada made a commitment in 1995 that it reiterated in 2000 and again in 2009 in L'Aquila, Italy. Today, the Canadian government is working to honour that commitment and has made it a priority.

I feel that all measures and all initiatives are good. But in countries with high infant and maternal mortality, I wonder what can be done in the way of prevention. Earlier, Ms. Fuselli talked about bike helmets and car seats. I went to Uganda last year and visited refugee camps. What impact can Safe Kids Canada have in Uganda, for example, Ms. Fuselli?

[*English*]

The Chair: Madam Fuselli, there's only one more minute left in this round, so perhaps you could be brief.

Ms. Pamela Fuselli: The leading cause of death worldwide is motor vehicle collisions. But certainly in the developing and middle-income countries, that needs to be looked at under the broader umbrella of road traffic safety, in terms of pedestrians interacting with traffic, cyclists, as well as motor vehicles. While the leading cause of death may be the same in Canada as it is in Uganda, in Uganda the focus is more in terms of pedestrian safety.

Looking at the specific countries and the issues that are facing them, we need—as Dr. Snowdon said—not a one-size-fits-all, but to take into consideration what is the most effective approach to reach the highest number of people affected.

The Chair: Thank you. I think we have finished with that round.

We will go to Ms. McLeod, for the Conservatives.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

The first thing I have is a comment. Certainly the G8 initiative is comprehensive. I think it's important to recognize that the WHO definition of family planning does not actually include abortion.

I do find it unfortunate that we keep getting sidetracked. We're here talking about child health, and we keep getting sidetracked back into that issue. Really, we don't want to reopen that debate and we don't want to be doing things that divide Canadians, so in regard to the initial comments in terms of the comprehensive plan, it is a comprehensive plan and it's certainly respecting the WHO definition.

From there, I would like to pick up on the topic of childhood injury. I'm actually struggling a little bit. When you go to these developing countries and you see five or six people, a whole family, on scooters, is it at all practical, or is it something that perhaps shouldn't take a prominent role, and we really should be focusing on maternal and child health, focusing on those interventions in these countries?

I guess that would be to both Dr. Snowdon and Pam Fuselli. How do you see that this might be practical in terms of childhood injury prevention in the particular maternal and child initiative with the G8?

● (1620)

Dr. Anne Snowdon: For road safety and injury prevention, you really have to look at a systems approach. One of the reasons we focus on car seats in Canada is because we have well-developed road infrastructure and we have very strong public policy to support road safety initiatives and injury prevention in particular.

In developing countries, they often lack road safety infrastructure, road safety policy, and trauma care as well. If you have policies against five people riding on a scooter, then many of the injuries that come with those scooter accidents decline rapidly, as we saw in Canada in 1977 with the seat belt legislation.

It's a complex problem. You need a very comprehensive strategy at the system level to get the policy in place and the road infrastructure issues started to be addressed.

I would advocate a partnership with existing groups, such as the Global Road Safety Partnership, which is affiliated with the Red Cross, because they're in these developing countries looking at each of those major issues.

Again, each country has different issues, but you would really have to address each of those four large levels of the system in order to make the impact.

Mrs. Cathy McLeod: But you are suggesting that it should be part of a plan as we move forward in terms of this maternal and child health initiative.

Dr. Anne Snowdon: Absolutely. It would have to be part of what I would see as a comprehensive plan.

Mrs. Cathy McLeod: Pam, could you comment?

Ms. Pamela Fuselli: I would agree with Dr. Snowdon. It needs to be part of a comprehensive plan because of the high burden that it has in terms of deaths and hospitalizations. Again, the one-size-fits-all approach does not work, but there are certainly similarities across interventions.

One example that has been quite successful is in Vietnam. The SickKids Vietnam group has worked on getting helmets on every child's head and really focusing on what works for that community and what leaders they needed to engage to make this something that was popular and acceptable. Not that this would work for everyone, but they actually engaged in their own helmet production facility so that they could control the style and the standards. They really worked hard at all those different levels in terms of looking at what children needed, how they needed to be protected, how that was going to be enforced, and working at the multiple levels in terms of education, enforcement, and environmental change.

It certainly is not an easy fix and it does take time, but there are some success stories out there that we can look to for guidance.

Mrs. Cathy McLeod: My next question I'll throw out to anyone, because I'm not sure the answer is readily available.

When we talk about the 68 nations that we are looking at in terms of this initiative and we have percentages around mothers dying of hemorrhage and in childbirth, to what degree do we actually know the numbers of children dying of injuries in our targeted countries?

Dr. Anne Snowdon: There are significant gaps in the data. Many countries do not have the systems for reporting, so we have best estimates, largely. The World Health Organization is one of the sectors that we look to for those, but it is acknowledged, and in childhood health particularly, that there are substantial gaps in actual numbers. We're at the moment working with best estimates.

Mrs. Cathy McLeod: So we perhaps have more accurate guesses on diarrhea and malaria than we do for injuries. Is that accurate?

Dr. Anne Snowdon: I would suggest that if we're not tracking injuries accurately, we're not likely to be able to track some of the other causes of death for children, which really speaks to the need for surveillance systems and using information technologies readily available through cellphones to track on the ground what's happening in these countries and in these communities.

Mrs. Cathy McLeod: My next question is for Ms. Dendys.

You talked about $1.4 billion over five years. How did you come up with that number?

● (1625)

Ms. Christina Dendys: That's roughly the fair share estimate in terms of the G8 calculation of the $30 billion over five years. It's also a number that we thought was realistic in terms of where new investment could go.

Mrs. Cathy McLeod: And in terms of the caregivers that you talked about, the lay caregivers trained in Ethiopia, was it just around the most common illnesses, or did they have any training for assisting in childbirth?

Ms. Christina Dendys: They did have training in that as well. They actually got a year's training in terms of leading causes of death, not only actually among children but also in TB/HIV, and in sanitation and hygiene promotion. They got supplementary and additional training in being available as a skilled birth attendant, not a doctor but a skilled birth attendant, to address maternal health and be able to monitor and track pregnancies and deliveries.

