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Monday, May 3, 2010

Chair

The Honourable Hedy Fry

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● (1530)

[*English*]

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

Pursuant to Standing Order 108(2), we are doing a study on 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:

> That the committee study maternal and child health following the government's announcement to make maternal and child health a priority at the G-8 in June that Canada will be hosting, as long as this is done before the end of May.

That is why the study is being done now: so that we can complete it before the end of May and have our report ready before the end of May.

We are holding four meetings on this question. The first two meetings will bring together non-governmental organizations and coalitions specializing in developmental issues as well as in maternal and child health.

Today we have three sets of witnesses. We have Dr. Dorothy Shaw, the Canadian spokesperson for Partnership for Maternal, Newborn and Child Health; Janet Hatcher Roberts, executive director of the Canadian Society for International Health; and Jill Wilkinson Sheffield, president of Women Deliver.

I want to welcome you and thank you for taking your time to come and present to this committee and answer some of the questions that everyone is obviously going to be asking you.

Each one of your groups has ten minutes to present. I will give you a two-minute warning so that you will know when you have two minutes left. Then we will have question-and-answer rounds. I think we may be able to do two rounds in this one, but we'll see.

Presentations will be in the same order as you are listed on the agenda. We will begin with Dr. Dorothy Shaw from the Partnership for Maternal, Newborn and Child Health.

[*Translation*]

Dr. Dorothy Shaw (Canada Spokesperson, Partnership for Maternal, Newborn and Child Health (PMNCH)): Good afternoon everyone, Madam Chair, Dr. Fry and members of the committee. Thank you for giving me the opportunity to meet with you.

I will speak in English because it will be easier for me to explain these very important things.

[*English*]

The Partnership for Maternal, Newborn and Child Health is based in Geneva and is a partnership of 300 organizations, including the UN, H-4, non-governmental organizations, health professionals, academics, donors and funding agencies. It's hosted by WHO and its aim over the next six years is that every pregnancy is wanted, every birth safe, and every newborn and child healthy, and that we will save the lives of over ten million women and children by 2015.

The next slide you should have gives you some statistics on the global situation. I'm not going to read them all. I want to bring to your attention that figures on maternal deaths on this slide at 536 are estimated because that's the last UN figure that we have. A paper recently published in *The Lancet* indicated that figure might be 342,900. That actually would be welcome progress, given all of the efforts that have been done on maternal health, in particular over the last several years. We were expecting to see some progress. The bottom line is that in fact hundreds of thousands of women still die from preventable causes every year.

I hope you are familiar with the millennium development goals. I'm not going to spend time detailing them, except to say that the millennium development goals that have been most off track have been numbers 4 and 5, but particularly goal 5, to improve maternal health. Child mortality has in fact been reduced to less than ten million, which is still a huge number, and that burden is now focused in the neonatal period.

Goal 6, HIV/AIDS, malaria, and other diseases, is obviously very much integrated into what we need to be doing to save the lives of women and children globally.

There is another map, which I hope you have in colour, on the next page. You don't? Okay, I apologize. It's a little difficult to see not in colour. I think essentially what it tells you is that we do have the most recent data now for children. Those will be released further in terms of country-specific profiles at the countdown meeting. Jill Sheffield may say more about that later. We're still waiting for updated information on the maternal health situation, but what those maps show you is that progress has been little in terms of MDG-4 in Africa and insufficient in Asia; and in MDG-5, for the last year that we have data, we are still seeing maternal deaths to be a very common problem in Africa and Asia.

The other thing that is really important to remember is that while you may think those numbers of deaths are not significant in the whole scheme of things in terms of maternal deaths from a numbers perspective, for every woman who dies—and more to the point, when we start getting into what we can do for those where we are providing effective interventions—there are another approximately 20 to 30 women whose lives are seriously compromised with problems such as obstetric fistula. I'd be happy to explain that later.

The next graph, on page 6, shows you in a different way the figures for child mortality for MDG-4 and MDG-5. We know there has been significant success in under-five child mortality in all regions and in many regions by more than 50%. But in sub-Saharan Africa, southern Asia, and Oceania, the regional rates are declining much more slowly. Maternal mortality ratios, which is not the same as the number of women who die—that's deaths per 100,000 live births—are slowly declining across the regions, with few exceptions.

● (1535)

I think what's also important to know is that when we look at the global causes of child deaths and the 8.8 million child deaths every year, we understand why those happen. These are very dependent on the health of the mother. We're again talking about under the age of five. Of those deaths, 41% occur in the neonatal period, which is the first month of life. Of those, we know that the vast majority occur in the first week of life. So this is something that is addressed by providing emergency obstetric newborn care through skilled birth attendants. That's why the focus has been particularly important on that particular group. We know that in terms of those child deaths, 42% are accounted for by pneumonia, diarrhea, and malaria, and under-nutrition contributes to up to about a third of child deaths under five. One of the things that we have learned over time is that there are important variations between regions and countries, and once we have country profile information, that becomes even more evident. So in fact it's very important that countries have their own data, derived ideally by them in order to determine their priorities for action.

When we look at the next slide, it is again from the last countdown figures, looking at the countries with the lowest mortality rates and also at the countries with the highest mortality rates. You will note that of the ten best performers, the last time these figures were released—and we won't have the new figures until June—seven of them have maternal mortality ratios over 100. Anything over 100 is considered high and anything over 500 is considered very high, and anything over 1,000 per 100,000 is extremely high. The solutions and the actions you need to take will differ, depending on the maternal mortality ratios, what is actually responsible for killing women during pregnancy and childbirth.

On page 9, the pie chart looks at why women die during childbirth. We know that postpartum hemorrhage is still the most common killer of women, and unlikely to change based on the updated figures this year. When you look at the obstetric causes of maternal mortality, the next causes after that are hypertension problems, blood pressure problems of pregnancy, and unsafe abortion and infection. When you then look at what we call indirect causes of maternal mortality, that is when you would include problems such as HIV/AIDS, malaria, and cardiac diseases. Altogether, we know that the three leading causes of maternal death are hemorrhage, high blood pressure, and indirect causes, and they account for about 70%.

If you look at the next slide, which is number 10, the coverage failures across the continuum are really quite instructive, and you can see the wide variation in those bars from where the actual bar graph block ends. So you can see that those are opportunities that we have in terms of this Canadian-led initiative, but a G-8 initiative, on maternal and newborn child health to actually make a difference.

Contraceptive prevalence is something where a significant opportunity exists. Skilled attendants at delivery.... We know that, globally, 40% of women deliver without skilled attendants, and in Africa it is higher in many countries. In Ethiopia it is still over 90%. Post-natal exclusive breastfeeding.... You can see where we have in fact many opportunities.

On slide 11, this is a reminder that MDG 5 is also about universal access to reproductive health and that family planning is very significant in terms of meeting the causes of maternal mortality. We know, in fact, the unmet need for family planning, mostly in married women, in the world is 215 million women.

I want to highlight the role of nutrition because this has been quoted in the media as being very significant in saving the lives of women and children. In fact, it's important to recognize that the nutrition of mothers is critical for their children's health—the newborn and child health—because under-nutrition, as you have heard, is implicated in one-third of child mortalities. However, there is no evidence at this point that addressing under-nutrition in women will successfully contribute to eradicating maternal mortality. What kills women, as I said, is hemorrhage.

● (1540)

Interventions needed to save the lives of mothers, newborns, and children are on slide 13. I want to highlight that community engagement is essential. We're talking about a continuum of care that supports nationally led health plans. So the countries need to determine their priorities.

On slide 14 is a demonstration of the platforms, starting with family and community, that are built to deliver integrated maternal, newborn, and child health packages. Through a major funding commitment we can and will save the lives of up to a million women from pregnancy and childbirth complications. You can see the other lives that we will save: 4.5 million newborns, 6.5 million children, and 1.5 stillbirths. And there will be a significant decrease in the global number of unwanted pregnancies and unsafe abortions. We would potentially end the need for family planning. That will take an additional 50 million couples using modern methods of family planning, and 234 million births taking place in facilities.

What will it cost? For the G-8, look at doubling in total bilateral aid, and an appropriate increase in multilateral aid. The funding mechanism is not something the partnership is pronouncing on, except to say that a new funding mechanism would not be recommended.

