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Chair

Mr. Dean Allison

Standing Committee on Foreign Affairs and International Development

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● (1105)

[*English*]

The Chair (Mr. Dean Allison (Niagara West—Glanbrook, CPC)): Good morning.

Pursuant to Standing Order 108(2), we're resuming our study of the protection of children and youth in developing countries.

I just want to introduce my witnesses very quickly before we get going. We have Eva Slawecki, the interim executive director for the Canadian Society for International Health. Welcome. We're glad to have you here.

We also have James Chauvin, a member of the board of directors of the Canadian Society for International Health. Welcome, sir. We're glad to have you here.

Also joining us here in Ottawa, we have David Morley, the president and chief executive officer of UNICEF Canada. Welcome, sir.

Joining us via video conference from Toronto, we have Zulfiqar Bhutta, the co-director at the Centre for Global Child Health at the Hospital for Sick Children. Welcome, Dr. Bhutta. We're glad to have you join us here via video conference from Toronto.

I'm going to start with you, Mr. Morley. Then we'll move over to Mr. Chauvin and finish off with Dr. Bhutta, who is joining us from Toronto.

Mr. Morley, I'll turn it over to you, sir.

Mr. David Morley (President and Chief Executive Officer, UNICEF Canada): Thank you very much, Mr. Chair. It's an honour for UNICEF to be here today.

As an agency of the UN, UNICEF works in more countries and saves more children's lives than any other humanitarian organization. UNICEF Canada was established 60 years ago, and we work as part of the UNICEF family to do whatever it takes to ensure that children survive and thrive, by providing health care and immunization, clean water, nutrition, education, and protection from violence. Here in Canada, we promote public policy and practices in the best interests of children to contribute to the fulfillment of children's rights, as outlined in the Convention on the Rights of the Child, here in Canada and around the world.

UNICEF and Canada have a long history of partnering to improve the health and well-being of children around the world. For decades —for more than 30 years—the Government of Canada has consistently been one of the top ten government donors to UNICEF, and we've worked in partnership to address some of the most urgent needs of children and their families in the areas of health, nutrition, protection, education, and emergency assistance.

Despite the progress that's been made over the last 25 years, we still know that 17,000 children die every day from preventable causes, where simple low-cost interventions exist to save them. Almost one third of those deaths are preventable by vaccines. Immunization is one of the most cost-effective public health interventions, and UNICEF is the world's leading agency for vaccine procurement. We must continue to support these efforts of vaccination around the world and here in Canada too.

Some of the recent significant progress that we've seen has been in polio, which is almost eradicated. Last year, we were down to about 400 cases in the difficult-to-reach places of the world. Also, in maternal and neonatal tetanus, we have a partnership between UNICEF and Kiwanis that has reduced the number of countries that have to deal with tetanus, from 59 down to 24, over the last 15 years.

We also have partnerships with the Canadian private sector. Diarrhea is one of the leading killers of children, and we work together in India with Teck Resources of Vancouver in scaling up effective diarrhea treatment and strengthening health care systems in some of the most marginalized communities there. We're educating health workers on the effectiveness and use of zinc supplements, along with oral rehydration salts, and strengthening the local supply chain to make sure these treatments are accessible to even the hardest-to-reach children.

Almost half of the child deaths that happen every year have malnutrition as an underlying cause. I wanted to show the members this middle-upper-arm circumference bracelet. Since I'm not a medical person, this is the thing that helps me see what malnutrition means.

A child's bicep doesn't change much between six months and five years, so you can put this middle-upper-arm circumference bracelet —forgive me, those of you who are medical and would give better details than I can—around their bicep, pull it, and then see whether or not they're malnourished. If it's in the green part of the bracelet, they're sufficiently nourished, but if it gets into the yellow and into the red, you have malnutrition. For a child who is suffering from chronic malnutrition—in the yellow—their arm is the size of a toonie. That's what malnutrition is. Not only does it cause half of the deaths, but it also is a huge contributor to stunting.

Stunting affects almost 200 million children under five years of age. It can trap those children in a cycle of poverty, but we know that key interventions, when delivered during the critical 1,000-day period from conception to two years of age, can lead to a reduced prevalence of stunting. Improved maternal and child nutrition gives children a much better start in life.

HIV/AIDS also remains a disproportionally heavy burden on the world's children and adolescents. We project that almost two million children will still require HIV treatment in the year 2020. We believe that the Government of Canada must ensure that investments in the prevention and treatment of AIDS remain central to our maternal and newborn child health efforts.

Something that crosses between health and protection is birth registration. Some 230 million children around the world have not been registered at birth. Without a birth certificate, unregistered children are far less able to access vital social services and the protection they deserve. Birth registration is a means of protection because it can protect children from being prosecuted or punished if they come in contact with the law. A valid birth certificate is so important to enforce minimum age legislation that can protect children from early child marriage, recruitment of children in armed forces, or some of the worst forms of child labour.

We know that protection is a vital part of rearing a healthy child. Canada has been a respected defender of children's rights. It has a strong history of protecting the world's most vulnerable children from violence. We welcome Canada's leadership at the UN General Assembly in securing a resolution towards preventing and eliminating child, early, and forced marriage. We share this commitment to end child marriage along with all forms of violence against children.

Protecting children from violence, exploitation, and abuse helps ensure that those children who survive and benefit from Canada's investment also have the opportunity to thrive. These two efforts—keeping children healthy and safe—work together. Children cannot thrive if they are immunized and well nourished but then suffer from violence. Violence and abuse affect the child's physical and mental health in the short and in the long term. It can impair their ability to learn and socialize, which will impact their transition to adulthood, with adverse consequences later in life.

A child-safe private sector is also key to the protection and realization of children's rights. Businesses have direct and indirect impacts on children's lives through their policies and operations. UNICEF, Save the Children, and the UN Global Compact have developed children's rights and business principles to equip businesses to address their impact on the rights and well-being of children. We at UNICEF Canada are engaging the Canadian extractive sector through the development of guidance and tools and through individual initiatives with companies, associations, and consultancies.

The Government of Canada has a responsibility and an opportunity to ensure that the Canadian private sector is enhancing efforts to protect children from violence, exploitation, and abuse through committing to support the Canadian private sector in respecting and supporting children's rights in their overseas operations. That is why we encourage the government to tie the children's rights and business principles and child rights impact analysis into any funding that goes to the private sector overseas.

This is a critical year for children. World leaders are setting out a road map for human progress that will drive investment and action over the next 15 years. Negotiations for the new post-2015 development agenda are well under way. Over the coming months, discussions will culminate into two critical milestones: the framework for the sustainable development goals, the SDGs, which are set for adoption at the General Assembly in September; and the framework for financing for development in Addis Ababa in July.

UNICEF is firmly committed to ensuring that children remain at the centre of the next development agenda as they have been with the millennium development goals. Furthermore, we believe that an equity-based approach is essential to ensure that the most disadvantaged children are included in future development progress. It's not just the right thing to do. It's in everyone's interest.

I'd like to acknowledge and welcome the Government of Canada's publication and request for feedback on Canada's priorities for the post-2015 development agenda. We see strong synergies with UNICEF and Canada's priorities. UNICEF Canada is pleased to see Canada's commitment to making a priority in child protection, to ending child, forced, and early marriage, and to renewing the global effort to end preventable child and maternal deaths and ensuring access to quality education. We also welcome the fact that Canada has recently become a member of the Group of Friends on Children and the sustainable development goals to advocate for the rights of children and ensure that issues relating to the survival, development, and protection of children are central during negotiations on the SDGs, and to the discussion on financing for development.

● (1110)

In July, the international community will agree on the financing strategies to attain the SDGs, and investing in children is essential for these. We encourage the Government of Canada to work to introduce and support strong language on investing in children into the Addis Ababa outcome document, because investing in the early years of a child's life in child nutrition, in cognitive development, in child protection, yields long-term benefits for the individual and for society.

Adequate and equitable investments in children are a precondition for sustained economic growth. Unequal opportunities for children and persistently high levels of malnutrition, child mortality, and child poverty impose large burdens on the future growth potential of our societies. Investing in children is the prerequisite for the eradication of extreme poverty and ending poverty in all forms, so that the devastating cycle of intergenerational poverty can be broken.