The Chair: Thank you.

Now we move to Ms. Mathyssen, for the NDP.

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

Thank you for being here. I appreciate your expertise.

I'm going to start with a couple of question for Madam Dendys, but I do want to talk to everyone.

Globally, the leading cause of death among women of reproductive age is HIV/AIDS. By the end of 2008, women comprised about half the adults living with HIV/AIDS, and in sub-Saharan African, women and girls account for six out of every 10 people living with HIV.

Could you tell us the impact of HIV on maternal mortality, or the implications generally for the G8 initiative and beyond? I wonder, too, what role Canada has to play and can play in addressing this crisis.

Ms. Christina Dendys: Thank you for that question, actually. It's a very good one.

HIV remains a significant crisis on this planet, yet it feels as though people are getting a bit tired of talking about it, which is too bad.

From the studies I've seen, there are indications that women who are pregnant with HIV are seven times more likely to die than women who are not. So HIV remains a critical issue in terms of women, but also in terms of the global toll of deaths and illness.

I think there's a significant opportunity. I think we're kind of looking at the G8, but we need to look beyond that in terms of Canada's role. The MDG summit is coming up in September. There are other dominoes in line and things that we need to address leading up to that.

I was actually at a session hosted just this week that talked about Canada's contribution to the international microbicides initiative and also to the international AIDS vaccine initiative, and that contribution has stalled. I think there is some interest there in looking into that, because that contribution has dimmed.

But also, the Global Fund to Fight AIDS, Tuberculosis and Malaria is up for replenishment in the fall. About half the people who have HIV in Africa who have, they suggest, been diagnosed and are on antiretrovirals...about half of those are due to the Global Fund support. So this is a critical year for the Global Fund in October. Just looking past the G8, to October, we should be thinking about our Global Fund investments as well.

Ms. Irene Mathyssen: Okay. And then, of course, there's the transmission from mother to child.

Ms. Christina Dendys: Yes, also there's the transmission from parent to child, which is absolutely and completely avoidable. It kills about half a million children every year, I think, and is very easily and cheaply avoidable, if we get moms on ARVs and give the appropriate drugs around delivery.

Ms. Irene Mathyssen: I want to talk about the kind of aid that Canada provides. In budget 2005—I'm very proud of this—the NDP was able to change $4.6 billion in planned corporate tax cuts into affordable housing, education, public transit, and $500 million for international aid.

Now we hear from the government in the current budget that the plan is to flatline aid overall past 2011. It seems to me that this goes against any previous commitments we've made. We talk a good game, but we haven't delivered.

I wonder what your thoughts are in this regard.

Ms. Christina Dendys: I think the decision to flatline aid past this year is unfortunate, obviously, because I work in this area and I think we can no longer think about what happens "over there" as something that simply happens over there. We live in an interconnected globe. What happens in Africa or happens in rural areas of Mexico, where H1N1 started, matters here. It's a world with decreasing borders and certainly no solid foundations between countries.

So I think it's unfortunate that there was a decision to flatline aid. I hope, and again this is a longer issue for the committee, that in terms of Canada's role beyond the G8 we should be working to reverse that decision.

● (1630)

Ms. Irene Mathyssen: Thank you.

Ms. Snowdon, I was quite interested in the discussion about having a comprehensive plan in terms of the G8. I want to read a quotation from Maureen McTeer. She was at the committee on May 5. She said:

> Some countries use the lakes as a method of transportation, or women will be on the backs of bicycles for 30 miles, in labour, trying to get somewhere. It's a bit late then.
>
> Why don't they go earlier? Perhaps it's because they have no money or perhaps they have no one to babysit their kids. Perhaps their husband says "No, you're not allowed to leave the village"...

That would seem to me to be the reality we're talking about in terms of this G8/G20 initiative. These are the kinds of lives we want to impact.

So I'm wondering how including this issue of transportation safety in the package is going to make a substantive difference when we consider this reality.

Dr. Anne Snowdon: I think the issue again goes back to engaging the key stakeholders in the countries we hope to be offering some aid and assistance and expertise to. The scenario you describe—for example, that culturally the women wouldn't leave the village, perhaps, without the permission, for lack of a better way to say it, of their spouse—really speaks to the issue of one size not fitting all. You have to engage the key stakeholders, the community leaders in the systems you're trying to have an impact on. I think we should use that as a guiding principle, rather than coming in with a very western view of health and health care delivery and health values. It's something you need to be aware of. You need to be thinking about engaging those people who are going to receive your care in planning how that care might be delivered.

I don't have expertise in maternal health—I'm a pediatric nurse—so I can't offer you an opinion or expertise in that area. In my experiences, when I work with injury prevention, I engage children. I ask them how they see themselves as being safe in a vehicle, and they tell me. That becomes a basis for how I teach families—children, mothers, parents—about how to stay safe in a vehicle. That kind of principle has been very successful. I would suggest it could perhaps be considered in the much broader system.

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

We're going to go into the second round. The second round is a five-minute round, with the same system: five minutes for questions and answers.

We will begin with Ms. Simson for the Liberals.

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

I'd like to thank all the witnesses for very interesting presentations.

I want to start by addressing something my colleague Ms. McLeod said. It was about shifting the dialogue, first and foremost.

The Prime Minister shifted the dialogue by becoming selective about what he was going to honour. The G8 declaration, signed by our Prime Minister in Italy, included a full range of reproductive interventions that, quite frankly, included family planning and abortions. It's this document that forms the basis of this year's G8 initiative, not a WHO definition.

So my question is this. Given that you all mentioned that you support a comprehensive approach, wouldn't you agree that this is now maybe becoming a menu-like approach, based on what our government would like to do, and would contradict this consensus on a comprehensive approach, and in doing so would drastically reduce its effectiveness?

The Chair: We'll begin with Ms. McWilliam.