I want to mention that we have problems at home in our fetal and infant mortality rates. In fact, the infant mortality rate in Canada in 2004 was nearly double in the first nations population, with 9.8 per thousand live births for infants under one month, versus 5.1 for the population as a whole, and over three times the national rate for infants between one month and one year. The problem with mortality and morbidity statistics for the aboriginal Indian and Inuit populations in Canada is that they are very difficult to track. I'd be pleased to explore that a little more with you.

The next slide shows that Canada did make progress when its own economic status was not rosy.

The next slide gives you more detail about the median coverage levels for countdown interventions from this year's report. It indicates that just over half of women have a skilled birth attendant.

The next slide gives you one example—there are many—of how Thailand used midwives, starting with village midwives who were certified, to reduce their maternal mortality.

Accountability is critical. There are some principles articulated on the next slide. All development commitments should be results-based, with specific and measurable objectives. They should be time bound, with clear start and end dates. They should be explicit about whether funding is additional or inclusive of previous commitments. They should also be clear about how much each donor and partner country is contributing.

Page 24 really gives the bottom line: skilled attendance at birth will save mothers and babies.

I think I'll leave it at that.

● (1545)

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

Now we'll move to the Canadian Society for International Health and Janet Hatcher Roberts.

Ms. Janet Hatcher Roberts (Executive Director, Canadian Society for International Health): Thank you. It's a great opportunity for the Canadian Society for International Health to be here.

We are a non-government organization committed to the strengthening of health systems. I personally have worked and interacted with ministers of health, education, family and youth, NGOs, and researchers, in over 35 low- and middle-income countries. I've had the privilege of seeing health systems in action and the importance of interaction with other ministries.

I first want to give two points on the political context, and then move into the health systems evidence and add on a bit from Dr. Shaw's comments.

In July 2009 in Italy, as you know, the G-8 heads of government agreed that maternal and child health was one of the world's most pressing global health problems. They committed to accelerating progress on maternal health, including sexual reproduction health care and services and voluntary family planning. They also announced support, as Dr. Shaw mentioned, for building a global consensus on maternal, newborn, and child health as a way to accelerate progress on the MDGs—millennium development goals—for both maternal and child health.

In June 2009 Canada co-sponsored a landmark resolution at the UN Human Rights Council recognizing maternal mortality and morbidity as a pressing human rights concern.

I'll talk a bit more on the health systems evidence. Most maternal deaths are easily preventable, as we said. We've seen this wonderful progress in Canada, although we do have some inequities. The gap between rich and poor countries is shockingly wide. In Canada, for example, the lifetime risk of maternal death is one in 11,000. In Ethiopia, the risk is one in 27. In Angola and Liberia, the risk is one in 12; and in Niger, it's one in seven.

Of the 10 million women who have died in pregnancy and childbirth since 1990, three-quarters of the deaths were preventable, primarily where they occur in Africa and South Asia. Millions of other women have been left with crippling injuries or illnesses as a result of poor care during childbirth.

A new study released in March 2010 by the United Nations Population Fund, UNFPA, and the Guttmacher Institute estimates that 70% of the world's maternal deaths could be prevented for $13 billion. That's about $4.50 per person, per year. That's not a lot of money.

Dr. Shaw mentioned some of the care gaps. Of the 123 million women in the developing world who gave birth in a health care facility and needed care, 62 million received it. Of the 5.5 million women who needed care for hemorrhage or bleeding, 1.4 million received it. You can see these huge gaps. Of the 7.6 women who needed care for obstructed labour—that means when the baby is not coming out very well—1.8 received it. There are huge care gaps.

There are 215 million who would like to delay or avoid child bearing and do not have access to modern contraception. A dramatic improvement in access to family planning, including contraception, would sharply reduce the number of unintended and unplanned pregnancies. That in itself means fewer pregnancy-related deaths and complications. Evidence shows that access to family planning alone could prevent as many as one in every three maternal deaths by allowing women to delay motherhood.

It's not just what we need to deliver but how we need to deliver it. And how we need to deliver it is through a sustainable and well-funded health system. That's not just the care part, the services and programs you've heard about, which are very, very important, but a whole health system.

There is a picture here of what a health system is—you will all receive copies of this. The services and treatment and programs are the health care system, but a health system has many elements. One is a vision for equity and a fair distribution of resources coupled with leadership and sustainability. It also has to do with a fair access, not equal access. We'll never have equal access, but we can have a more fair distribution and availability of services for health care.

● (1550)

We also need health information systems. That is often forgotten about, but unless we have funding for health information systems when we also fund intervention programs for maternal health, we will never know how well we are doing. So we need to make sure that is integrated within the health system, because that gives evidence for policy, but it also gives evidence for how well we are doing in terms of quality of care.

A great gap in many low-income countries is the ability to plan, the ability to say where these resources should go. Most countries have a decentralized social system in education and health. They were decentralized almost overnight as a result of World Bank demands and their structural adjustment, and they have very little capacity for planning. Therefore, the decisions about where the money goes are left in the hands of people who don't have data, who don't have capacity, and thus the resource allocation is not evidence-based. Of course, we need well-trained professionals—nurses, doctors, midwives, community health workers—to be in the right place at the right time doing the right thing, but we also need to promote a continuum of care throughout: a primary health care system that delivers a large part of maternal and child health, well baby care, well pregnant care, and we need emergency obstetrical care. That is essential. Without a primary health care system—if that gets gutted—we don't have a continuum of care. That's the access point for mothers and for their children. It allows for anything that needs to be dealt with at a specialist level to be picked up.

Sub-Saharan Africa faces the greatest challenge. While it has 11% of the world's population and 24% of the global burden of disease, it has only 3% of health workers. In addition to the care part of the system and the health information, it's also important that there be public participation in health care decision planning, as we have here in Canada. People get involved and make their views known. Non-governmental organizations need to be funded to build that capacity for communities so they can start to understand what they need and where and how they need it.

Finally, there needs to be a transparent and accountable public system. Most countries have a publicly funded system, and they often have a privately funded system. Doctors sometimes work in the mornings in the public system, and in the afternoon they go to the private system. So if you go to a clinic in the afternoon in many of these countries, there is nobody there. That is because the doctors are off in the private system, because they have probably not been well paid in the publicly funded system. This shows the need for a well-funded public system.

There are two pillars that really support a health system. One is the determinants of health, and you have probably heard about those: poverty, education, peace, gender. These are things that make us healthy. If we have a peaceful situation, if we don't have an environmentally challenged system, if we are not poor, if we are well educated, if we have jobs, we tend to be healthier. You will get copies of these maps that show the absolute significant and critical inequities of the distribution of these determinants of health. If you look at education, if you look at poverty and wealth, the maldistribution is huge.

Finally, we have to look at the policies that have an impact on health. It's not just the ministry of health. It is the ministry of transportation. It's the ministry of environment. It's trade. It's labour. It's human rights. If we work with the transportation sector to look at where the roads would go, we could hook up with the primary care systems and the delivery of good care. If we know that the environment and environmental policy are health promoting, we have a better chance at improving our health, so we have to look at all of those policies in terms of health, but more particularly in terms of maternal and child health.

Finally, Canada has played a leadership role in promoting good governance and accountability across many sectors, including health, and we feel it could take a leadership position in supporting this as it relates to maternal and child health.

I'm sorry that you didn't get the slides, but I'm sure you will get them later, and you will be able to see them in colour as well. I'm sure that's the case for yours too, Dr. Shaw.

Thank you.

● (1555)

The Chair: Thank you very much.

Now we are going to go to Women Deliver and Jill Wilkinson Sheffield for ten minutes.

Ms. Jill Wilkinson Sheffield (President, Women Deliver): Thank you, Madam Chair and committee members, for inviting me here this afternoon to talk about the fact that women do deliver. They deliver babies, and they die in large numbers. They also deliver a lot of other things. They are major benefits to our social and economic fabric of life around the world.

I am Jill Wilkinson Sheffield and I am the president of Women Deliver. We're a global maternal health advocacy organization. We use all the data that Dr. Shaw has shared with you, and I'm so pleased to be speaking after Dr. Shaw, so I can save on the numbers.