Private and innovative sources of finance will be of increasing importance in financing the new SDG framework, and we welcome Canada's leadership in promoting innovative ways to finance development. But official development assistance remains critically important for countries that have limited capacity to raise public resources domestically, as does halting the decline of ODA to the world's poorest countries. Official development assistance and concessional finance should be targeted at those countries with the greatest needs, and an increased amount of ODA allocated for spending on children.

In closing, I want you to know that Canada's investment in children is paying off. In fact, we're in the middle of a child survival revolution that's happening around the world. Fewer children are dying before the age of five than ever before in human history. Fewer children are not going to school than ever before in human history. More people have access to clean water than ever before in human history.

This is the child survival revolution, and it doesn't look like it in this room, but we are in fact all revolutionaries and part of making this global change. This is a foundation for the future.

Now we need to take the next steps. We need to be sure that children have birth certificates, that they have quality secondary schooling, that they have strong laws to protect them from exploitation and abuse, so that all of these children—our children in the world—will not only survive, but thrive in peace and prosperity in the years ahead.

Thank you.

● (1115)

The Chair: Thank you very much, Mr. Morley.

We're now going to turn it over to Mr. Chauvin for his presentation.

Mr. James Chauvin (Member of Board of Directors, Canadian Society for International Health): Thank you very much, Mr. Chairman.

On behalf of the Canadian Society for International Health, I thank the committee for providing this opportunity to us to share with you our perspective and our recommendations about the mechanisms to protect the health, livelihood, and well-being of children and youth in developing countries.

The Canadian Society for International Health is a national, non-governmental, membership-based organization and charity working to improve the health for all people, to reduce global health inequities. and to strengthen health systems.

I'm not a doctor. My background is actually medical geography, and my career in public health and community development began in 1976. Over the past four decades, I've worked both in Canada and overseas with CARE, CIDA, IDRC, and up until June 2013, with the Canadian Public Health Association. I became a member of the board of directors of CSIH in November of last year.

My colleague Eva Slawecki is CSIH's interim executive director. She brings 15 years of experience in international health and health system strengthening, both in Canada and overseas.

[*Translation*]

Before I share our society's perspective and recommendations, I would like to define the term "global health". A number of definitions exist, but I will present the two that, according to the Canadian Society for International Health, reflect best principles and practices in global health better than others.

The first definition, put forth by colleagues from New Zealand, defines global health as an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide.

[*English*]

Global health has also been defined as the worldwide improvement of health, the reduction of disparities, and the protection against global threats that disregard national borders. Global health entails the design and putting into place of effective strategies for health improvement, whether population-wide or individually focused, that support and strengthen disease and injury prevention, health promotion, health protection, as well as treatment and care of the sick, the injured, the disabled, and the dying, with actions across all sectors, not just the health sector, to achieve the goal of health for all.

We appreciate that your committee is looking particularly within the theme of protecting children and young people in developing countries on issues related to trafficking, early marriage and forced marriage, the sex industry, female genital mutilation, and online abuse of children and youth.

● (1120)

[*Translation*]

The Canadian Society for International Health does not work directly on those issues, but thanks to its field experience in developing countries, it has seen first-hand the serious consequences those issues have on the health of mothers, children and youth.

[*English*]

Child marriage is a reflection of many of the social determinants of health, including poverty, poor education, and a lack of opportunities for safe and meaningful employment. Several organizations appearing before this committee proposed actions to modify the drivers of early marriage.

Too-early marriage can lead to adolescent pregnancies and increased maternal mortality, increased cases of fistula, heightened infant mortality, and disabilities owing to complications arising from mistreatment, abuse, poor living conditions, including malnutrition, limited access to health services, and premature labour. Too-early marriage can also have an impact on the health of newborns. For example, malnutrition indicators have been found to be worse for children born to mothers married as minors.

As Dr. Peter Singer of Grand Challenges Canada remarked in his presentation to this committee in June 2014, that Canada's approach to child protection should start just before the time of conception, with adolescent girls, and follow through to protecting pregnant women and the newborn child's mental and physical development throughout the first few years of life.

We appreciate that the health sector cannot improve health and health equity by itself. Addressing and ending child marriage requires a preventive, integrated, and multi-sectoral approach that goes beyond the health sector with action led by and supported through other sectors. These actions might include culturally appropriate communication messages, flexible education systems that allow young adolescent mothers to return to school following the birth of their baby, nutrition supplementation, and social welfare engagement.

One of the best value for money and highest return on investment public health-based strategies identified by the World Economic Forum and the Harvard School of Public Health for improved health and well-being is improved maternal, fetal, and newborn care, linking health care, public health, social, and educational strategies. A health systems approach to protect the health of young girls and women, and which could contribute to reduce and ultimately end child marriage, involves the deployment of fully and adequately trained community health workers and skilled birth attendants, skilled anesthesiologists and medical practitioners, the availability of information that enables young girls to make informed choices about their reproductive health, a good referral system to the next level of care, adequate transport for emergency obstetric cases, and a safe blood supply.

CSIH and the Canadian Public Health Association, through separate CIDA-funded initiatives in the post-war Balkans a few years ago, demonstrated the value of youth-led safe places where they could discuss issues they face and come up with strategies to reduce the risk of sexually transmitted diseases, sexual exploitation, drug use, and abuse. Youth-oriented models and initiatives were developed to increase access to counselling, prevention, diagnosis, treatment, and education for young people, thereby promoting healthy choices for youth.

[*Translation*]

As our colleagues from the Right To Play and War Child organizations explained when they appeared before your committee, there are several ways to empower children and young people, including by helping them become their own agents of change when it comes to safety and protection, by allowing them to actively participate in discussions about their safety, and by ensuring that they have real legal protection. Our society supports those strategies. We encourage you to give them your full attention and consideration.

[*English*]

Our colleagues have also commented on the need to engage and support the family in their efforts to care for children. CSIH would like to add to that the importance of ensuring that health professionals are also equipped to protect children and youth.

We seem to have a tendency to put lessons learned from projects in a drawer once the initiative is completed, rather than referring back and gleaning information from them. We always seem to want to reinvent the wheel, when so often we might already have the answer. I suggest we take time to re-examine lessons learned from past initiatives funded though Canada before we launch into new ones.

In Mali, CSIH and its partner organizations helped create a better integration and coherence between the various levels and components of the health system, particularly related to HIV/AIDS prevention, reproductive and sexual health, and nutrition, thus resulting in improved quality and access to, and use of, medical and social services offered in community health settings. There are as well important strategies to protect children and youth to be gleaned from CIDA-funded initiatives, such as the maternal-child health initiatives carried out in Zambia and Malawi several years ago.

And let's not stop once mother and child are discharged from the hospital or health clinic. Adequate and appropriate follow-up are prerequisites to a healthy life. I'd like to present an example from another former CIDA-funded initiative to rebuild public health capacity and services in the post-war Balkans region. Administered by the home-visiting nurses in the city of Belgrade, this service provided much-needed postnatal counselling and services to ensure the health of mother and newborn. It also identified health high-risk situations. Although the service focused on health, it served as well to protect women, newborns, children, and youth against abuse and neglect. This model was adopted recently by UNICEF as a best practice model in Europe and Central Asia. I think it's something we could learn from.

Another population health intervention with a high return on investment to protect children and youth is universal comprehensive immunization against vaccine-preventable diseases.

● (1125)

[*Translation*]

Canada has made and continues to make significant investments in global vaccination programs. Although considerable progress has been made in terms of reducing the burden of vaccine-preventable diseases, much remains to be done. Developing countries are facing a number of challenges in terms of vaccination, including the introduction of new vaccines, the impact on the vaccination of outbreaks of other diseases such as Ebola and the replacement of less effective vaccines with more effective ones.

[*English*]

An issue that has also been referred to by other witnesses and which has a significant impact on immunization programs is the effectiveness and reliability of civil registration. If a newborn's birth is not registered, then it is likely that he will not be vaccinated. Through CSH's work in Tanzania, we witnessed the impact of a lack of reliable baseline census and registration data on the capacity of health managers and planners to effectively allocate scarce resources to the most needed programs, places, and people.

The improvement in civil registration will help national immunization programs to achieve the goal of reaching every child. But one shouldn't stop just at civil registration. Investment should also be made in improving national census capacity, and not only in terms of collecting but also its analysis and utilization. National census data is critical to determining the effectiveness of health programs and how they protect women, children, and youth.