Ms. Cicely McWilliam: To be honest, I actually will choose to stay silent on that, in large part because there is a reason why we as a group, and Save the Children in particular, in our brief focused on community health workers. It's that we really felt that this was where the need is.

It's not that we don't support the notion of a comprehensive approach. We're a member of the Partnership for Maternal, Newborn and Child Health, and as a member we have certainly endorsed their overall mission statement.

But from the point of view of the work that we do, what we see—

● (1635)

Mrs. Michelle Simson: Yes, you did testify that your organization doesn't offer any abortion services.

Ms. Cicely McWilliam: Right, but beyond just the services we provide, I'm talking about what we see on the ground and the fact that roughly 85% of the women who are dying are dying not because of or related to abortion.

Those are all reasons why we felt it was important to focus on providing skilled attendants—

Mrs. Michelle Simson: You mean they're not dying as a result of a lack of access to abortion?

Ms. Cicely McWilliam: No, no, 85% are dying through lack of access to skilled birth attendants and because of sepsis, etc.

Mrs. Michelle Simson: I don't mean to cut you off, but this is a five-minute round, so I want to give the other witnesses an opportunity.

Ms. Cicely McWilliam: Fair enough. But that's why I sort of stayed silent, on balance.

The Chair: Ms. Dendys.

Ms. Christina Dendys: I actually didn't think you stayed silent. I thought it was a good answer.

We focused on Canada's value-add being front line workers because we thought that's where we could have tremendous impact for the very poorest people where they live.

But in terms of a comprehensive approach, what I heard coming out of the development ministers meeting was that under the G8 initiative as a whole, countries will have an opportunity to invest where they feel they can have the most impact, based on their skills and their capacity, and that Canada's approach would be focused on contraception and other ranges of opportunities, but not necessarily abortion.

Dr. Anne Snowdon: I have nothing further to add.

The Chair: Ms. Fuselli.

Ms. Pamela Fuselli: No, this is outside of my scope of expertise, for sure. Certainly we focus on the child side.

The Chair: Thank you.

You have one and a half minutes.

Mrs. Michelle Simson: If you focus on the child side, would you reject evidence that access to safe abortions and contraception could prevent up to 40% of maternal deaths, which has a direct impact on a child, who can die as a result of their mother having died?

Ms. Pamela Fuselli: The topic is completely outside of my scope of expertise.

The Chair: Ms. Dendys, did you want to answer that? You seemed to be...

Ms. Christina Dendys: I'm sorry, I was confused about who it was directed to.

You said that a large proportion of women die because of lack of access to contraceptive care. What we're advocating concerning these front line health workers is certainly the capacity to deliver a full range of supports in terms of contraception and family planning and birth spacing.

The Chair: You have 30 seconds.

Mrs. Michelle Simson: The other part of the question was this. If mothers are dying, if 40% of maternal deaths are lack of access to safe abortions, because they're jumping off roofs, would you not agree that it has a direct impact on the lives of children?

Ms. Cicely McWilliam: I'm sorry, I've not heard that statistic, so I can't speak to it.

The statistic that I've seen repeatedly is that it's roughly 15% of women. That's not something to sneeze at, not by any stretch of the imagination. I don't want to leave the impression that I think that's an acceptable number. But as I said, because the majority of the women, according to the statistics, whom we've seen and worked with as organizations are dying because of problems related to the carrying of a child to term and the problems during delivery and after delivery, that is where we felt the focus should be.

The Chair: Thank you.

I'm going to go to the second person on the list. That's Ms. Wong, for the Conservatives.

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

Thank you, ladies, for coming to this committee.

I think we have looked at something very important. I agree that there are a lot of cultural impacts in the fact that some children are not well protected. When I was in Swaziland, when I was in some remote areas of China, I saw children who were not protected at all on most dangerous roads. I applaud you for the great work you've done.

Likewise the global agenda, and also the influence of social networking, is equally important. However, I'd also like to look at some of the issues you brought forward in your presentations earlier.

Right now, for children, for the mothers, and also to improve their lives and to make sure that they're healthy—this is addressed to all of you—what is the role of nutrition, clean water, and inoculation in addressing maternal and child mortality? We know that in Canada those are very important issues and we were able to handle them. What about internationally? What do you think the role is in your experience?

● (1640)

Ms. Cicely McWilliam: Clearly, clean water is incredibly important. It prevents diarrheal disease, as an example. Undernutrition, malnutrition, is an underlying factor in many diseases and across the range, including pneumonia, but also HIV/AIDS, etc. It has a negative impact, obviously, across the board. Clearly, addressing undernutrition is important, and providing clean water and sanitation is important, if you're going to not only reduce these numbers but reduce them in a sustainable way moving forward.

Mrs. Alice Wong: Ms. Dendys?

Ms. Christina Dendys: I would echo what Cicely has said. Nutrition is absolutely crucial, but it's part of an integrated package that must be delivered—not a single bullet, but an integrated package. Children don't just die from malnutrition; they die from a number of different things at different points. We need to ensure that it's an integrated bundle of interventions that are delivered to save lives.

Mrs. Alice Wong: Yes. I also applaud you for the beautiful graph you've produced for a household-to-hospital continuum of care, which actually is equally important in developing countries where I have worked before.

Under the household you have the mother, the newborn, the husband, the inlaws, the women, and others. Can you expand on that? How important is it that these people in developing countries will have access to well-trained medical personnel?

Ms. Cicely McWilliam: One of the things that you may notice we talk about in the household... That is the area in which we talk about traditional birth attendants, and community health workers can have a great impact.

An example that's very interesting is in India, where local women who were respected—who weren't health professionals, but were married ladies, as it were, and were respected within the community—were given training, went into the communities, and created women's groups, essentially, in which they shared information, taught each other, and acted as key facilitators. In those communities, the newborn mortality rate dropped by 45%.