It's a really important time for the women in the world, and frankly a momentous time for Canada. Women are the economic heart of the developing world, and they really need to know that their lives, their health, and their rights matter. Perhaps just as importantly, they need the funding committed to make that happen.

I want first to thank the Canadian government, which for decades has worked steadfastly toward improving the health of mothers and their newborns and children in developing countries. In my 30 years in the maternal health field—and in the reproductive health field, more largely—my fellow advocates and I have known Canada as a true ally and we have appreciated your strong leadership and your commitment. And we're counting on it now, as June approaches.

As you may know from the news, the most recent studies on maternal mortality demonstrate that we are making progress. This tells us that investments are paying off, and it tells us that there are solutions at hand that we can employ more broadly.

We have only five years left to achieve the millennium development goals. You know that MDG 5 is to improve maternal health. Its target is to reduce maternal mortality by three-quarters in these remaining five years. Unfortunately, so far this is the goal that has made the least progress. It has also had the least investment. And if women are the heart of our families and our economies, it's time to change that.

Canada has an unparalleled opportunity to lead the promise of progress on this issue with its legacy initiative on maternal, newborn, and child health, to be introduced at the G-8 and G-20 summits in June. And yet as Canada seeks to shape its legacy, I urge you not to forget your past legacy. It's building on great success.

In 1994 in Cairo, Canada joined 178 other countries in a global consensus on the importance of addressing the health and rights of women in a comprehensive framework. That was the United Nations International Conference on Population and Development. And since that time Canada has not erred from its commitments. Now is not the time to do it either.

In 1974, even longer ago, Canada was at the table in Bucharest when it was agreed by the nations of the world that individuals and couples had the right to plan the number and spacing of their children, and that it was the responsibility of governments to ensure this happened.

Fortunately, to address maternal mortality and to achieve MDG 5, we really don't need the discovery of a miracle drug or an expensive medical breakthrough. We have low-cost solutions now. We know what works and we know it now. You've heard it already, just before my turn.

Women need access to family planning programs and modern contraceptives. And they need access to skilled care before, during, and after childbirth, especially access to emergency obstetric care. And we don't know when these emergencies will arise; that's one of the problems. Women also need access to safe abortion services when and where they are legal.

● (1600)

These solutions aren't rocket science, but they do save lives and they present enormous economic, social, and health benefits. Hundreds of thousands of women die each year in pregnancy or childbirth. We now know that the world loses $15 billion in lost productivity because of these deaths. I'm not sure anyone feels that this sum can afford to be lost—lost lives or lost productivity.

So while I wouldn't claim that maternal health is a simple issue to address, if we are to advance as a global community into a millennium of stability, prosperity, and dignity, it's a very necessary issue for us to address. Global consensus has been achieved before; we can do it again. In fact, we have to do it again for the sake of the women and the girls and our futures worldwide. We know what it costs to do this. It's an additional $12 billion a year, and that's not a lot in the scheme of things.

Over the past decade, since the global efforts, there have been setbacks and stagnation. We also know that we've made enormous progress. There are low-resource countries that have made dramatic changes in the situation of health for mothers and girls. Rwanda, Bangladesh, Honduras—the mark that all of these countries have in common is political will. They simply decided it had to be done and they are doing it, just as we know that not to decide is also to decide.

There are few times in your careers as parliamentarians that a problem and terrible injustice that has brought suffering to millions of women and their families can actually be solved. This is our moment to make this happen. We can do it. We absolutely have to do it. It's over to you and up to you, and civil society is ready to help in any way we can.

Thank you again for the invitation.

The Chair: Thank you very much.

Now we are going to go to the question and answer period. The first period is a seven-minute period, and that includes questions and answers. So I would like everyone to be as succinct as they possibly can.

We begin with Anita Neville for the Liberals.

Hon. Anita Neville (Winnipeg South Centre, Lib.): Thank you. My challenge is to be succinct as well.

Thank you very much for being here today and thank you very much for the work you're doing.

I don't know whether you were all downstairs this morning at the event on international leadership and Canada's role on the promotion of gender equality and women's rights. If you were, I'd ask you to comment on it. I would ask you to particularly comment on some of the funding challenges we heard about.

I want to just comment briefly on the fact that at the G-8 meeting last year in July, the G-8, including our government, committed to accelerating the progress on maternal health, "including sexual and reproductive health care and services and voluntary family planning". I just wanted to get that on the record.

You referenced the economic cost of the death of so many women around the world. Last week the Minister of International Cooperation said:

> It's our responsibility to our taxpayers and our peoples to ensure that we are getting the biggest bang for the buck.... We spent a lot of attention on how we are going to measure outcomes, how we are going to ensure that our investments are actually going to pay off and make a difference.

I wonder if any of you have had any experience in measuring outcomes in terms of what it means in a country when a mother of four, five, or six children dies and is no longer able to create economic viability for her family. Is there a way of measuring those kinds of outcomes?

My other question is talking about the funding of the work that needs to be done and some of what we heard this morning.

I don't know who wants to go first.

● (1605)

Ms. Jill Wilkinson Sheffield: I was not there this morning, but I really do want to comment on women being the economic heart, particularly in low-resource countries. Did you know that women drive the economic development in virtually all agricultural economies? They operate the majority of small businesses and farms. It's women who do the agricultural labour. When they die, it's their daughters who come out of school—and that's the investment in the future. That's one of the investments.

There are systems to track this. They track the level of mortality of those under the age of five. The newborn babies, if they do survive, are likely to be dead within a year. So yes, it's possible to track the investment in keeping mothers alive.

Hon. Anita Neville: And keeping them well, presumably.

Ms. Jill Wilkinson Sheffield: Yes, well—you bet.

Dr. Dorothy Shaw: I also wasn't at the earlier session today, but I think Jill already referred to the $15 billion in potential or real productivity that's lost every year related to maternal deaths. I think I did give you some figures on what it will cost, in one of the slides in my presentation. Clearly, the overall gap is roughly $30 billion a year between 2009 and 2015.

I think the issue we're looking at here is what does this really mean for the G-8? How can they leverage funds both from the non-G-8 countries and the private sector and other donors, so that we can in fact bring this home? There certainly are a number of innovative financing mechanisms that have been suggested.

In terms of the economic cost to the family, the only other comment I would make is that not only is there a higher chance of the newborn or infant dying if the mother dies, but also the fact that for children under ten there are now data to suggest that if there is a maternal death, children under ten are also much more likely to die. If the father is killed for some reason, that isn't there.

Hon. Anita Neville: Thank you.

Just to follow up with Ms. Hatcher Roberts, who was here this morning, I would ask the following. Given that Stephen Harper signed the G-8 agreement last year and committed to what I read—and much more—what do you see as the responsibilities, obligations, and commitments of Canada in this area?

Ms. Janet Hatcher Roberts: Well, we have committed to this and many other agreements that promote women's health and women's rights. Our commitment is to maintain or hold the line on what we committed to last year—at the very least. At the very most, we should be expanding that commitment and putting some money toward that commitment. I say this because last year there was just the actual commitment and no dollars were put toward it. The hope was that this year we would put some dollars toward that commitment. Our hope is that we will live up to what we agreed to last year as Canada. Mr. Harper did sign onto that and to the whole ball of wax.

Earlier today we were talking about challenges around gender and women in a broader sense, but to come back to this discussion, what are the rights-based issues here and the rights of women with regard to maternal and child health? If we keep to that line, I think we can stay true to where we should be going. It's right out there, as we have committed to this and to these kinds of agreements for many, many years. It's very clear what this means in terms of a full range of comprehensive reproductive and sexual health services. Without that comprehensive range of services, we can't promote women and children's health.

One other figure is the following: if a mother dies, I think a child has a four times greater risk of dying before the age of 12. That, clearly, is another high risk. On that, there's been a great deal of work going on in terms of the disability-adjusted life years, potential years of life lost, and the economics of that. There is very good economics that talks about what all of that means in terms of dollars, as Dr. Shaw mentioned. There's a lot of analysis there that you could be provided with, which really gives you an idea of what the economic implications are of women dying prematurely—not just for themselves and the labour market, but also the impact on their families and their children. Should you want it, I'm sure we could get hold of it for you. The World Bank has done some good analysis of this, as well as other organizations.