Before concluding my remarks, I'd like to return to the term "worldwide" within the definition of global health. Whatever the government of Canada decides to do in funding and strategies aimed at protecting children and youth in developing countries, it should ensure that it matches, if not surpasses, its overseas commitments with action on issues related to protecting children and youth in Canada. The Government of Canada can be commended for the international mother-newborn-child health initiative. We suggest a comprehensive national MCH program for Canada should also be considered.

[*Translation*]

In closing, thank you for your attention.

[*English*]

Ms. Slawecki and I look forward to your questions and further dialogue with you on this issue.

Thank you. Merci.

The Chair: Thank you very much.

We're now going to turn to our witness in Toronto.

Dr. Bhutta, the floor is yours, sir.

Dr. Zulfiqar Bhutta (Co-Director, Centre for Global Child Health, Hospital for Sick Children, As an Individual): Thank you.

Good morning. I am very grateful for the opportunity to appear before your committee. I am sorry that I couldn't be in Ottawa in person.

I'll say a word about our centre as we start. I am the chair of global child health and policy at our Centre for Global Child Health at the Hospital for Sick Children. I am also one of the seven member experts in the independent Expert Review Group of the UN Secretary-General for monitoring the MDGs and chair of the countdown process for monitoring trends.

Let me speak generally in terms of the issues that your committee has set in front of itself and start with the whole discussion on the millennium goals. I'll try very hard not to repeat and underscore some of the important points made by the preceding speakers.

Ladies and gentlemen, the last decade has been a phenomenal decade in human history. When we started the millennium development goals journey in 2000, the world had set itself a huge target of reducing child mortality by two-thirds and maternal mortality by three-quarters from a 1990 base by the year 2015, the year we are in. As we approach September 2015, when many of these targets will be reviewed, I think the last decade has seen tremendous progress. Today, from a base figure of around 12.5 million child deaths in 1990, we have been able to bring those down to around 6 million deaths worldwide, and maternal deaths worldwide from about 580,000 to a figure of around 280,000.

That has been a remarkable success in many geographic areas, including in global awareness of the importance of this issue. But it has also come with the realization that perhaps the focus on survival and on reducing this burden of premature mortality over the last decade has also led to several gaps. Those gaps have been highlighted by several of the presentations you have heard today.

One of those gaps was a lack of focus on equity. We have recognized that the bulk of the global progress and change has been driven by progress in a handful of countries, the Brazils and Chinas of the world. If you look at inequity in maternal and child health and survival today in the world, there are many countries that are still far away from achieving those survival targets. I very strongly underscore the huge role Canada has played, and is playing, in ensuring that we keep our eye on that principal focus of reducing premature mortality in some of the poorest countries of the world.

There has also been the recognition that in our desire and quest to achieve these goals perhaps we have not paid equal attention to several aspects that are important in terms of your committee's task. One of those is not having adequate focus on the determinants, particularly the social determinants, of maternal and child health and survival.

As I speak, I am very cognizant of the fact that over the last decade and a half, because of a lack of targets, the survival of newborns and the reduction of stillbirths have been orphaned as global priorities. As we speak, of the six million children who die prematurely every year before reaching their fifth birthday, around half or 45% die within the newborn period—the first four weeks of life—and the vast majority of them within the first few days of life. As my colleague David Morley pointed out, many of these are a direct consequence of inadequate maternal nutrition and factors that sometimes transcend one pregnancy, and maybe even a generation.

There hasn't been enough focus on morbidity and consequences. As we move toward sustainable development goals and the important issue of trying to address human capital and human development, we haven't paid enough attention in the last several decades to the whole concept of morbidity, mental health, and the important issue of child and family development. These are extremely important when you consider some of the tasks you have set in front of yourselves.

I want to underscore the whole issue of adolescence, particularly adolescent girls but also adolescent boys. This has not been on the radar screen over the last 20 years or so while we have been focused on the development of the MDGs and the post-MDG process.

● (1130)

As we speak, it is a startling statistic that around 60 million births every year, around 11% on average—in some populations, it's close to around 20% of all births—are by adolescent girls. In some parts of the world, these also include a substantial number of pregnancies in girls under 15 years old.

There are not just socio-cultural factors that contribute towards child marriage in many communities. They also reflect the lack of attention towards gender empowerment, the ability of girls to be in schools, and ensuring that state systems provide equal opportunities to boys and girls in those environments.

When, yes, we move towards the whole issue of trafficking and protection, it is important to recognize this is also a very important issue. What do we need to do to address the global tragedy of early child marriage, of children having children, which has consequences across generations?

We now know, colleagues, that close to a fifth of all stunting in children at six months of age is determined by the nutritional status of the baby. The nutritional status of the baby in turn is closely dependent upon the nutritional status of the mother. The nutritional status of the mother in turn depends upon what she was like when she was a girl. If you just do the statistics, it turns out that for around a third of all small-for-gestational-age births worldwide—babies who were born less than five pounds in weight and are therefore exposed to a developmental trajectory that's very different from their normal counterparts—the root cause lies in the way we support young mothers, young girls, in opportunities for development and education.

This is also very closely intertwined with the issue of how societies protect girls and the issue that you're tackling around female genital mutilation. The stunning figure is that of the 125 million individuals who are victims of female genital mutilation in the world today, the vast majority, or close to 80%, are from the 29 African and Middle Eastern countries. In these countries, it is also recognized that close to a fifth, around 18% to 20%, of all these female genital mutilations are at the hands of health care professionals.

I would very strongly underscore what my colleagues have said around the importance of Canada engaging, in our support to these countries around maternal, newborn, and child health, on these important areas of child rights and child protection, and particularly in working with governments to ensure that there are opportunities provided for girls' education and for their fulfilling their complete potential for contributing to society.

I want to say a word or two about boys as well in terms of the important subjects around conflict, child-trafficking, and exposure to violence. Very few people are aware of the global statistic that around a third of all under-five deaths and maternal deaths worldwide are now in geographies that are affected directly or indirectly by conflict. In many of these countries, as you are aware, perhaps better than others, children are not only just being exposed to violence; children are being forced, conscripted, to become part of that violence themselves. You just need to see what is happening at the hands of ISIS in Syria, and in geographic areas like Nigeria and Somalia, to see how important this whole issue of child soldiers is. Most of them are forced to play a part in this.

I wrote a paper, given my work in Afghanistan some 15 years ago, talking about the children of war, talking about the potential consequences of children being exposed to nothing but violence as they were growing up. As David has said, some of the problems we face today are because a generation has grown up facing nothing but violence. I feel very strongly, although I come from a child survival and maternal survival background, that, as we move forward to the sustainable development goals, we keep our eye on the importance of child rights and protection. We need to ensure that these children bearing arms, these children being confronted with violence in many of these geographies, are protected. I feel that whatever mechanism we have at hand, be it through development assistance or be it through working with countries as we implement our Muskoka II initiatives, we can support this through mechanisms that are promotive, protective, and legislative.

● (1135)

Lastly, I want to say a word or two about school-aged children. I say that with the recognition that the global science and public policy community hasn't sufficiently addressed the issue of school-aged children in relation to their morbidity, mortality, exposure, and the importance of this particular group in helping them enter adolescence in optimal shape.

We have focused largely on under-five survival and under-five needs as an agenda. There hasn't been enough focus, in the very countries that have about a 95% burden of maternal and child mortality, on addressing the issue of what happens in schools to health, nutrition, and development of children. They are very closely intertwined.

I would like to thank you, ladies and gentlemen, for your attention and the opportunity to share this testimony with you. I would like to underscore the fact that social determinants of health, which are the living conditions in which many women, children, and families in these developing countries live, are a reality. As we move forward, we need to expand our repertoire of work to include social determinants of health, not just social determinants of survival.

Thank you.

● (1140)

The Chair: Thank you very much, Doctor.

We're now going to start our first round, which will be seven minutes for questions and answers. I'm going to start with Madam Laverdière.

[*Translation*]

Ms. Hélène Laverdière (Laurier—Sainte-Marie, NDP): Thank you very much, Mr. Chair.

I want to thank all the witnesses for their extremely informative presentations.

I could easily spend a few hours asking you questions, but I will be fairly quick under the circumstances. I will first turn to Mr. Morley.