There are a lot of examples of that. In Bangladesh we have female community health workers. In Nepal there were also female facilitators, and also in Bolivia. We see it here, actually; we see it in lactation clubs and groups that support lactation services and help each other. We see it in our public health, which we don't think of, maybe, but there are people who go out from public health and who can provide assistance with lactation counselling.

We do it here, and they can do it there. They just need some training and support to formalize it.

The Chair: You have 20 seconds left.

Mrs. Alice Wong: So that is what the countries you have served have told you.

Ms. Cicely McWilliam: I'm sorry?

Mrs. Alice Wong: So that is your experience internationally? Those are the needs?

Ms. Cicely McWilliam: Yes.

Mrs. Alice Wong: Thank you.

The Chair: Thank you, Mrs. Wong.

Now we go to Madame Demers for the Bloc.

[*Translation*]

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

Ladies, thank you for being here.

The World Health Organization says that for the fifth millennium development goal to be achieved, maternal mortality rates will have to decrease much faster that they did between 1990 and 2005, which means that there must be greater focus on women's health care and prevention of unwanted pregnancies and unsafe abortions, and women must be able to receive quality obstetrical care during pregnancy and childbirth.

Today, one seventh of the women in Africa die from failed or unsafe abortions or in childbirth. Nearly 1.7 million women a year have abortions that leave them injured, mutilated, unable to have children after or dead because they had children after. A total of 45,000 women die every year.

You said that was nothing to sneeze at. Don't all these women have the right to stay alive, like any woman who wants to have children, and look forward to having a child one day when they are ready to have one?

Don't you think that our goal as a country should also include ensuring that all women can live and survive pregnancy and childbirth or an abortion of an unwanted pregnancy?

● (1645)

[*English*]

Ms. Cicely McWilliam: First of all, as I said before, Save the Children is a member of the partnership, and we support the notion of an entire support of reproductive care, or health care in totality. What I was saying in relation to the focus of this brief is, again, where the consensus of the organizations who drafted it felt that the value-add for Canada was. Again, the G8 as a whole will take reproductive care up—

[*Translation*]

Ms. Nicole Demers: I am sorry, but I did not read your brief. I did not have time to read it because we just received it. I am asking you a very simple question.

You said you agreed that the full range of care should be provided. I do not agree that women in other countries should receive less care than women here. I am sorry.

Ms. Dendys, I would like your opinion on this.

[*English*]

Ms. Christina Dendys: I don't disagree with you, in the sense that all women should have access to health. What we were asked to present on was where we thought the value-added was and where we thought we could have tremendous impact in terms of the vast majority of women and children who are dying. We collectively have determined, based on my colleagues' expertise or the groups' expertise, that community care and front line health workers can have a tremendous impact and give tremendous value-added to the continuum of care.

A bigger issue related to what you are talking about in terms of the full range of reproductive choice is that one of the challenges in 90% of African countries is that there is no access to abortion. It's illegal.

Ms. Nicole Demers: *Madame Dendys, je comprends—*

Ms. Christina Dendys: I mean, there are ways to address that through the UN, and other ways as well, but I am just saying that we were asked to present here on what we thought our value-add was for Canada. So that's what we're presenting on.

[*Translation*]

Ms. Nicole Demers: I understand that you likely receive funding and cannot speak. That is clear.

[*English*]

The Chair: You have one more minute.

[*Translation*]

Ms. Nicole Demers: No, thank you, Madam Chair.

It is pointless for me to be here today after what I have heard.

[*English*]

The Chair: Thank you, Madame Demers.

Ms. Mathyssen for the NDP.

Ms. Irene Mathyssen: Thank you, Madam Chair.

I have another question in regard to the consensus in terms of the international community. We've obviously been looking at MDG 4 and 5, and we're hearing over and over again that the developed nations of the world are failing to meet the millennium development goals.

What are your perceptions of these goals? Are they attainable, how so, and how do we best explain the failure to meet these goals?

I'd like to start, if we could, with Ms. Snowdon.

Dr. Anne Snowdon: I'll comment primarily on the issue of health professional capacity. The health professionals are the delivery system in any country for health care to whoever needs health care. I think, really, one of the major challenges we face going forward in the next five to 10 years—which is very short term—is the availability of qualified health professionals globally, and developed countries will face that challenge just as the developing countries will.

Are they attainable? I think we are in serious risk of not attaining them, for many reasons, but one of the significant ones we face is the capacity to deliver health care through educated, qualified, knowledgeable health workers, whether they are registered nurses, physicians, specialists, or community aid workers. I would see that as one of the major challenges we face.

● (1650)

Ms. Christina Dendys: I think they're attainable if we want them to be attainable, and I hope that we do, because as my colleague said so eloquently in her presentation, this is a huge global tragedy that exists that 1.4 billion people live on less than $1 a day. For them, a luxury is a shack in a shantytown, or access to a toilet. And that's abysmal and abhorrent to me.

I think it's a lack of political will globally in terms of wanting to put our priorities in other places. Obviously, if we build that political will and we stand up and say this is unacceptable, then, if we can put a man on the moon, surely we can ensure that a child in Africa doesn't die for lack of drugs that cost pennies.

Ms. Irene Mathyssen: Okay.

I want to talk a bit about family size. In North America, we've just celebrated 50 years of access to birth control, and family size has decreased considerably. It has meant economic security and health benefits. A recent study, in fact, indicated that women who had taken birth control have a greater life expectancy and are at decreased risk for some kinds of cancer. Most importantly, it has given them control over their own fertility. That's not the reality in the developing world in so many instances.

What is the impact of a large family on women, on the family unit, in terms of the resources available to the family unit? You've described some of the reality. There is virtually nothing in terms of resources. What impact does that have on children's susceptibility to malnutrition, disease, living in poor conditions when women cannot control the number of children they have through any means?