● (1610)

Hon. Anita Neville: I would be interested in seeing that. Thank you.

The Chair: Thank you very much.

Now I will go to Madame Deschamps and the Bloc Québécois.

[*Translation*]

Ms. Johanne Deschamps (Laurentides—Labelle, BQ): Thank you very much. I am very happy to see you again, dear colleagues. I had left you some time ago.

Good afternoon, ladies. I will try to be brief so that you can do full justice to my question in your answers.

It is said that we have barely made any progress on goal 5, which is to improve maternal health. Actually, the goal is to reduce maternal mortality by three quarters. The deadline for achieving the goals is 2015. There is very little time left for attaining this goal, among others. That seems to me to be virtually impossible. Do you think it is a realistic goal?

To succeed, we have to have all the necessary tools. We should not give some up at the expense of others. If we accept the figures you gave us today, almost 13% of maternal mortality—the estimated number varies from 350,000 to over 500,000—are the result of unsafe abortions performed by quacks. Those women chose to do it because they had so many children that they could no longer feed them. So they reached a dead-end and had a decision to make.

How can we reach the goal of reducing the number by three quarters if we do not give them all the necessary tools?

● (1615)

[*English*]

Dr. Dorothy Shaw: I would say two things in answer to your question. First of all, will all target countries achieve millennium development goal 5? The answer is no. At the same time, many of them can—or at least they can come close. They can certainly make very significant progress. I think that, as in many challenges, when you are making progress and you have made the commitment to focus on maternal mortality and maternal health and you have a national plan—and most countries do have a national plan—then you are in a good position to determine the priorities that will actually help you accomplish your goals.

It really does depend on the country. It depends so much on the specific problems the country faces. Sometimes there are geographic problems, in addition to the country's other problems, and it depends on how many human health resources they have. Africa has very depleted human health resources to begin with, and the distribution of them is also a problem. So I think that each country needs specific information about its own indicators that will help inform where it needs to place its priority actions. That information is going to be available. It's partly available now, but we will have more current data coming up in June.

I think there are two key issues that we know would make a huge difference to mothers and newborns, and to the overall rate of maternal and child deaths: skilled birth attendants, and family planning.

Ms. Jill Wilkinson Sheffield: Some countries are making huge progress and some countries are actually moving backwards. For example, Bangladesh is now on target to meet the goals. This is a dramatic thing.

There are two ingredients required. Political will is the bedrock issue. Without the political will—the will of governments and the will of society at large—the rest of it won't happen.

The other thing is resources. We need resources of different kinds to do this, and some of it's money. I wanted to say in partial answer to the earlier question that in fact we shouldn't assume that donor countries are the only ones making these investments. In the budget and the agreement on how to meet the cost of the Cairo plan of action, developing countries said they would contribute two-thirds of the cost and donor governments said they would pick up the remaining third. Fifteen years after Cairo, who has lived up to their commitment? It's the developing countries themselves, because they saw what a difference it made.

I want to say that if you have only one short-term investment to make, it needs to be in family planning. If those 215 million women had access to modern contraceptive supplies, the Guttmacher report, which is just out, tells us that you would reduce maternal mortality by 70% because you would have removed unintended pregnancies, which are the biggest problem.

Family planning is your quick win. I have given you six wins. Some of them are quick; most of them aren't, but it's for sure that an investment in family planning, which is safe, is really one of the best investments the G-8 and G-20 can make.

[*Translation*]

Ms. Johanne Deschamps: Do I still have time, Madam Chair?

[*English*]

The Chair: You have ten seconds.

[*Translation*]

Ms. Johanne Deschamps: I only have time to say this. Following the G8 meeting held in Halifax last week, we were informed about a decree under which each country would define its own policy to be implemented. Do you not think that operating that way would be a headache in terms of logistics? Also, if each one defines its own policy, how are we going to measure our progress?

● (1620)

[*English*]

The Chair: You have gone over time. Perhaps I can ask the witnesses to hold the thought, and if it's pertinent when you're answering other questions, you can do it. What I may want to do in this instance is give you about a minute each to wrap up at the very end, if you feel that you weren't able to put stuff on the table. I think it's really important to have you get these unanswered questions in.

Thank you very much.

Now we will go to Ms. McLeod for the Conservatives.

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

I have a couple of quick questions. To refresh my memory, how many target countries are there?

Dr. Dorothy Shaw: There are 68.

Mrs. Cathy McLeod: There are 68. Okay.

Dr. Shaw, in your slides you had some comments about the work done in Thailand involving skilled birth attendants. If you wouldn't mind, could you take a bit of time to describe that a little better and also tell us whether it's translating into other countries?

Dr. Dorothy Shaw: Thank you.

Thailand, as I said, is just one example. We could give you Sri Lanka, Malaysia, and in fact Brazil. Brazil is probably the most recent example where they have managed to reduce the under-five death rate and they've now managed to get free primary health care for everyone. All Brazilians have access to skilled attendants at birth. They now have to work on other issues, such as the quality of the care that is being delivered, but they do now have that. So that's been a huge undertaking, because we often still see inequities in poor countries between the richest and the poorest quintiles in both maternal and child health. Brazil deserves a great deal of credit for that.

So I think that Thailand's success story, mirrored by others—and Janet and Jill probably can also answer this—is interesting in many ways, because it really does involve the community. You need to involve the community. Often we have traditional birth attendants in villages who attend mothers if they don't give birth alone, and those were substituted by certified village midwives.

Now, I don't have the specifics of how long they would train for in Thailand. There are some other countries where midwives are being trained for less than the four years that we train our midwives here in Canada, and we can debate the merits of that. But six months is a bare minimum for training. They are trained close to the village and go back to the village.

What happens is as you begin the training, you scale it up over time. You can see in this graph what happens when you start training and then when you scale it up.

In fact, what's really fascinating.... I do have a slide that's not in this set that takes you back to the Taj Mahal, which is a monument to a woman who died of a postpartum hemorrhage after giving birth to her fifteenth child. At that time Sweden also had a high maternal mortality rate, and the queen of Sweden decided that she was going to start a midwifery training school. The rest is history in terms of what happened in Sweden with maternal mortality.

Yet in India until very recently—the most recent figures for India are showing progress—the most common cause of death, as with the rest of the world's women, is still postpartum hemorrhage.

Mrs. Cathy McLeod: Okay. My quick next question would be that I guess every country would be very different, but would you perceive that this really needs to be integrated into and enhancing whatever primary health care system is already in place?

Dr. Dorothy Shaw: Yes. I think that the whole point of any initiative—and certainly the one that's envisioned by the partnership, by the NGOs in Canada who have been working on this, and I believe by the Canadian government and the G-8—is that this has to be an initiative that begins with community engagement and that involves community health workers. They currently might be doing things at the moment like providing immunizations, family planning, well-baby, and in some cases providing HIV prevention and screening. It takes that and adds to it a trained health professional, a primary health care worker.

Generally speaking, that would be someone with midwifery skills who can then provide safe birth attendants at a clinical facility that's appropriately resourced. That's the first basic level of emergency obstetric care. The next level of emergency obstetric care would be the ability to provide blood transfusions and Caesarian section.

● (1625)

Mrs. Cathy McLeod: We talked earlier about family planning, contraception, and skilled help at birth being a huge need. You talk about HIV/AIDS certainly as a big issue. To what degree would impacting mother-to-child transmission support have in terms of the goals of reducing mortality?

Dr. Dorothy Shaw: Again, it's going to depend on the country. The last maternal mortality audit figures for South Africa made it clear that HIV/AIDS was the most common cause of death, except that it's an indirect cause of death. What that really means is that it's not a primary cause. Women might die of something else, but they were HIV positive and had AIDS. Therefore that contributed significantly to why they died. In South Africa, it's huge. In other sub-Saharan African countries, it's also very significant. But you do have to have the data for your country specifically.

What we know is that as few as 15% of pregnant women are tested for HIV, and that this is significant both for them and their newborns. At the same time, we need to be extremely careful that if we are going to introduce screening of women during pregnancy for HIV, it is done in a way that is sensitive to their needs as women in the community and not in a way that will aggravate stigma and discrimination and leave them isolated.