You suggested that it would be important to tie in the support provided to private companies, especially in development, with children's rights.

[*English*]

If you could expand on this a bit more, I would appreciate it.

Mr. David Morley: Thank you.

We've worked together at UNICEF and with the Global Compact, which is a private sector connection with the United Nations, to develop essential principles called children's rights and business principles.

I didn't bring them with me today, but the 10 principles are laid out and there is also the question of implementation. We introduced them in Canada about a year ago at a conference in downtown Toronto.

When businesses sign on to this, it's a way to ensure that they're taking into account the rights of children in their corporate social responsibility policies. Some of it has to do with not marketing certain products to children, and some has to do with ensuring that there is no child labour. But it does go further. As Zulfigar was saying, issues of the social determinants of children's rights are in there as well for children who are affected around the world. It also supports community development, education, and health.

So there is a whole tool kit, which we have shared with the private sector. We think it's important that Canada look at it. As we look at these new innovative ways of funding with the private sector overseas, here is a way to make sure that children's rights are respected and that it is truly beneficial to all children.

Ms. Hélène Laverdière: Thank you very much.

I think it is indeed a key point, because as we work with the private sector, there are the old issues of accountability, transparency, and respecting the Canadian ODA Accountability Act concerning human rights and children's rights.

You all made very good points. I should also tell you that I am a sociologist by training so when we're talking about social determinants of health I'm always quite interested.

I think you made another excellent point, Mr. Morley, that although we're trying to find new ways to finance international assistance, ODA is still essential. Right now Canada's ODA has fallen below the OECD average. It stands at 0.24%.

Can you tell this committee what kind of impact lower levels of ODA have?

Mr. David Morley: Well, I'd rather think about what higher levels could do, because they could make a—

Ms. Hélène Laverdière: Okay, fair enough. I like that.

Mr. David Morley: —because there's no doubt that the target that was set 40 to 45 years ago by the Pearson Commission of 0.7% of gross national income is one that we at UNICEF still believe in, and we still believe we should try to make it. It doesn't mean we should just scatter the money willy-nilly. I think what we have seen as an excellent example is from the United Kingdom, which has said 0.7%; Prime Minister Cameron said that. He's kept it there in the last couple of years. To go from where they were to 0.7% has been difficult, because you have to be able to spend it wisely, as I say, and we recognize there's been a process that U.K. aid—as they now call DFID—has done.

But we at UNICEF see that it has meant that more assistance reaches the poorest people, because frequently the private sector is not enough, because poor people are often even out of the market. So that increased ODA spent wisely on women and children and the poorest makes a huge difference.

At the same time, we support the efforts that have been made by the Government of Canada to get these other sources of funding, because we need the other sources of funding as well, but ODA is still crucial to global development.

● (1145)

Ms. Hélène Laverdière: I don't know if we'll have enough time, because I think my next question is for all of you, but we'll have a second round and we can come back.

Speaking of where ODA is essential, I believe it is the public health systems. You've all been involved in the ebola crisis. I know UNICEF has, and I presume you've mentioned it. Now that the crisis is winding down, what needs to be done in respect to the health systems in particular with the three main affected countries?

Mr. James Chauvin: Do you want me to answer that one? Okay.

Thank you very much for the question. Actually, it's an interesting question, because we just held the 14th World Congress on Public Health in India two months ago. I was the chair of the planning committee for that event, and we had more than 1,650 people from 70 countries. One of the topics discussed was the ebola situation. Actually, it was at a session organized by our own International Development Research Centre.

One of the critical elements that people felt should be looked at was that disease surveillance systems needed to be upgraded drastically. First, emergency preparation plans had to be put in place and applied, not just written up and put in a desk drawer, which has happened; and we needed to have sufficient internal response, basically country capacity response, for these emergencies.

Unfortunately, as we saw in the countries that were affected, many of the medical staff were affected by ebola and several of them died. Once you've lost a highly trained person in these countries, you've lost a generation of people. So how do we improve the internal capacity to take care of public health emergencies?

I think one of the other issues that came to light was the whole issue—and it reflects on sociology and anthropology—of understanding people's belief systems. One of the issues that was dealt with was the preparation of dead people, the washing of bodies; and of course, this couldn't be done with someone who had been infected with ebola, but people refused to bury them without doing these practices. So how do we, as health people, understand these practices and work with communities in order to protect them but, at the same time, take into account these very important social aspects?

I'll leave it at that for the moment.

The Chair: Thank you.

That's all the time we have. We'll probably get back to it at the next round.

I'm going to move over to Ms. Brown for seven minutes, please.

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

Thank you very much for being here. It's nice to see you all again.

Dr. Bhutta, thank you so much for joining us from Toronto. I think I'm going to be down visiting you sometime in June. I think there's an event then and I look forward to that because we have a great partnership with SickKids Hospital and you have been outstanding in the work you've done. Thank you so much.

Mr. Morley, one of the things that we've talked about is the need to continue with ODA and the disbursements. However, from my own experience I've seen how money has perhaps not been spent wisely in the past and I'm not convinced that it is about the amount of money necessarily but how we spend the money. I use the example of a project that I visited in South Sudan that had been funded some 10 or 12 years ago.

When I looked at it, I came back and I said to the minister, I don't believe this is getting the kinds of results that we really feel should be accomplished. I suggested that we actually double the capacity of the nurses training school in Juba, which would get front-line nurses out into the community.

Do you not think that those are the kinds of effective programs that we can engage in, because we know there is never going to be enough money? The Addis meeting is looking at a call for some $1 trillion globally, which is not available. We know that there is donor fatigue in many of the countries and in many of the projects we see a diminishing amount of money.

How do we ensure that the money that is being spent is going to be spent the most effectively and get the results that we know we need to accomplish?

● (1150)

Mr. David Morley: Thank you.

We can't just spend it willy-nilly. My career has always been in NGOs and I remember 15 or 20 years ago people saying that we needed focus in our international development and in what CIDA was doing, and I do believe that with the focus that has come to DFATD starting with Muskoka, now we're starting to see that it's mutually reinforcing. The focus has been helping what we've been doing and that's been very important in making things better.

As for some of the work on accountability, it is difficult for all of us involved in international development to admit when we fail because you're afraid you're going to lose your support, or your donors, because for us at UNICEF almost 50% of our money comes not from governments but from individuals and businesses. So admitting you failed is a difficult thing to do, but that's when much of the learning happens, and so then we would be investing more.... We see too often the money getting invested in things when it needs to be invested in the people and the capacity-building.

That kind of focus, be it for education or for health, is a vital focus that we need to have and we need to have the accountability as well.

Ms. Lois Brown: All of you have talked about the success, and here I'm going to come to you in a moment, Mr. Chauvin. Maybe you could wrap your question in here because I'd like to just pose a question as well.

You've all talked about the success of the maternal, newborn, and child health focus that we've undertaken. Of course, complementing that there needs to be a larger vision now for what we do with educating these children whom we've saved, and I hope that all of us have our eyes on that generation that is moving forward into school age and into adolescence

My question for you, Mr. Chauvin, is this. You talked about changing cultural norms, and when I was in Malawi the first time I met with a group of women who were talking to us as a parliamentary group about early and forced marriage and how they wanted us to take action to stop this. We heard that our foreign minister has brought this to the table at the UN, but when we were asked them why they didn't stand up they said that it was really important for them to be grandmothers, and that it is a cultural norm over which they have no control.

How do we start that education process that, yes, lifespans are not what we expect here in Canada, but how do we start to shift that dial?

Mr. James Chauvin: That's a good question and not an easy one to answer. When you were talking about that situation, I was reflecting on a former CIDA-funded program called the Southern African AIDS Training Program, or SAT, which was managed by the Canadian Public Health Association. It was dealing with the issue of HIV/AIDS in southern Africa, which of course in the early 1990s, when it started, was almost a taboo topic. We were dealing with people who were both infected and affected by HIV/AIDS, and the question came up, how do we give them the voice, or how do we help them get the voice? For it's not we who should be out there advocating; it's they who should be advocating.

It came down to providing them with safe spaces and an opportunity to connect with other people who were feeling the same pressures and issues and giving them some protection. Actually, it ended up that the SAT office became the safe place for them, where they felt they could speak together. I don't know whether CSIH did this in the Balkans, but we also used the Canadian embassy as a safe space where people from the various Balkan countries that were at war with each other could come together to talk safely.