Ms. Cicely McWilliam: I think you've painted the picture, actually. Large families, for poor women, do have those impacts in terms of health, in terms of nutrition, food availability, etc. Clearly, contraception is a very important piece of the maternal, newborn, and child health initiative, and it was something that our group felt very strongly about and has advocated very strongly that it is absolutely imperative for women to be able to space their births, to be able to control their reproductive lives in terms of the number of children they have. We do think that's very important and we do think contraception is an important piece of the maternal, newborn, and child health initiative.

I hope that answers your question.

Ms. Christina Dendys: I would just add that in study after study, when infant or child mortality rates go down, fertility rates go down as well. I just want to make that connection.

Ms. Irene Mathyssen: So do we need, absolutely, to have the full range of opportunities for women to control the size of their families?

The Chair: That would have to be a yes or no answer from anyone who wishes to answer, because we've run out of time on this round.

Ms. Christina Dendys: Yes.

Ms. Cicely McWilliam: Yes.

The Chair: The final question will be from Ms. Brown, for the Conservatives.

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

Chris, first of all I want to thank you for the opportunity to go to Bangladesh with you last year. It was an amazing, life-changing experience for me, and has given me a whole new perspective on what we need to do globally.

Each one of you spoke about prevention, and prevention being so important. I want to take us to an issue that affects so many of the countries we talk about, particularly in Africa.

I don't know how many of you have read the book *Infidel* by Ayaan Hirsi Ali. She talks at length in that book about her experience, where female genital mutilation took place, a custom performed by her grandmother on both her and her sister at the ages of 9 and 11. It's brutal. The stitching done to these young girls afterwards is for pleasurable sex for a male later on. But the effects on those girls—infections, bladder infections—were ongoing in their lifetimes. The psychological and physical impacts of that custom are horrific.

When we talk about prevention and these young girls who are becoming pregnant, the access to medical care is non-existent. But what if you had someone in the village who was a trained professional, at whatever level?

Chris, you and I saw women who were the *sasthya sabika* in Bangladesh. They were trained in the area of tuberculosis in particular. What would be the benefit of having someone trained in midwifery attending these young ladies in these countries where we are not going to be changing these cultures any time quickly, if ever? That is going to be a long-term strategy. How would such a preventative strategy influence the health of these young girls?

● (1655)

Ms. Cicely McWilliam: Save the Children actually works on the ground with partners. We do have an FGM program. I want to say it's in Burkina Faso, but I can't remember exactly. Essentially, the most important thing is that the health arguments and the health discussion are often the best ways to discourage this practice and make the link that it harms not only the mother but also often the child. It can lead to stillbirths and a number of problems in birthing the child.

Again, it must come from the community; it can't come from outside. They must make the arguments themselves. By having trained community health workers who understand the health implications of something like this, you often have better results in convincing the community—and convincing other women. We have to remember that it's other women, mothers and grandmothers, who actually not only perform this...

Ms. Lois Brown: Mutilation.

Ms. Cicely McWilliam: Yes. I can't even articulate it, actually.

So the education also has to come from other women.

Ms. Lois Brown: Would we prevent maternal deaths if we had someone there who was able to educate them through these things?

Ms. Cicely McWilliam: I couldn't give you a percentage. I imagine that, yes, maternal deaths would be prevented if you were able to prevent this atrocity from occurring, for sure. But I couldn't give you a statistic off the top of my head.

Ms. Lois Brown: Do I still have time, Madam Chair?

The Chair: You have one minute.

Ms. Lois Brown: Thank you.

Ms. McWilliam, you made a comment earlier that they reduced their child mortality rate by 50%. I missed something in there. What was the investment that achieved that, and what would it take to repeat that success?

Ms. Cicely McWilliam: I will probably have to come back to you with that. I don't have in my notes the investment that delivered that number.

It is in the *State of the World's Mothers* report. I have a copy of it. I can't distribute it widely, unfortunately, because it's not translated. If you want I can give it to you later, and then I can get back to you on that number, if you don't mind.

Ms. Lois Brown: Thank you. I'd appreciate that.

The Chair: Thank you.

That is the end of that round.

I want to thank the witnesses for coming. Sometimes I take the opportunity to ask one question, because as a chair I don't ask many questions.

One question I want to ask is simply this. I've heard the question asked around the room, but I have not actually heard an answer. I'm a physician, and the word "comprehensive" means the whole range of services that are available to people. I note that you talked about front line workers being important, and I agree with you. A basic health system that is functioning is an important thing. Both of those are extremely top priorities, but I don't understand how one can suggest that you can then achieve the millennium development goals by only focusing on those two, and not completely ensuring that the other comprehensive range of services is there.

Ms. Cicely McWilliam: I wasn't saying you would only have to focus on two. We are saying that the value added for Canada could be or should be this piece. It's not to say that the other pieces don't have to be addressed and shouldn't be addressed. That is the point we're making. We put the focus there because that's where we believe it's needed.

● (1700)

The Chair: I understand that.

Ms. Dendys, do you have anything to add further?

Ms. Christina Dendys: I absolutely agree with what Cicely just said. The broader G8 initiative—and beyond, because it's not all going to get solved in June—is comprehensive continuum of care. Our brief just focused on where Canada's specific contribution could be.

The Chair: Ms. Snowdon.

Dr. Anne Snowdon: Comprehensive in my perspective would also suggest balance. Just as an example, 3,000 people around the world today will die in road crashes, and another 3,000 the next day, and the next day—1.2 million every year. A balance would suggest to me to look across all of the threats to both women's and children's health.

The Chair: Ms. Fuselli.

Ms. Pamela Fuselli: I agree with Dr. Snowdon about incorporating injury prevention into that comprehensive approach. If you want to achieve results in children's mortality worldwide, injury prevention has to be a piece of that solution.

The Chair: Thank you very much.

I want to thank the witnesses for coming.

Ms. McLeod.

Mrs. Cathy McLeod: I know in past practice when we had extra time you asked the witnesses to do one-minute wrap-ups. Perhaps we don't have a lot of committee in camera business, so do we have time for that wrap-up?