Ms. Janet Hatcher Roberts: If I could add—

The Chair: One minute left.

Ms. Janet Hatcher Roberts: Yes.

One of the other reasons for success is when there's donor harmonization, and if we're all working to the same drummer, things work a whole lot better in the field, on the ground. If you have a sector like the health sector, all harmonized, and the donors are all thinking and working together with common goals, it works very well. That speaks to, I think, a previous comment in terms of competing priorities or competing packages. The more things are harmonized at a country level, at a national level, the more ability people have to implement programs that are comprehensive and represent a continuum of care. I think we've all worked at that field level where things aren't always working that way, so we appreciate when things are harmonized. That's part of the Paris Declaration that Canada signed on to as well. So we believe in it. We've signed on to it and it fits in with some of the issues that were raised today.

The Chair: Thank you.

I will now go to the fourth person, who is Ms. Mathyssen, for the NDP.

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

Thank you very much for coming here and providing your expertise.

I had a number of questions. I'll start with Dr. Shaw, because I'm using this document, but please, I welcome input from all three, with any of these questions.

In one of the first slides it is very clear that improved maternal health has been the least addressed issue in terms of the millennium development goals, and you said the most neglected. Now, Ms. Sheffield, you suggested that it was because there hadn't been much investment here. I'm wondering if there are other reasons.

We know, for example, that in a lot of countries women have absolutely no control or say over their own reproductive health. They're living in a world where men dominate them and they have no rights in regard to their sexuality and their bodies. Is that part of it? Or is there something else at work here? Why on earth is this at the bottom in terms of progress?

● (1630)

Dr. Dorothy Shaw: Thank you. I think there are several answers to your question, and I'm sure my colleagues will be happy to contribute as well.

First of all, I think the reason there has been much more attention paid to child health is that it is actually easier to save lives quickly through immunization-type programs and treatments of diarrhea, and those kinds of vertical programs, we might call them. It's much easier to do that and to get good results quickly than it is to build a public health system. Emergency obstetric newborn care, or skilled birth attendants, primary care, all of that, but particularly the emergency obstetric newborn care, is the cornerstone of building a public health system.

So I think what you have seen is that even in fragile countries, in terms of their economic state, their health systems, or lack of them, they have been able to be supported to provide significant advantages or advances in terms of child health, and it has been more challenging to provide the advances on the maternal side.

We know that decision-making is often not with the woman and that this is a factor in terms of her being able to access care, both with respect to the decision made in the first place and the finances related to being able to fund that care once it has been sought, which is why there has been a significant push and an uptake from committed countries to either provide free access at point of care for mothers and young children, or a coupon-type system.

Ms. Jill Wilkinson Sheffield: I'd also like to add that until recently, I'll say three years ago, in particular, the conversation changed from a social justice issue to an economic issue in pointing out that women bring social benefits to families, communities, and economies, but they also bring major economic benefits. I think this has suddenly begun to effect a change in the way people think about the fact that women die. You may smile when I say women deliver, and more than babies, but for so many people it was simply a categorical thing. They delivered babies and were a disposable asset, shall we say, and I think that those doors are now behind us and we're moving into the mode of thinking of women as major economic benefits to the small micro-economy of their family, but also to the macro-economy of nations.

Ms. Irene Mathyssen: Thank you. It's interesting that you raise that, because after the violence in the Congo, all the rapes and the degradation of women, they discovered that their agricultural production was down by 70%. They were in a terrible situation, because women were so traumatized and they'd been so brutalized that they weren't able to perform that economic aspect of what women do.

Ms. Janet Hatcher Roberts: Gender is a determinant of health. The socio-economic aspect of being a man or a woman or a boy or a girl is a determinant of health. Even though we're making progress and even though we're starting to talk about the economics of production and women being productive, you're still arguing with a chief in a village about whether to put a hemorrhaging woman into a truck. You're still fighting those fights, and there's still at that micro-level a huge amount of work to be done.

In many small villages and in many parts of the world, the value of women is still not where we want it to be, and that's still going to be underlying what's happening here in terms of valuing women. You could be pulling your hair out trying to argue that with a chief, and he's got the power. So until you've got the chief in the village onside, that truck's not going to move out.

Ms. Irene Mathyssen: You make a salient point, and I'm assuming that's part and parcel of what you mean when you say that for every woman who's helped, there are 30 whose health is severely jeopardized and compromised.

In terms of what you just said about valuing women, countries like Canada have a role to play, do they not, in terms of making a clear statement that women matter—their equality, their equity, their ability to play a part in the economy and be leaders matter? We need to do that in order to have any substance at all, in terms of what we say at meetings, to have that kind of credibility.

● (1635)

Ms. Janet Hatcher Roberts: Countries are looking to us for that leadership, especially low-income countries.

The Chair: Thank you, Madam.

I'll move on to the second round. This is a five-minute round. Again, that means five minutes for questions and answers.

We begin with Michelle Simson for the Liberals.

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

I'd like to thank the witnesses for appearing here today. It has been interesting reading and getting up to speed on this particular issue.

I'd like to address this to all of you, so I'll quickly pose the two issues I'm concerned about. I'd like to pick up where my colleague, Ms. Deschamps from the Bloc, asked a question about the viability of countries that have signed on picking and choosing what they will and will not fund. I am addressing the practicality of how you see this working. It was Ms. Roberts who mentioned that harmonization is something you like to see, but if there isn't harmonization and picking and choosing goes on, how big an impediment do you think it will be to making progress in this area?

The second issue I have is with respect to our government's most recent statement with respect to funding reproductive health and in fact restricting it. How do you think this is going to be viewed by the WHO assembly in two weeks? How can we reasonably explain that?

Perhaps you would care to comment, bearing in mind I only get the five minutes.

Dr. Dorothy Shaw: I'll take a stab at the first question you asked, and others may wish to comment.

I think that at this point a funded mechanism for the G-8 initiative has not been determined, as I understand it. Therefore, what really needs to be determined is how the commitments that were made last year will be met, with whatever funding mechanism is put in place, given those who will be contributing to it.

I think when we look at how other funds, such as the Global Fund, work, as I understand it—and I'm an obstetrician and gynecologist and not an economist or a finance person—what happens is that this is really country-driven. In other words, a country has a plan, it establishes its priorities, and it applies for funding to a fund. That's one scenario.

Obviously, specific bilateral relationships are a little different, and it depends which one we're speaking of.

Ms. Janet Hatcher Roberts: It can create difficulties. When I was working in Guyana, for example, during the Bush gag order, we were working on HIV and AIDS and STD programming on behalf of the Canadian government, but we were also trying to figure out who was doing what and what were they doing, and the extent to which they were doing it, etc. It was difficult for some of the donors, like USAID and the PEPFAR groups. But then there were a lot of other bilateral organizations, mostly faith-based organizations, that were in Guyana as well doing HIV work, and it was very difficult to control the quality, the training, the protocols, the guidelines, the standards, etc., when we weren't all speaking from the same book.

With regard to WHO, you're correct, there is an agenda item on the World Health Assembly agenda with regard to the progress of the MDGs. Canada as a member country will be there, and it won't necessarily be addressing it but will be part of the commitment to the MDGs. Everybody's assumed that we have committed to those, and the assumption would be that they would be consistent with their previous commitments at the World Health Assembly with regard to the MDGs. Whether that's consistent with what happens at the G-8 is a reasonable question.

● (1640)

The Chair: Thank you.

I think we have half a minute, Ms. Wilkinson.

Ms. Jill Wilkinson Sheffield: In half a minute, some of your parliamentarians were at a meeting in Addis Ababa, Ethiopia, last October. We came out with three priorities. One of them is exactly that when you make a commitment to strengthen the health system, we added a phrase that says “with a positive bias toward sexual and reproductive health for women and girls”, because what we've noticed in the past is that when it is that categorical contribution, not a penny of it goes to women and girls. So now we want governments to make a positive bias toward the health of women and girls.

The Chair: Thank you.

We go to the Conservatives. Mr. Calandra.

Mr. Paul Calandra (Oak Ridges—Markham, CPC): Thank you.