I think the concept of safe spaces needs to be looked at better: how we provide these safe spaces for people to talk, to come together, to look at who is dealing with the same issue and at what they can do about it. It's not an easy process and it's not something that's easily funded.

It goes back to your earlier comment. Organizational capacity-building is something that has fallen out of favour, and unfortunately we're now paying the price. We do not see investments in public health institutes in countries; we do not see investment in organizations. Organizations take time to create themselves and nurture themselves. Unfortunately, they're not things that ministers can clip nice ribbons on, and they extend over many years. It might take 10 to 12 years to build the organizational capacity and create a functioning public health institute in a country. Look at our own public health agency here—a fantastic group, but their budget is being cut every year. At some point, they're going to hit the wall. I think we have to understand that, if we're going to invest in organizations, we need long-term programs that do this and we need sustained input into it. Again, it's providing a space in which they can get together.

I got off-topic a little. It's one of my passions. I'm sorry.

● (1155)

The Chair: Thank you. That's all the time we have.

We're going to turn it back over to Mr. Garneau.

Sir, you may take seven minutes, please.

Mr. Marc Garneau (Westmount—Ville-Marie, Lib.): Thank you very much.

I'd first like to thank all of the witnesses who have come today to give their excellent testimony. I very much appreciate not only what you're doing, but the explanations that you've provided today.

I'll start with a comment. I won't ask you to comment on it; I don't want to put you on the spot. I want to pick up on Madame Laverdière's comment, because I was going to raise it myself. Canada's development assistance has dropped to 0.24% of GDP—that comes from the OECD report that came out very recently. Last year it was 0.27%, so this is a fairly important drop. Of course, it puts us in the lower half, because the OECD average is 0.29%. Whilst yes, money has to be spent in the right programs and in an efficient manner, there's no substitute for also having money to do some of the programs that you have eloquently spoken about. That's my comment.

We have, in the course of the last few months, had the opportunity in the study of the protection of children and youth in developing countries to listen to many witnesses. I am beginning to get a sense of some of the challenges and areas that are important. Many were mentioned today—vaccination, malnutrition, HIV/AIDS, and obviously early and forced marriages and female genital mutilation. These things are subjects we've been hearing about quite a bit.

For me personally, one that was new for me—and two of you brought it up—was birth registration. I was not aware of this. I guess it makes a lot of sense that much of this is not happening.

How are your organizations encouraging countries in which these births are occurring to put in place the necessary registration, or is it sometimes a difficult thing to do because of remoteness of places, that kind of thing?

Mr. David Morley: In Uganda we have a program that we've been working in to do birth registration with SMS—"dumb phones", as we say. That's one of the ways you can get out to the rural areas. You need a community health worker—you need that structure there—but you're using the phone, and it goes into a central repository. It's already electronic, which is good, because I was in the house of records at the central hospital in Kampala, and it was not a house of records; it was a bunch of paper. So this is a way to get it in all ready.

As to its importance, I first learned of the importance when I was working in a refugee camp on the border of Zambia and Angola. This was awhile ago, when the war was still on in Angola. People had fled across Angola for about three weeks. One morning I was working at the reception centre. Women were dressed in rags, and their children were dressed in rags, and out of those rags one mother pulled a little bag with her child's birth certificate in it. She hadn't been able to protect anything else, but she had kept that piece of paper, because it gave the access to so many things, and that's so key for protection.

● (1200)

Mr. Marc Garneau: And the SMS texting of this birth has legal...?

Mr. David Morley: Yes. We tied it in to the government system as well, and we are also working out.... It has to be tied into the state system.

Mr. Marc Garneau: Very good.

A voice: I was going to let Eva answer that one.

Mr. Marc Garneau: Sure, absolutely.

Ms. Eva Slawecki (Interim Executive Director, Canadian Society for International Health): I just want to add that, as Mr. Morley pointed out, many of these records departments are just filled with paper. There often is a culture of collecting useless information—a lot of information. Physicians, community health workers, nurses collect information. What's lacking is the collecting of the good information and using it properly.

One of our projects in Tanzania witnessed an interesting event wherein one of the districts reported a vaccination rate of 120%. We said "Something's wrong here. Are you fudging the numbers?" The physicians weren't and the community health workers weren't fudging the numbers, but the census data—the denominator data they were using—was terribly outdated. The population had grown. The number of vaccinations that had been provided was correct, but they were basing it on a poor denominator from poor census data.

So it's all tied together. How can the planners ask for more resources for their vaccination programs or other health programs when the numbers they're using don't support it? It's all tied together.

Mr. Marc Garneau: Good. Thank you.

Dr. Bhutta, you mentioned one of the millennium development goals respecting mortality at birth or soon afterwards, and maternal mortality as well. I'm certainly encouraged to hear that there has been an improvement with respect to these rates.

I can guess what some of the factors are that help to reduce the number of deaths. Can you zero in on any particular measure or set of measures that have been particularly effective in allowing us to diminish the number of deaths?

Dr. Zulfiqar Bhutta: Yes, thank you.

In particular, what has been successful in the last decade for child mortality reduction is immunization. The scaling up of vaccinations and the provision of these vaccines to countries that would have had no hope of ever getting them through GAVI and other mechanisms has been an extremely important factor.

There has also been a considerable impact of improvements, where they have taken place, on provision of skilled birth attendants. Maternal mortality reduction, to a large extent, has been related to changes in practices, moving from home births to births within facilities, and thereby there have been reductions in some of the morbidities and causes of maternal deaths.

Be that as it may, as I pointed out, this progress isn't universally distributed amongst the countries that have the highest burden. A lot of this is, in the global scenario, dictated by a relatively small number of countries, countries like Brazil, China, and perhaps to a certain extent India. There are also remarkable examples of countries like Bangladesh, which has made tremendous progress through concerted government effort and a focus on provision of care to remote areas, to women, through community health workers, through provision of interventions, through innovations, and again, through health workers who can reach populations that were difficult to reach.

I did want to take the opportunity of making just one point around this important issue of reaching babies early, reaching mothers and babies within the critical period around childbirth. There is a huge opportunity with this important focus on birth registration. Now, we don't necessarily only do this because it makes good sense; it can actually have an impact on mortality. Our data indicates that it does: a post-natal visit to a mother and baby can have an impact on survival, on picking up on problems. But I think there is a huge opportunity here of incentivizing that.

In many countries there is this importance of linking some of that early documentation, such as immunizations, to things like school entry and admissions. I wonder if there isn't an opportunity of tying it all together to incentivize the important issue of registration at birth, coupled with strategies to reach those families in difficult-to-reach slums and rural populations, with the benefits that will come out of such a birth registration process that are tangible and visible to families, such as benefits in terms of school entry and other benefits that can be linked to conditional cash transfers, etc.

● (1205)

The Chair: Thank you, Mr. Garneau.

We're going to start our second round, which will be five minutes.

We're going to start with Mr. Hawn, sir, for five minutes.

Hon. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

Thank you all for being here and for what you do around the world.

Dr. Bhutta, I want to start with you. You talked about what we would certainly call barbaric practices: female genital mutilation, early and forced marriage, and so on. I think you said the FGMs are being carried out by medical professionals for the most part, or a lot of them are. You focused on the 29 countries in Africa and the Middle East.

How much of that is culturally and religiously rooted? Can we ever change that, particularly on the religious side? Can we ever hope to change that? We may tap dance around this, but is there a religious determinant of health?

Dr. Zulfiqar Bhutta: Mr. Hawn, thank you so much for that question. I'm glad you asked it because I've been asked this before.

The answer to that is absolutely not. It's a lot like some of the religious misinformation around vaccines. The campaign against polio vaccines, that there is some idea that they're against religious tenets, is misinformation that we have now shown can be very effectively tackled.

In Nigeria, where there was such a pushback against polio vaccines because they were considered un-Islamic—or for that matter containing things that would somehow or another produce sterility or infertility—it's now been shown over the last year that, with education, with community engagement, and with mobilization of community volunteers, this can be addressed very effectively. My group has done so also in the federally administered tribal areas of Pakistan.

I think that, around female genital mutilation, there is a very promising trend of gains and improvements. When I mentioned the health care professionals as being responsible for 20% or so, from available statistics, I also pointed that out as being the low-hanging fruit. As a group, we can tackle that much more efficiently than trying to get through to a lot of lay workers and quacks out there.