The Chair: We actually do have a motion, and you know how in this committee a motion sometimes takes a long time, depending on the motion.

I don't know if the motion can be presented, though, because the presenter of the motion is not here.

Mrs. Cathy McLeod: Her substitute is here.

The Chair: The committee will have to decide whether they wish the substitute to present the motion.

Mrs. Cathy McLeod: I believe in the Standing Orders it's appropriate for the substitute to present the motion.

But I'm talking about the practice of wrap-up.

The Chair: I must say that, yes, obviously the Standing Orders say that you should. But I do recall, in this very committee, that when Ms. Mathyssen was not here to present her motion, this committee did not allow her substitute to present it, because the committee had agreed that this was how they wanted to function.

So I'm just talking about this particular committee.

Mrs. Cathy McLeod: Oh, I think we go with the Standing Orders, Madam Chair.

The Chair: Yes, but this committee always agrees at the very first meeting how they want to conduct themselves. A lot of standing orders are not observed by this committee. For instance, we don't have a steering group that decides what we will do next. We have made a lot of decisions in this committee as to what we do, and how we allow people to speak who are not members of the committee. We have to get unanimous agreement.

This has all been decided by this committee, and committees can decide on particular manners in which they want to comport themselves. I know that this committee has different rules from any other committee I've been on.

So I just thought I would mention that.

We now have 25 minutes for what has been allocated as half an hour for committee business. I would like to just thank the witnesses for their presence. Thank you very much.

Does this committee agree that they want Mr. Watson to present Ms. Boucher's motion?

Some hon. members: Agreed.

The Chair: Good. I will read Madame Boucher's motion, and Mr. Watson will speak to it.

This committee actually has to go in camera.

Does the mover of the motion wish to go in camera for the motion?

Mr. Jeff Watson (Essex, CPC): Do we have to?

The Chair: You don't have to.

Mr. Jeff Watson: We can stay here.

The Chair: That's fine. Okay. We'll stay here. Good.

The motion reads:

> That the Committee, as part of the motion agreed to on Wednesday, April 28th, 2010, invite as well as witnesses for the meeting of Wednesday, May 26th, 2010 an equal number of groups receiving funding from the list of 78 groups funded in 2009-2010 through Status of Women Canada.

Mr. Watson, you may speak to the motion.

● (1705)

Mr. Jeff Watson: Thank you, Madam Chair.

I will simply move the motion for discussion. I suspect others will want to discuss the substance of it. I don't want to step too far beyond Madame Boucher.

The Chair: Ms. Mathyssen, you had your name up.

Ms. Irene Mathyssen: Thank you.

Madam Chair, I have to confess that it's very difficult to make a determination about this motion. As it indicates, there were apparently 78 groups funded in 2009-10. We've asked several times to see the list of who is funded and who is not, and we have only been advised of three.

I think it would be very helpful to know who did in fact receive funding, and when we see that list then we can make the decision. But at this point I think it would be very, very difficult unless that list was provided.

The Chair: Ms. Brown.

Ms. Lois Brown: Madam Chair, first of all, there was a press release put out by Status of Women Canada that listed all 78.

But I wonder if I could make a friendly amendment to this motion.

The Chair: Mr. Watson.

Mr. Jeff Watson: That's fine.

An hon. member: [*Inaudible—Editor*]

The Chair: Well, if the mover agrees they don't want to debate it, that they accept it as it is, it does work.

Ms. Brown.

Ms. Lois Brown: So it would be amended to read this:

> That the Standing Committee on Status of Women, as part of the meeting agreed to in the motion passed on April 28, 2010, invite also as witnesses for the meeting of May 26, 2010, three groups from each of the five funding regions (National; Atlantic; Quebec and Nunavut; Ontario; West, Northwest Territories and Yukon) to be chosen by the Committee from the total list of 78 groups that received funding in 2009-2010 through Status of Women Canada-Women's Community Fund, as the Committee is inviting groups who did not receive funding during the same fiscal year through the fund.

The Chair: That is more than a friendly amendment, because it changes some of the intent.

Ms. Lois Brown: Really it's to expand it to include those other groups.

The Chair: Well, it changes the intent of the motion. The motion was for an equal number, and if you're asking for a certain amount from each region that may be more than an equal number.

Ms. Lois Brown: Hopefully it's just to put fairness into the process from across the country. That's the intention.

The Chair: I'll read the amendment...

Did you want to speak to the amendment, Ms. Demers?

[*Translation*]

Ms. Nicole Demers: Yes, Madam Chair.

There would be five regions and three groups per region, so we are talking about 15 groups that received funding and 15 that did not, which makes 30 groups in total. The meeting runs for two hours. I don't know whether we'll be able to give them a minute each.

[*English*]

The Chair: And to have 30 groups at one meeting for two hours—that's going to be fairly difficult.

Ms. Lois Brown: Well, it's 15.

The Chair: It's 30; if you have 15 who received funding and 15 who did not receive funding, that's 30 people.

[*Translation*]

Ms. Nicole Demers: She just suggested three groups from five regions that received funding.

[*English*]

The Chair: Then what you're suggesting is that you want to stick to the four who did not receive funding and add 15 who did. You realize you're moving away from the concept, in this motion, of equal. You realize that. So that's not a friendly amendment.

We don't have the mover of the motion here. It makes eminent sense to have the mover of the motion to speak; they know exactly what they intended and if they want their intention not to be there or not.

We don't have Madame Boucher here to say whether she agrees to moving away from equal and into what I would consider to be a huge number of people who were funded to a small group of people who were not funded. That certainly isn't equal.

The question I would like to ask the mover is does he mind if it is no longer equal?

Mr. Jeff Watson: I was almost going to raise a point of order. I thought the discussion of whether it was a friendly amendment or not would be up to me as the mover, not the chair of the committee.

The Chair: But that it is changing the word “equal” in this amendment.

Mr. Jeff Watson: Madam Chair, I'm entirely comfortable with the amendment as a friendly amendment.