I have a couple of questions. I was reading some of the millennium development goals, the report that was issued by the UN with respect to Africa, and one of the items they mentioned—and you mentioned it too, Ms. Sheffield—was with respect to the role that women play in agriculture. I'm going to go into a bit of a different area here. One of the things they mentioned was the need for more of a role, better sustainable agriculture, crops that for instance are more resistant, better transportation. I think somebody mentioned infrastructure modes as being one of the big issues that is stopping Africa from achieving some of its millennium development goals. I wonder if you could comment on that.

One of the other things that struck me was they mention in this report the lack of actual statistics. A lot of the member nations that the report covered actually don't have appropriate statistics. They don't maintain statistics and they don't look at things in the right way, so it's very difficult for organizations and for governments to truly understand the depth of the problem they're having.

Another area they mentioned was with respect to trade and how it's important that developed nations improve their trade with Africa so that there's more of an opportunity to trade agricultural products. I suspect that goes not just for Africa, but for other impoverished nations. The reason I bring that up is because we've been focusing a lot in Parliament with respect to opening up new trade markets for Canadian goods and there have been a lot of delays with respect to opening up trade markets in some of the poorer nations. There's also a lot of discussion right now about potentially limiting the access to modified seeds with respect to agriculture. I'm worried about that in relation to how this will impact Africa in the future.

I wonder if any of you can talk about that as well, more of a long term with respect to how we meet the nutritional needs in Africa.

Ms. Jill Wilkinson Sheffield: I'd like to start.

You are absolutely right. The statistical information is pretty dreadful. I'm sure you all know that the number of women dying is an approximation. It's not an exact number because in many places women's lives don't count and they aren't counted when they die, nor are many of the newborn deaths counted. So one of the things this new study that has come from Washington State tells us is that we see a downward trend, but the statistics are still unacceptably poor. We hope that one of the outcomes is going to be that this gets a major polish-up in doing that.

I want to make one observation. I don't have my number exactly right, but it's relatively exactly right, which is if women had the same access to agricultural education and agricultural extension services as men in Africa, production would be up 20%. They don't have access to that, and 20% is a lot.

Mr. Paul Calandra: It strikes me that Canada in particular could have a positive role in that.

I don't know if you have any comments.

Dr. Dorothy Shaw: Unfortunately, my partner in crime, so to speak, the coordinator for the partnership in Canada, is not here today, and she has quite a bit of experience in terms of the agricultural area. She is an economist. We'll be pleased to provide you with that information if that would be helpful.

Mr. Paul Calandra: Thank you.

● (1645)

Ms. Janet Hatcher Roberts: There is quite a bit of evidence in terms of the impact of microenterprise with women, that by giving them the power and giving them the opportunity, they are able to improve their lot, and therefore improve their access to other services, and therefore improve their health. You can look at it in different ways.

In the health area we say all these things determine whether you get up in the morning and go to work. If you are healthy, if you're not sick and you have food in your belly, you can learn, and you can get up and go to work. You become a productive person. If you're not having babies every 14 months, then you have energy and you can get up and work and be productive.

Looking at that whole infrastructure is really important. Just as roads are important for transporting agricultural goods, they're also important for transporting a woman from A to B. But they're also vectors too. As the trucking routes increased in Africa, they became the routes for the spread of HIV/AIDS; so it's not always good and it's not always bad. We have to look at it in a very broad and very intersectoral way.

On the lack of statistics, you're correct, but in terms of health, the health statistics are probably better than many of the other statistics because we're really good at doing that. If you die or if you live, it's pretty easy—although not always are you counted—and those statistics are gathered up at the smallest little health centres on little scraps of paper and put into a binder and sent up to the minister of health. What is done with them is the issue. They are not analyzed well, they are not interpreted well, and they're not fed back down to the district level where the planning takes place, and that's a huge issue. So the health information piece is huge.

I think CIDA has only funded four health information systems projects in the last 10 or 15 years, and that kind of shows where you need to be integrating it within all of the health projects.

Mr. Paul Calandra: How much time is left?

The Chair: Thank you, Mr. Calandra. Your five minutes are up.

I am going to go now to Madame Demers, from the Bloc.

[*Translation*]

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

Thank you for being here, ladies.

I agree with my colleague. This morning, Ms. Ravololonarisoa told us that the G8 members, including Canada, were serious about women's health and their willingness to help them get out of the prevailing poverty of Africa. African women should be supported as agents of change and transformation, and not just as child bearers.

Ms. Sheffield, you were talking about $12 billion per year to support all areas of women's health. Are the $12 billion intended for all 68 countries under the initiative? That is not a lot of money per country. I have a hard time understanding how we can put so much money towards war and so little into an initiative that could save lives and really allow women to get back on their feet and take control of the destiny of their loved ones and of their families.

Last week, a representative from World Vision said that half a loaf is better than no bread. That was insulting to me because that meant that women are not worth more than half a loaf.

How can we really change things in African countries? How can we make better use of the funding available for that program?

[*English*]

Dr. Dorothy Shaw: I think the very first thing we need, and we already have it in several African countries—in fact in most African countries, but not all—is a real political willingness in the country to engage, to make commitments, including commitments to their own health budgets so this can materialize.

Then after that it's a question of what support they need. With the limited information we have.... It's actually quite good information in terms of quantity; its quality may be questioned, but we do have quite a lot of information on the health of children and even on mothers. We could do with more. What can we do with that at the country level that will help inform the priorities for that country, and how will that then be responded to in terms of international aid? It has to start with the country. You can't have an initiative that wants to go somewhere where there's still conflict, for instance. You can't build a public health system in a country where there is still significant conflict.

When you have no health system to speak of except in a major city, such as perhaps Ethiopia at the moment, your approach would be very different from what it would be in a situation where you might well have some distribution of health facilities, weak though they might be. I think it isn't a question that you answer with any one approach.

● (1650)

Ms. Jill Wilkinson Sheffield: The fact is exactly that. Some ingredients in this stew are similar, but the specifics are very local and they need to be. On the other hand, what we now know and what the Women Deliver conference in five weeks is going to talk about in great detail is the variety of solutions that have worked in comparable areas, whether they're urban or rural, with or without manpower or womanpower.

If we truly strengthened health systems that benefited women, guess what that would also be. The best indicator of an overall health system is to deal with the population at large. So the basic health system needs to be one of our overall investments. I'm not talking fancy; I'm talking basic, practical, needs-based health systems.

[*Translation*]

Ms. Nicole Demers: If—

[*English*]

The Chair: Sorry, that's it, Madame Demers.

Ms. Mathyssen, for the NDP.

Ms. Irene Mathyssen: Thank you, Madam Chair.

I'd like to get back to something that Dr. Roberts said with regard to the global gag rule. Of course we know Obama revoked that, but Bush put that in place in 2000 in the first week he was in office. It barred any foreign organization from receiving U.S. funds if they provided or advocated or informed or counselled women with regard to abortion.

Based on your experience, what effect did that have? What happened as a result of that withholding of funds?

Ms. Jill Wilkinson Sheffield: Disaster—really bad. The International Planned Parenthood Federation has a report that itemizes the people who didn't get services. It wasn't just contraceptive services. It included contraceptive services, but it was prenatal care and emergency obstetric care. It really is a hard statement to make. It's itemized by country, by the lack of money, and it is incredibly unfortunate that this happened.

It was also a difficulty when PEPFAR, the president's emergency plan for AIDS relief, began spending, because a number of difficulties became very obvious. People tried to use PEPFAR money in place of. That was absolutely not acceptable and couldn't work.

PEPFAR paid salaries that were way out of range of local hires, local employees. They offered services that couldn't be continued with local sustainability.

I think we have learned really sad lessons writ large because of a withdrawal of that support and the misuse of some of those other moneys. It's just really too bad.

● (1655)

Ms. Irene Mathyssen: It's interesting that those agencies, the organizations that advocated, were basically, I would say, held at ransom. We are perhaps seeing some of that. Women's organizations here in Canada have been warned, “If you keep pushing this abortion question, you're going to lose your funding”. In fact, we heard that as early as this morning. It's out there, that the Canadian government is borrowing a page from George Bush's gag rule.

Ms. Sheffield, you also said that if the G-8 focused only on family planning, we could reduce maternal mortality by 70%, and that's significant. Can that reduction be achieved without access to safe abortion?