There needs to be a very clear focus on engaging communities, sir, and also religious leaders, in getting the message out that this barbaric practice, which actually precedes both the Christian faith and the Islamic faith and any others in the region, has absolutely no roots in religion. There are now very strong religious edicts, available from some Islamic scholars, against this practice.

Hon. Laurie Hawn: That's encouraging.

Mr. Morley, I think you talked about your reporting and so on, and the difficulty in some places of getting accurate data. There's mounds of data that mean nothing. It sounds like we're making progress. How important is that to give donors comfort that they're actually putting their money somewhere that matters?

Mr. David Morley: Absolutely. First of all, for the donors it's important that we can really show what we do when it's with UNICEF, the Government of Canada, or if it's somebody who's given us a hundred dollars at Christmas. So we put a lot of work into that.

But it also means we can do a better job of figuring out what to do next when we have the right information and when we look at it honestly because it helps shape the programs that we would be doing or that colleagues would be doing, because UNICEF gathers a lot of data that we share and others use as well.

That notion of accountability and transparency that I know the Government of Canada has been leading on in the last few years is extremely important, not only just in our field, but in all of these efforts, because if we just go with rhetoric, it's not going to be good enough.

Hon. Laurie Hawn: Yes, I understand.

Mr. Chauvin, you talked about—and Dr. Bhutta mentioned it too—immunization and getting over some of the misinformation, and so on. I'm assuming that Jenny McCarthy is not part of your program.

Voices: Oh, oh!

Hon. Laurie Hawn: You talked about the importance of organizational development. Obviously that does take time, and so on. Do you have an example from your experience of somewhere out there that has made significant progress, and the ability to use that as a template somewhere else?

● (1210)

Mr. James Chauvin: Yes, thank you. I'm going back to my former work with the Canadian Public Health Association. It was a CIDA-funded program that also received funding from the Pan American Health Organization and the World Health Organization. This was the strengthening of public health associations program in which we helped nurture the creation and organizational capacity development of non-governmental public health associations.

Over the 25 years that we received funding for that program, we helped create 32 public health associations around the world. Some of these are now leading public health associations in their own right. For example, the Ethiopian Public Health Association, which was founded in the late 1980s, has done an incredible job of advocacy on different health issues with its own government, and actually convinced the Government of Ethiopia in the early 1990s to create a women's directorate within the Ministry of Health. It was the first time that had ever happened.

When they achieve things like that, I think it's a feather in their cap that we have to applaud. It takes time. In Ethiopia, the public health association is now one of the leading organizations in that country and has sought to partner with UNICEF and other organizations. When we have this happen, this is the type of thing we want. We want to build that local capacity. It's not CPHA or CSIH being there; it's their being there, but we're giving them the support to help make it happen.

Hon. Laurie Hawn: Thank you.

The Chair: Thank you very much.

Now we're going to turn it over to Madame Laverdière for five minutes, please.

Ms. Hélène Laverdière: Thank you very much, Mr. Chair.

I'll start with a few comments. Maybe I am more optimistic than Madam Brown. I am not quite sure about donor fatigue, as the OECD registered a significant increase in ODA from various countries—not Canada, of course—last year. This year there is still an increase, so I am not quite sure we can speak about donor fatigue. Sorry, it's a French word and I can't pronounce it in English.

I was quite struck by your comments, Mr. Chauvin, that we should look at ourselves also. Would it be used in Canada or public health institutions, or even the census maybe? That is my point of view. I think it matches very well with the sustainable development goals that are being developed and that are going to be universal, which means that we will have to look at ourselves also.

I was struck by the answer you gave, Dr. Bhutta, about female genital mutilation. I lived in Senegal for a few years, and they basically managed to get rid of female genital mutilation, which indeed was not linked to a religious belief or anything like that. As you said, it was through working with community leaders and religious leaders, and also offering an alternative job to the women who used to do that, which is a very practical thing—training them to become nurses, midwives, and other things—along with education. It did work.

I am finally getting to my question. The issue of education is absolutely key. Do you think that sexual education is also important and can help prevent early and forced marriages?

Maybe Dr. Bhutta can begin, and then anybody else who has something to add. It's sexual education and women's empowerment, of course.

Dr. Zulfiqar Bhutta: Madam, thank you very much for your comments.

I completely agree with you in terms of the innovations and strategies. I would say that perhaps the order in which these have to be included within the curricula and programs in the countries has to be culturally contextualized and be pragmatic. Where the issue is just getting girls into school and ensuring that the drop-out rates are reduced and that, if girls are going to school, there are career and development opportunities and something tangible that families can see, I think that has to come first.

When I talk about girls going to school, Madam, one of the big issues is the infrastructure of the schools. I work in South Asia and east Africa where if you do not have adequate structures, if you do not have adequate toilets and running water in those schools, then to expect girls to stay in those schools the moment they reach puberty is impossible. One of the biggest reasons for dropouts in many of the environments is that these structures are just not girl-friendly and are therefore a barrier in terms of families sending young girls to these schools. I think getting girls into school and having a formal education system are extremely important. Once that is in place, and once the community and families are comfortable that the education the children are getting is meaningful, tangible, and has some social value, then I think including things like reproductive health and sexual education within those curricula is absolutely fine. Where we run into trouble is when we put the cart before the horse. Even before education has permeated and families have confidence in the whole system, if we start with things like HIV education and education on some of the issues that have hitherto been taboo subjects, they become an additional barrier to attracting people to schools.

I think there is a process. In that process, I absolutely support the notion of having health, reproductive health, and sexual education within those schools and within the confines of cultural acceptability.

● (1215)

The Chair: Thank you very much.

We'll now finish off the second round with Mr. Trottier for five minutes.

Mr. Bernard Trottier (Etobicoke—Lakeshore, CPC): Thank you, Mr. Chair.

Thank you to our witnesses for being here today. Thank you for your presentations.

Doctor Bhutta, you mentioned in your presentation that the last decade has been a "phenomenal decade in human history". I sense that a lot of that was based on different countries working together towards a common set of objectives. I think the millennium development goals were very helpful in getting countries focused on the countries that were providing some of that development assistance and providing some of that effort, and also on the countries that were on the receiving end.

You mentioned a couple of things. One was about the need to be more involved in terms of adolescent boys. Part of the problem is with regard to social determinants around things like teenage pregnancy and so on. Are there development goals currently, or are there development goals being discussed for the next round of development goals, associated with that challenge of adolescent boys? What are some things we can try to marshal our thinking around to try to focus on that challenge of adolescent boys in developing countries?

Dr. Zulfiqar Bhutta: Thank you, sir, for your question.

This is indeed an extremely hot topic as we speak. In the quest for getting a democratic and engaged process worldwide, the development of sustainable development goals and the indicators related to that has been one of the most involved processes I've ever witnessed. It's quite a contrast from the way we set up the millennium development goals in the year 2000. It has also led to this plethora of everybody wanting their favourite target and favourite indicators in. But we are now in a situation where, in the final stretch, I think there is consensus.

I'm looking at a document in front of me, which is for global consultation, that says there should be targets related to adolescents, and there should be targets related to what the world should set itself to in terms of particularly specific goals that it can achieve within its own countries. It talks about universal health coverage. It talks about access to reproductive and other services. It talks about quality education.

Now, in quality education, there is a target percentage of youth and adults proficient in literacy and numeracy skills. I think on balance we are moving towards measurable things that governments can potentially begin to recognize and give value to.

As you mentioned, the millennium goals were successful because country X versus country Y versus country Z could see a common metric for comparison. As we move forward, I hope that in the sustainable development goals for adolescents, for both girls and boys there will be tangible goals: boys will not be ignored just because our focus has been on adolescent reproductive health in girls in particular.

Mr. Bernard Trottier: Some of the other witnesses may have comments to add to that.

Go ahead.

Mr. David Morley: I've read through the 17 goals and 169 indicators, and I am concerned that....

I think you've raised an important point, that when gender inequity is discussed, what is discussed is girls. That's very important, and of course we have to do all that. But clearly, how do we work with boys who are not then going to be threatened by the empowerment of girls as things start to change? We have to show that everybody wins when there's greater equality.