The Chair: You are comfortable with it as a friendly amendment.

● (1710)

Mr. Jeff Watson: That's correct.

The Chair: Good.

So if you're comfortable with it, we will read the amended motion.

The motion then—in effect it's really a new motion—is as follows:

> That the Committee, as part of the motion adopted during the meeting on Wednesday, April 28, 2010, invite also as witnesses for the meeting of Wednesday, May 26, 2010, three groups from each of the five funding regions (National; Atlantic; Quebec and Nunavut; Ontario; West, Northwest Territories and Yukon) to be chosen by the Committee from the total list of 78 groups that received funding in 2009-2010 through Status of Women Canada—Women's Community Fund, as the Committee is inviting groups who did not receive funding during the same fiscal year through the fund.

That is actually seven groups we're asking for, at three times. That's 21 groups in total.

If I read your motion, it says the areas are national, Atlantic, Quebec, Nunavut, Ontario, west...

Ms. Lois Brown: There are five regions, right?

Mr. Jeff Watson: There are five groups—separated by semi-colons.

The Chair: Okay: it's one, two, three, four, five.

Now we will discuss the new motion.

Ms. Neville.

Hon. Anita Neville: Thank you, Madam Chair.

Let me go on record right at the outset as opposing both the amended motion and the original motion. Let me just speak to the amended motion.

I did see the list of the 78 organizations that received funding, but it was a list. It was not full disclosure as it came out in the quarterly reports. In the fully disclosed list, we would have not only the names of the organizations but the amount of money for each organization. If I remember correctly, that was not the case. So that's point one.

Point two is that we heard Ms. McLeod today talk about division. We heard the minister in the House talk about divisiveness. At a press conference we heard groups that did not receive funding talk about division. Everybody is latching onto this whole notion of dividing women's groups.

I would say that the amended motion, even more so than the original motion, pits one women's group against another. I find it abhorrent that we bring in winners and losers to tell their story and to say “I was better than you were”.

I simply won't support this kind of divisiveness and—I'm repeating myself—this pitting of one group against another.

The Chair: Thank you.

We have Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I believe in the original motion there was accommodation for other witnesses. Certainly the opposition has come out very strong and loud, with some very perhaps...I consider very insulting accusations regarding what has been happening with Status of Women and the funding.

I believe we're particularly proud of the amount that is in the fund and the great projects it's funding. So to have a completely unbalanced panel, yes, albeit disappointed that they did not get funding this time, I think is not being fair in any way whatsoever in terms of the reality of what we're trying to understand, which is how Status of Women is moving forward initiatives for women.

The Chair: Ms. Brown.

Ms. Lois Brown: I think Ms. McLeod said it very well. What we are trying to find, if I read this correctly, is what are the initiatives that are being successful in their communities, that are really helping women into productive and self-reliant and...just opportunities for them that are there. What are the initiatives that are really working in Canada?

Is one group entitled to funding forever just because they've had funding in the past? Is it their entitlement, or are there new initiatives that are going to be worthwhile to fund that may need seed money and they haven't been able to get it in the past because other projects have been receiving the bulk of the money?

In my own riding, several women's groups have not been successful in the past but are very intent on providing new services to women. Their funding has not been looked at in the past...not that they were all successful this time either. But it's just that they do have some new initiatives, and some of them need that seed money in order to get started.

I don't think we are really here evaluating the project itself but looking for how fairness should be across the country. I mean, I'm sure there are initiatives that have been funded in all our ridings that are new initiatives, and I would very much like to hear about some of those new ways that are being funded.

Is it possible for us to divide up the hours?

● (1715)

The Chair: We are getting ahead of ourselves here. First and foremost, we have to get this motion passed before we decide how many hours we will dedicate to it.

Before I go to Mr. Watson, I would like to quickly refocus everybody on exactly what we are talking about here. The original motion that was passed, that was going to ask for the special meeting, was asking for the special meeting specifically to examine the manner in which funding is distributed by Status of Women Canada, and in particular, it was to examine the apparent denial of funding to previous Status of Women grant recipients in the 2009 call for submissions, and invite the current and former ministers of Status of Women, etc., and other witnesses the committee wishes to invite.

So the reason for the meeting is to examine the manner in which funding is distributed and examine the apparent denial of funding to previous Status of Women Canada... So just refocus on what that original motion said when you speak to it.

Mr. Jeff Watson: Madam Chair, I think you just gave us the exact reason why we would want to call, if not 15, all 78 groups. If you want to talk about the manner in which funding is distributed, all the more reason you'd want to hear from groups that were successful. They may have opinions as to why their particular projects were successfully funded.

I want to respond to Madam Neville's intervention. I don't see why there is a fear of inviting other potential witnesses, other potential opinions. Surely there would be no objection to having the widest possible discussion on funding of Status of Women projects, unless, of course, there is a fear it doesn't fit in the opposition's narrative against the government. That could be the fear here...[*Technical difficulty—Editor*]...seen the list of groups but questions the amount they've been funded. What better opportunity to find out how they've been funded than by questioning the groups themselves? They'd be able to tell you. Call all 78 groups and have them tell the committee. It would be the opportune time, I would think, to pose those types of questions.

I'm not sure there's a common sense objection—at least not put forward yet—to say no to this particular motion and to call these particular groups.

The Chair: Madame Demers.

[*Translation*]

Ms. Nicole Demers: Thank you, Madam Chair.

I am having some difficulty understanding. The original motion, which we agreed to here, was designed to determine what had happened with the funding from Status of Women Canada. Ms. Boucher initially asked us to invite an equal number of organizations that had received funding, but that proposal was modified. Now, we are being asked to invite 15 groups that received funding so that they can tell us what really works in Canada. That is what you said:

[*English*]

what really works; let us see what really works in Canada.

[*Translation*]

That means that these 78 organizations that received funding would know what it takes for things to work in Canada, but the other 328 would not. So only the organizations that received funding deserved to be funded.