Ms. Jill Wilkinson Sheffield: I'm sorry, what...?

Ms. Irene Mathyssen: Can that 70% reduction be achieved without access to safe abortion?

Ms. Jill Wilkinson Sheffield: Let's hear the doctor.

Dr. Dorothy Shaw: That figure actually comes from the Guttmacher “Adding It Up” report, which is about a combination of family planning and maternal health care. That 70% is from that combination. It doesn't include access to abortion. You can save even more lives if you add in access to safe abortion.

Ms. Jill Wilkinson Sheffield: In fact the Guttmacher report—which I'm happy to leave a copy of, if you'd like it—basically says that if you made that investment in family planning, for every $1 you invest, $1.40 is returned to you in terms of health services that are unused because they're unnecessary. It says: “Seventy percent of maternal deaths would be averted”, “Forty-four percent of newborn deaths would be averted”, and “Unsafe abortions would decline by 73%”.

This is dramatic.

Ms. Irene Mathyssen: Ms. Sheffield, you said that Canada has not yet erred from its commitments, the ones that it made decades ago. What's your concern? Why did you raise that? Are you afraid that we may be...?

Ms. Jill Wilkinson Sheffield: Quite the contrary. I am so thrilled that the G-8 and G-20 are going to be here, our neighbour, and it's going to be two weeks after the Women Deliver conference. There's a continuum of effort that is happening. It starts with you folks right here, right now. Women Deliver, and then it's the G-8 and G-20, where we can really make good on the agenda on which the G-8 and G-20 agreed. Then it's the African heads of state meeting at the end of July. And then in September, starting on the 20th, it is the special session of the General Assembly focusing exactly on the millennium development goals. The Secretary General has said that his energy is going into MDG 5, so we need Canada to help this momentum build and become as important as I believe it needs to be. It's an opportunity.

The Chair: Thank you.

We now move on to the final person in this round, Lois Brown for the Conservatives.

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

Thank you, ladies, very much for being here. I found your presentations very enlightening and very educational.

I want to pick up in just a minute on an issue you spoke about, Ms. Sheffield.

But Dr. Shaw, you spoke specifically about countries being willing countries, saying that we need to work with countries that are prepared to make changes and work with us on issues to build the capacity they need to build health systems.

I was very privileged last year, Ms. Sheffield, to visit Bangladesh. This year I happened to be in Zambia and Botswana and had some observations there too. Bangladesh is a very needy country, but one that has recognized some of the problems it faces and is prepared to work on them.

My comment is that what I also observed was that the day that a girl starts her period, the day she begins menstruation, is the day she becomes, in their culture, of marriageable age. We are dealing with culture shift in many ways and we know that culture shift changes at glacial speed. So we have issues there that we need to work with.

What I saw in Bangladesh was the introduction of what they call a Shasthya Shebika in the villages, whereby they have a woman who is trained in basic health initiatives to be the first responder, as it were. She is given some very elementary training in midwifery. What she is really trained for, though, is tuberculosis identification and giving access to medications, which the state is working on providing. That was very helpful.

I also had the opportunity to visit a maternal health centre, if I may call it that, in the slums of Dhaka, where birthing units are available. They are elementary, by all means.

If girls are leaving school at the age of 13 because they are now of marriageable age or eligibility, how do we go about changing the attitude to keep girls in school? We know that education is what's going to change. I watched them having to teach women over and over again how to wash their hands, because they don't know to wash their hands after they have been to the sanitation facilities, or lack thereof. And clean water is absolutely non-existent there. We know this is transferring disease to young children.

When we say that we're prepared to work with the vertical issues, how do we change this and help create educational opportunities for girls, because we know they're going to be the ones who take this forward?

Could either of you comment on that?

● (1700)

Dr. Dorothy Shaw: I'll start briefly.

I think you've hit on something that is definitely important. It underpins all of these efforts in several countries. Bangladesh is one of them, Ethiopia is another, and Mali is another where child marriage in particular, regardless of laws that may have been implemented, is still very common. The last time I looked at the statistics, I believe that Ethiopia and Mali actually have the highest overall rates for child marriage.

But there are changes that can be made. India has used an incentive program in a number of ways. They've used different incentivizations. It depends what resources are available. Sometimes showing the way from a donor country can help with incentivized programs, but then, is that a sustainable effort?

It's complex to get that cultural shift. All I can say is that there are examples of it happening, but in a big picture sense, for any given country it's going to take time.

Ms. Jill Wilkinson Sheffield: I'd like to answer, because I have two specific examples. One is Indonesia. In Indonesia in the early 1990s or late 1980s, the imams, on one Saturday morning a month, would give their sermon to the group assembled there. They would talk about the importance of educating girls and women one month; the next month they would talk about family planning, saying that it's important to space children for healthier children and healthier mothers; they would talk about women in the work place. They were working at changing cultural norms and expectations about girls.

In Bangladesh there's a tool that we all know and have in our handbags called a mobile phone. The mobile phone in Bangladesh is making a huge difference. Starting in July, there's going to be a program in Bangladesh and seven other countries. It's now in the United States. It's called “text for babies”. Every week you get one text message that tells you, if you're pregnant, a fact that you need to know about pregnancy. Once your baby is born, your “text for babies” is in fact about your baby and about the mother: when to go for a visit; when to go for an inoculation; be sure to drink lots of water; be sure to wash your hands, and why.

This mobile phone technology is going to be one of the best friends of women and girls and health on the planet, really soon. It's going to speed those cultural changes, because the phones are everywhere.

● (1705)

The Chair: I'm sorry, that's it, Ms. Brown.

We've finished our round. We do not have time for another round, because as you know, we should be doing some business at five o'clock and we're past that.

I want to thank the witnesses and allow them one minute to round up anything they felt they needed to say that they didn't say, a question they thought needed to be answered—and I'm holding you to one minute, guys—and any recommendation they want to put at the very top of the page for this committee.

I will begin with Ms. Hatcher Roberts.

Ms. Janet Hatcher Roberts: I think what hasn't been said is that when talking about what needs to be done, Canada has been historically known for its role in supporting gender equality and empowering women in low income countries. Around the world, CIDA has been known for that work for 20 to 30 years. Some of the good work that's been done has been done because of that CIDA funding. We need to make sure that this funding is maintained amongst women's groups to ensure that the empowerment of women continues, which then enhances the whole picture.

My final point would be that I believe the strengthening of the whole health system is the way to go and that we have success stories that we can count on.

That's really it: strengthening the health system in a comprehensive fashion—and when you get the PowerPoint, you can see what we're talking about—is the way to go.

Thank you.

The Chair: Dr. Shaw.

Dr. Dorothy Shaw: Thank you.

I circulated ahead of time the consensus document from the Partnership for Maternal, Newborn and Child Health, and the “Call to Action”, both of which essentially have the partnership's broad-based position on what needs to be done, how much it's going to cost, and how we can accomplish it.

This should be, I hope, very useful to the committee; it represents the input of the world's expertise.

I'll leave it at that.

The Chair: Thank you.

Finally, Ms. Wilkinson Sheffield...?

Ms. Jill Wilkinson Sheffield: Thank you very much.

Something I feel we didn't talk about enough today was young people, especially young girls. They're half of our planetary population now, and we need to really pay attention and work with them.

Did you know that pregnancy complications are the leading cause of mortality of young women around the world? This is really staggering. So I think my final word is invest in women, because it really pays.

Thank you.

The Chair: Thank you very much, again, for taking the time. You've answered a lot of questions.

Before we go, I just want to remind Ms. Janet Hatcher Roberts about the data she had discussed. Could you please give it to the clerk or to the analyst?

Dr. Shaw, you talked about some agricultural data that your partner in crime has. So perhaps you could also make sure that gets to either the clerk or the analyst.

Ms. Wilkinson Sheffield, you have a copy of the Guttmacher analysis. Perhaps you could give it to Ms. Cool and we will make sure it is distributed.

In terms of a budget—

Hon. Carolyn Bennett (St. Paul's, Lib.): Dr. Shaw said that she had—

The Chair: I think it's in this document. She's already distributed it in both languages.

So thank you again.

We now have to move in camera, so I would....

Oh, you want to stay public? All right.