I've only read these—I haven't tried to unpack them too much—but in my reading of them, I haven't seen enough about boys. When we talk about gender, I think it's only girls and not that relationship. It's important, I think, that we talk about both. Otherwise there will just be backlash.

● (1220)

Mr. Bernard Trottier: Mr. Chauvin, you had some comments to add on that?

Mr. James Chauvin: Yes, I just wanted to add something.

I had the opportunity of working in Pakistan several years ago with an organization called SMI. They were working on reproductive health. One of the young Pakistani doctors I happened to be working with gave me a beautiful card with a beautiful photo of a young man holding a child. At the bottom it says, "When a child is born, a father is born". I framed it and put it up on the wall in my office.

I think this is something that we need to be looking at more and more. How do we engage young males in this whole issue? They can't be left out. It takes two to create a child. We need to have the young males involved in this.

I don't know what the way is to do it, but I think it's something that we need to be focusing on.

Mr. David Morley: But there is a way; to what we've been hearing, part of it is the safe spaces we're talking about. At UNICEF we talk about child friendly spaces, or safe spaces for children. I've seen some safe spaces for adolescents. You start with finding a place to start the discussion, because then you get your agents of change, and people will be.... It's soft, and it's hard sometimes to show the accountability of it. I appreciate that you need a longer-term vision. But it's the foundation for making some of that change.

Mr. Bernard Trottier: Thank you very much.

The Chair: Thank you, Mr. Trottier.

We're going to start a third round, starting with Mr. Schellenberger, followed by Madame Laverdière, and then Mr. Goldring.

Mr. Schellenberger, the floors is yours, sir.

Mr. Gary Schellenberger (Perth—Wellington, CPC): Thank you.

First of all, Mr. Morley, you have spoken about making sure Haiti does not fall off the world's radar. I know we've talked a lot about Africa today. What is happening in Haiti specifically at the moment in terms of international development initiatives, and what still needs to be done?

Mr. David Morley: That's a lot. I'm not going to start with the end of that question.

I was most recently in Haiti for the fifth anniversary of the earthquake. I had worked there before and after. One of the most promising things that's happening in Haiti is that there are now more children in school than there were before the earthquake. That's very important, because that education is laying the foundations. But the list of what needs to happen is still very long. A big issue for us on the issue of child protection is the *restavek*, the children who are often hidden and out of sight because they're working as servants. It's one of those things, too, that we have to understand through talking, because some of the rural families send their children to Port-au-Prince because maybe it will be a better life for their children. But they can't guarantee if, as a *restavek*, things will be good or bad, right? They lose touch with that. It's been a part of cultural history of Haiti, too, and I think we can't just say, “This is all bad”. We have to figure out; we have to have the discussions. Personally, I think it's more damaging than not, but we still have to work through that in Haiti. I think that's very important.

Right after the earthquake, I remember the conference in Montreal when the Prime Minister said we have to think of 10 years for Haiti, which I know is a very long time. I don't know enough about the data, but I hope we are still thinking of at least 10 years, because Haiti is our neighbour. We can be of assistance there in a way that the United States can't just because of who we are.

There is hope. There is hope.

● (1225)

Mr. Gary Schellenberger: I know that you spoke about registration. Are pretty well most births registered in Haiti? I know they have a real problem with land registry—

Mr. David Morley: Yes.

Mr. Gary Schellenberger: —and I know their records aren't very good, but is some of that prevalent there, too?

Mr. David Morley: I don't know enough, I'm afraid. I'm sorry, I can't answer that.

Mr. Gary Schellenberger: Okay.

I know that rule of law is very important. Without a strong system, it must be very difficult to implement almost any of the great work you have suggested today. Without rule of law, poverty, lawlessness, and concern for those most vulnerable to death and child mortality have to be very difficult.

How can we engage the population in these areas, or are you able to work in these areas? I ask this of the Canadian Society for International Health.

Ms. Eva Slawecki: Sure.

This is one of the things. It is challenging to work in areas where there is limited rule of law. You have to engage the government, and you have to engage the community. You have to engage across all sectors. You find your champions and you do what you can. Questions about the rule of law shouldn't be a reason to give up on a country. There are always opportunities, and there's always a way to make progress.

One of the previous comments was about a failure of a project in South Sudan. I think one of the challenges for those of us who implement projects is the expectation of the donors and the funders. We have to be realistic about what can be accomplished within a given environment. I think it's important to find that little chink in the armour where you can make a difference and to move forward with that.

The Chair: Gary, that's all the time we have. Five minutes goes by so quickly, doesn't it?

Madame Laverdière, you have five minutes please.

Ms. Hélène Laverdière: Merci, Mr. Chair.

I think it's Mr. Morley who made the comment about accountability. It's a preoccupation I have. I think that very often more and more we're confusing accountability and accountancy, which shouldn't be the same thing. So how do you answer the challenge of having to provide accountability on exercises like safe spaces? What could we do to improve the system? Everybody, of course, is free to provide....

Mr. David Morley: I wrestle with that, because I think part of what we have to have is a longer time horizon. We have to understand—and I think the academics here would be able to do a better job than I—what are some of the markers along the way to show that it's not just a safe space, it's not just a bunch of people sitting around talking forever just to each other, but that things are starting to change. How do you start to measure that subtle change? If you're a sociologist you would know. But you need a longer time to be able to understand that and you need the right things.

Mr. James Chauvin: It's a very interesting question. Actually going back to Mr. Schellenberger's comment, I think it ties in nicely because one of the issues that we deal with when we talk about the rule of law is the capacity of people to speak out and say, look, something's wrong, we need to get some change here. And are they safe in doing that? Again, I go back to when I worked at IDRC and one of my colleagues challenged us. She said it's very well for us to tell people to go out and do advocacy but are we willing to stand next to them and actually go to jail with them when they're rounded up for speaking out? So I think the whole issue of advocacy needs to be looked at and I think there are markers within the advocacy process of what is it we can be saying that if you achieve this then you've made progress. You might not be able to get to the full nine yards, but if you've gotten to two yards that's amazing and we accept that and we paid for that and that's fantastic. But how do we then protect those people who are the advocates?

Ms. Hélène Laverdière: Thank you very much. In fact I had a question about advocacy but I may keep it for a bit later—

● (1230)

[*Translation*]

Ms. Slawecki, you have also worked on reproductive health and reproductive rights issues. Do you think that female reproductive health, family planning, contraception and so on are important for ensuring the health of the woman, the mother and the child?

[*English*]

Ms. Eva Slawecki: Obviously education is critical. The reproductive rights need to be there. A woman has to be educated enough to know what her rights are. It's not enough for the policy-makers to say that there are rights. It has to trickle down to the community level. You need to have it across the spectrum, the education of the support for the reproductive rights. The family has to feel safe in asking for their reproductive health rights to be enforced. It's critical that people know what those rights are to begin with. That has to happen throughout the education process and from the community as well informally and formally.

Ms. Hélène Laverdière: Informally and formally.

Ms. Eva Slawecki: Exactly.

Ms. Hélène Laverdière: I think this is key.

[*Translation*]

Mr. Morley, I did not get a chance to ask what your opinion is on the need to help build public health systems. Do you have any comments on that?

[*English*]

Mr. David Morley: You had mentioned Ethiopia and I think in the health system in Ethiopia, which is one that UNICEF and the Government of Canada and the Government of Ethiopia have worked on a lot, they have been training and equipping community health workers who go out around the country. There are two things I think in the kind of big picture that we see where this works. Three years ago in the Horn of Africa there was a famine. There was a famine in Somalia and there wasn't in Ethiopia. Why? Ethiopia had that grassroots.... It is the same climate, they're next to each other, but the health system in Ethiopia worked. Two months ago when Bill Gates was here I was part of a small meeting with the minister and some other NGO people. His comment was about Ethiopia—he didn't know that you were going to say this—but Bill Gates said that if Ebola had hit Ethiopia there would have only been one case because they have a strong health system that's out into the communities.

The Chair: Thank you very much.

Mr. Goldring, for five minutes, please.

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

Thank you for being here today. It's very interesting.

You had mentioned Haiti. I visited Haiti and spoke with the president and his cabinet there, too. One of the difficulties that came through very, very strongly is that they were very dismissive of the role of their members of Parliament. They were very negative, surprisingly, about them as being troublesome and argumentative. You could see that they treated them with disdain. What struck me, being there for the election, at the election of the MPs, is the disconnect between the communities and the members of Parliament —an absolute disconnect. We were at a social community function with a newly minted MP who just sat in a corner and didn't mix with anybody.