I am having a hard time understanding. It is as though the organizations that received funding are being pitted against the ones that did not. All we wanted was to understand why organizations that had received funding for 15, 20 or 30 years were no longer being funded even though they had the same goals as before. That was our question.

I don't understand anymore. I'm certainly going to vote against this. We are talking about 20 groups, which makes no sense.

● (1720)

[*English*]

The Chair: I think what we have here, Madame Demers, is that Mr. Watson agreed to this new motion, dubbed a friendly amendment. It's not an amendment; it's a new motion. Mr. Watson has actually removed the motion and allowed for the new one to sit.

So that's what we're talking about, the motion that was brought forward. Just to be clear on what we're talking about, it's Ms. Brown's new motion now.

Ms. Wong.

Mrs. Alice Wong: I want to clarify a number of things.

Whenever we talk about funding, we keep saying those are funding cuts. In fact, if you look at the total amount of money for Status of Women for these groups, actually it has been doubled.

If we go back to the original idea of having the study, it's to study the manner in which it is distributed. Right now, we are looking at the redistribution of funds.

If we just look at one side of the picture without looking at the other side as to how it is distributed—those who do not have the funding now and those who now have the funding—if we only look at those who do not have access to the funds, it doesn't tell the whole picture. That is why I think the whole spirit of the motion right now addresses the original purpose of this study, of asking the panellists to come to us. That's why I'm supporting this.

The Chair: Ms. Brown, and then Ms. Neville.

We're running out of time, so I would like everyone to please note what has already been said but just add something new here.

Ms. Lois Brown: Just to speak to what Ms. Neville was saying, hopefully we would be looking at this reallocation, because I see this as an education for myself. There may be organizations in my own riding, as in yours, where one might ask, what if their proposal had something else in it, or what was it missing? What would help them get funding another year?

So it's looking at a reallocation of the funds. It's not a smaller amount; it's more money in the fund. What was the reallocation, and does it mean that there is an entitlement because they've had funding in the past? I think that's what we're looking at.

The Chair: Order, please.

Yes, Ms. Neville.

Hon. Anita Neville: Thank you.

Let me say right at the outset that I'm not fearful in any way of hearing from anyone or seeing anyone, and I'm not in any way fearful of having the narrative altered, or whatever you want to call it.

What I am concerned about...and we heard it. I think it unlikely that we will have the previous minister come to this committee, but when she was here, at her last appearance before this committee, she made it absolutely clear—I asked her, and I went back and asked her again—that she had the final say on who got funding or who did not get funding. I remember the words. I said to her, "Minister, are you saying yea or nay?"

We know categorically that there are groups that went through the process that had every reason to believe from the bureaucrats that the funding was coming to them. Either they spoke out or the minister didn't like them or somebody didn't like them, and their funding was withheld, or not approved.

So I'm not fearful of the narrative being changed. I am sorry that it's unlikely that we will hear from the previous minister to ask her the process by which she determined how the funds would be given out or not.

I don't think it's our role to micromanage groups that get funding. There is a bureaucracy. I know, because I've spoken to bureaucrats over the years, that they work with the organizations, they work with the groups, to try to help them fit the criteria of the funding, and to advise them on how to fill in their applications. And it's been much more of a challenge for them since the offices were cut across the country; they've had to do it by phone, by e-mail, occasionally by travel. I met a group in Winnipeg a couple of years ago that were coming out to do it. But the reality is that that minister—I don't know whether this minister is operating the same way—had the final say on who did or who didn't get funding.

I want to know from the organizations that did not get funding whether they had every expectation that the funding was there, whether they adopted the criteria to meet the existing criteria, and what their history was, because many of them had a long, proven track record with capacity.

You talk about new organizations. There's no question: if we've got increased funding, then there's an opportunity for new organizations to get funding.

Just as a note with the new funding, I'm advised that some of the money under the partnership program has been lapsed for a few years, so we haven't spent all the funding under the Status of Women funding.

I just find this games-playing a charade, and I'm not prepared to support something like this.

● (1725)

The Chair: Okay, Ms. Neville.

Is there any further discussion on this motion?

No? I'm going to call the question.

I'm going to reread the motion so everybody knows what we're voting for here. We proposed that the original motion be amended to read as follows:

> That the Committee, as part of the motion adopted during the meeting on Wednesday, April 28, 2010, invite also as witnesses for the meeting of Wednesday, May 26, 2010 three groups from each of the five funding regions (National; Atlantic; Quebec and Nunavut; Ontario; West; Northwest Territories and Yukon) to be chosen by the Committee from the total list of 78 groups that received funding in 2009-2010 through Status of Women Canada-Women's Community Fund, as the Committee is inviting groups who did not receive funding during the same fiscal year through the fund.

Those in favour of that motion?

Those opposed?

I guess I will have to break the tie.

I always try to tell this committee why I'm voting the way I'm voting. I actually could have supported—very much so, because I thought it was fair—the original motion, which said “equal”. I think if you have 15 people who received funding and you happen to have five people who did not receive funding, it's an unfair grouping of people. I think it should be equal.

So I cannot vote for this motion.

(Motion negatived)

The Chair: There's a motion to adjourn?

Thank you, Mr. Calandra...

Mr. Paul Calandra (Oak Ridges—Markham, CPC): I wasn't actually moving adjournment. I was wondering if it's in order to actually move the original motion.

Can I do it now? Can I do it in 48 hours?

The Clerk of the Committee (Ms. Julia Lockhart): It has been moved.

The Chair: You can't. It has been moved.

Mr. Paul Calandra: I mean the original one. I'm wanting to....

The Chair: The person who originally moved the motion had ceded...

Mr. Paul Calandra: Does it need another 48-hours' notice?

The Chair: You'll have to come back with another motion, if you wish, after 48 hours.

Is there a motion to adjourn, please?

Hon. Anita Neville: So moved.

The Chair: The meeting is adjourned.

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