What struck me was that perhaps dealing with this sort of rule of law goes along with dealing with governance, and to bringing the government into buying into having long-term understandings of ways forward. One of the things, of course, that would be very helpful to them would be if you were able to put what you've been talking about into print in some way that can be published as a direction of a way forward, much like your Convention on the Rights of the Child, but greatly expanded so that people could emulate or follow best practices. Has there been consideration of doing this to engage the governance this way and to put some of these best practices out so that everybody can see them?

I learned a lot today. I'm sure many people in other countries can, too.

● (1235)

Mr. David Morley: I haven't thought of that before, but I know that at UNICEF we're always working with governments, because ultimately members of the United Nations, member states, are on our board of directors—from that level. But we are also all the time working with ministries of health.

I think that's a good idea, but I don't know what has been done. Clearly, there are good lessons to be learned. In some countries, it works, but you need the politicians and the senior public servants ready to make it work.

Mr. Peter Goldring: You're saying, on one hand, push back on the myths, like genital mutilation. You have your rights from the convention. Surely, that type of barbaric fashion can be written into those rights in some fashion, in some way? But, ultimately, it's going to be the governance in the country. And who is the governance from a political aspect? We know it's the various political parties and how they develop their principles and policies that they bring forward to speak about in their various governments.

Mr. James Chauvin: Perhaps I could just add something on this again. I work with public health associations in capacity-building for them and in governance, not only their governance, but the whole issue you're talking about of how they reach out to the government structures and talk to them. One of the things that has been very successful is that some of the public health associations hold legislative assemblies during their annual conferences in their own countries. They draw in a lot of parliamentarians around issues of immunization, HIV, whatever. It's quite exciting to see them get engaged with the parliamentarians around health issues. Certain parliamentarians representing a region have said to them, “Can you give us data on your region? We want to go back and actually see what's happening.” Well, that's a problem because of what we were just talking about—civil registrations, etc. The data isn't necessarily there. But some of the public health associations have been working to create the data so that these engaged parliamentarians can go back and be engaged as champions around health, and they can help within parliament as well.

Ms. Eva Slawecki: I like that you use the term “best practices”, because best practices should be written up, and they should be shared, and they should be disseminated. But that's again a long-term investment in order for a country to have the capacity to write up the best practices and to disseminate them appropriately. That has to start from engaging the academic sector, the education process, so that people know what is a best practice. Then how do you translate and transfer that knowledge to the people who can make good use of it?

The Chair: Thank you.

Everyone has had a chance now. I'm going to ask a question. Are there any additional questions that people have while we have our guests here?

Do you have a question?

It was your turn next but I know we're okay over here.

Mr. Rousseau, why don't you ask a question, and then Madam Laverdière.

Ms. Hélène Laverdière: I'll go ahead with my short question.

[*Translation*]

Dr. Bhutta, you pointed out that not enough attention is being paid to young people and teenagers in the post-2015 objectives or the program.

Could that still be introduced without potentially undermining the delicate balance and the consensus that have been achieved?

[*English*]

Dr. Zulfiqar Bhutta: I think there is language in the post-2015 sustainable development goals that does address young people, adolescents.

What I was pointing out is that the language is disproportionate in terms of what is there for young girls as opposed to young boys; boys seem to have an education target and girls have more than one.

First, I think it's a bit late now to be...and there has been a very involved process. With all due respect to everybody who's been engaged, this has been, as I said, very inclusive. Perhaps one of the reasons we have these 160 plus indicators, which we have to bring down to 100, is that everyone wants their favourite indicators in there.

Be that as it may, I think the proof of the pudding will be in the implementation of these sustainable development goals. After we have reached a consensus this year, the big challenge I see will be working with countries to make sure that they are as engaged in this process as they were with the millennium goals, particularly millennium goals IV and V.

One big concern that I have, and I indirectly expressed it in today's conversation, is that we don't want to lose sight of our goals and declare premature victory in the maternal and child mortality scenario. We still have 6 million children dying every year. We still have close to 280,000 women dying around childbirth and in childbirth every year. That's a huge global challenge. In the quest for new indicators and new targets we shouldn't lose sight of that core function.

I think what will happen, and what should happen—and this is where Canadian leadership is so important because of Muskoka ll and the fact that, as a society, we have very strong feelings on this—is that as we move forward next year we must ensure that we don't throw the baby out with the bath water; that we have our four health indicators; that we open the door to integrating some of the other indicators for social determinants of health, including education, empowerment, gender empowerment in particular, and particularly things that relate to a safe environment, which is so important moving forward; and that we bring them closer to the health indicators, which is the third millennium development goal.

I think this will happen, but what we require is concerted pressure until September and then even more pressure beyond that for their adoption by countries.

● (1240)

[*Translation*]

Mr. Jean Rousseau (Compton—Stanstead, NDP): Thank you all for being here today.

My question is for Mr. Morley, Mr. Chauvin or the other two witnesses.

Europe is currently being hit by a wave of immigration. That always seems to be a result of conflicts. If we consider the situation as a whole, conflict zones are often the cause of malnutrition and of all the problems that have been raised. There are more and more immigrants all around the world. Climate change is also to blame. Population displacements in certain parts of the world are expected.

What can a global leader like Canada do to identify areas that will be problematic in the future? Despite all the good things currently being done and the fact that the situation is improving in certain parts of the world, there are other places—such as Haiti—where not all the problems have yet been resolved. Problems are expected in some countries as a result of conflict zones and climate change. What can we as a country do to be a global leader in this regard?

[*English*]

The Chair: It's a short question.

Mr. David Morley: Yes, really.

I'm very lucky because I get to travel a lot around the world and spend time with people, from street children to leaders in countries.

We are doing something special in Canada that people look up to. I'm not talking about money. I find that what we're trying to build in Canada constantly, for all of our imperfections, is something that many other countries look at. They scratch their heads and they're wondering.

I was working once in Brazzaville, Congo. There was a war going on, but they were asking a couple of members of Parliament to go there to talk about how we run our country. They wanted to learn.

I think we bring a diversity here. I don't know how we export it, but I think we model it a lot in our behaviour. There are more things we can do. You would know much better than I do because you're closer to the levers of power. But there is something we do when we're out there as Canadians.

When I was with Médecins Sans Frontières, sometimes when there were disagreements in the teams they would call us up and say, “Can we just have a Canadian?” It wouldn't matter if it was a francophone, an anglophone, or an allophone. You didn't even have to be born here; usually if you went to school here.... There's something we do that's good. I think there's that kind of leadership.

I would like us to take a bigger leadership in the United Nations, but I think that's a place where I see it happening around the world.

● (1245)

Mr. James Chauvin: You've asked a very interesting question. Actually we have with us Dr. Jan Hatcher Roberts, who did work at the International Organization for Migration. Jan would probably be much better than the rest of us to answer this question.

One of the things Canada used to champion—and I don't know if it still exists, David—was days of peace, with immunization programs. Was it days of peace?

Mr. David Morley: Yes, days of peace. El Salvador was the big success.

Mr. James Chauvin: This was where you would basically get the parties to stop fighting in order to allow children to be vaccinated. This was amazing work. It took a lot of time. But again, it worked. You could move in and actually create peace. Now, it was temporary, but still, people sat back.

Again, from my days working in the Balkans, I mentioned the Canadian embassy as a meeting place. We had together people from the Balkan countries who were previously fighting. They came together and they were talking about how to ensure that polio didn't cross over from Kosovo into Montenegro. How do we ensure this, or how do we ensure that?

These were people who were belligerents, but who found a safe space within the Canadian embassy, and they talked. It was amazing to watch this happen. We got out of there thinking that we helped create bridges across some big gaps. I think that's where Canada can lead.

I'll just leave that with you.

The Chair: Thank you.

To our witnesses, thank you very much for today. It was a very good session.

I'm going to suspend for 30 seconds. I have a little committee business. We don't need to rush you out. It does need to be recorded. I just want to talk about some guests who want to come and let you know what we're doing. I'll give you the update and then I'll adjourn the meeting.

Thanks.

[*Proceedings continue in camera*]