We're going to begin. We don't have very much time. We have as the first item on our business agenda a public item, Ms. Demers' motion. I will read the motion to the committee.

Ms. Demers' motion, which was distributed on April 30, reads:

● (1710)

[*Translation*]

> That the Committee ask the Minister of Justice to appear before the Committee between now and June to explain what he intends to do with the $10 million that was transferred to his department to deal with the high number of Aboriginal women who have gone missing or been murdered.

[*English*]

Now we're going to open the discussion of this motion. We will ask Ms. Demers to begin, since it's her motion.

[*Translation*]

Ms. Nicole Demers: Madam Chair, this is just to follow up on Ms. Morency's appearance last week from the Department of Justice. We learned from her that the minister had already had the intention to do something with that money and that he would present us with a plan. I would have been interested in hearing what he wanted to do with that money. It is $10 million—that is a lot of money. That money was set aside for missing or murdered Aboriginal women.

That is the reason for my motion. It is not complicated. I am not asking him to stay for three hours. I just want him to appear before the committee to simply tell us what he plans to do with that money.

[*English*]

The Chair: Ms. McLeod, in discussion of the motion.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I understand—and perhaps the clerk can check this out—that the aboriginal committee is studying this specific issue. If that's true, I understand the tradition is not to overlap. I believe Madame Neville is on that committee.

Is that accurate?

Hon. Anita Neville: Yes, I am.

The Chair: I think the question is whether the committee is studying the utilization of the $10 million that has been transferred to the Minister of Justice.

Hon. Anita Neville: Not that I'm aware of, but that doesn't mean anything.

The Chair: All right.

Hon. Anita Neville: I'm not aware of that, Ms. McLeod, that the aboriginal committee is looking at it.

Mrs. Cathy McLeod: Sorry, I was confusing it with the next motion. So I'll withdraw that for this motion.

The Chair: Thank you.

Ms. Neville, do you want to speak to the motion?

Hon. Anita Neville: Briefly, Madam Chair, I have no problem supporting it. My only concern is about timetabling. How are we going to fit everything in, given that we may have one leg here and one leg somewhere else in the country? That's the challenge of it. So I don't know....

The Chair: All right. Thank you.

Now we'll go to Madame Deschamps.

[*Translation*]

Ms. Johanne Deschamps: I just wanted to add one thing to Ms. McLeod's questions.

Last week, I attended the meeting of the Standing Committee on Aboriginal Affairs and Northern Development where we talked about the money from the Aboriginal Healing Foundation. I think it is quite appropriate for the Minister of Health to come here and explain all that.

[*English*]

The Chair: That's not a motion, Madame Deschamps.

We're dealing with the one on the Minister of Justice at the moment.

[*Translation*]

Ms. Johanne Deschamps: My apologies, it must be because it is not warm enough in here. That is why we cannot follow you very well.

[*English*]

The Chair: There are two. We're dealing with the Minister of Justice at the moment.

Mr. Dreeshen.

Mr. Earl Dreeshen (Red Deer, CPC): I was actually going to speak to the second motion as well.

The Chair: Maybe Mr. Calandra wishes to speak to the motion on the table.

Mr. Paul Calandra: I wonder if Madam Demers would accept a friendly amendment, just to remove the word "June". That way we could schedule it when we have time and we're not specifically—

[*Translation*]

Ms. Nicole Demers: That is fine.

[*English*]

The Chair: We have agreement by the mover.

There being no further discussion, I'm going to call the question.

It's a friendly amendment. Madame Demers has accepted it.

The motion would read:

> That the committee ask the Minister of Justice to appear before the committee to explain what he intends to do with the $10 million that was transferred to his department to deal with the high number of aboriginal women who have gone missing or been murdered.

(Motion agreed to)

The Chair: It's unanimously agreed to. The motion has passed.

The next motion from Madame Demers is:

● (1715)

[*Translation*]

> That the Committee ask the Minister of Health to appear before the Committee between now and June to explain what she intends to do with the money that was transferred to her department for the Aboriginal Healing Foundation.

[*English*]

I would like Ms. Demers to quickly introduce her motion with whatever she'd like to say.

Ms. Demers.

[*Translation*]

Ms. Nicole Demers: Madam Chair, it is somewhat specific. Since the Aboriginal Healing Foundation does not receive the money it used to get over the last 10 years, some of the shelters for Aboriginal women, victims of violence, funded by the foundation can no longer operate.

So I wanted the Minister of Health to provide clarifications. I wanted her to tell us what she is planning to do with the money that was supposed to go to the foundation, but that was given back to the Department of Health. Perhaps there is a very good reason and I would like to know what that is.

[*English*]

The Chair: Thank you.

Mr. Dreeshen.

Mr. Earl Dreeshen: Thank you very much.

I think I am on the right motion.

Madam Chair, this has been covered at the Standing Committee on Aboriginal Affairs and Northern Development. We've had a lot of discussion just this last week. We did have Health Canada officials in, so perhaps the committee might consider receiving some of that information, as far as it pertains to your concerns, and then we wouldn't be overlapping.

I think a lot of what had been discussed and what you're suggesting has been dealt with in these last few sessions that we've had. I would make the suggestion that perhaps you either wait or just look at the materials.

Thank you.

The Chair: Thank you, Mr. Dreeshen.

Madame Deschamps.

Now we're speaking to the health issue.

[*Translation*]

Ms. Johanne Deschamps: Yes, I would like to add something to that.

Last week, I attended a meeting of the Standing Committee on Aboriginal Affairs and Northern Development and officials from the department were there. The answers to the questions were quite confused, especially when we asked them how those funds would be allocated given the work the foundation was doing and that now will have to be handled in another way.

There is great concern since the foundation is no longer funded. It would be interesting if the minister came to let us know about her intentions about those funds.

[*English*]

The Chair: Thank you.

Ms. Neville.

Hon. Anita Neville: Thank you.

I too was at the meeting, Madam Chair, and was not satisfied with the answers from Health Canada. At least six projects were funded by the Aboriginal Healing Foundation, and I suspect there were more that had some involvement with violence against women and aboriginal women. The officials from Health Canada indicated how the moneys were going into Health Canada. They certainly did not address the full complement of programming that was done under the Aboriginal Healing Foundation funding, and there's clearly a significant gap.

My concern with this motion and the previous motion is not only timing. I was part of the health committee discussions on another issue, and ministers were invited and simply refused to come. So I would say let's invite the minister. I want to know. One of the grants was actually in her own community where the funding was. What Health Canada is doing is in no way making up for the disparity and the lack of funding under the Aboriginal Healing Foundation.

So I would support—

The Chair: You are speaking for the motion but you are concerned about timing.

Hon. Anita Neville: Timing, and whether in fact they'll come.

The Chair: Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I appreciate the comment that you didn't feel fully apprised of what was going on, but I do believe the right place to have that discussion, in that you have started a foundation, is to continue to build on that foundation within the aboriginal affairs community, as opposed to our committee going in. For that reason, I will vote against this particular motion.

The Chair: Thank you.

Mr. Calandra.

● (1720)

Mr. Paul Calandra: To Mr. Dreeshen, when is the aboriginal affairs committee expected to report back? Can we delay it until we see their report? Then we could consider that report as part of our work. As opposed to getting them in here and repeating everything, why don't we go on the basis of what is tabled at that committee?

The Chair: Ms. Demers, would you respond to the question?

[*Translation*]

Ms. Nicole Demers: Madam Chair, it is because they have already appeared and we did not get the answers we wanted from them.

The foundation no longer exists, Cathy. It closed down due to lack of money. That is what Ms. Quinn told us last time. Since the foundation is shut down, we cannot rely on it for answers anymore. It no longer exists.

But, as to the deadline, like we did with the other motion, I would be ready to remove the wording “between now and June”, so that the motion simply asks the Minister to appear before the committee. If my colleague wants to make a friendly amendment, it would be my pleasure to accept it.

[*English*]

The Chair: You are amending your own motion, so it doesn't have to be friendly. You could dislike yourself as much as you want, Ms. Demers.

[*Translation*]

Ms. Nicole Demers: As you wish, Madam Chair. I can be friendly to myself and remove the wording.

[*English*]

The Chair: So the committee will have the Minister of Health to appear before the committee to explain what she intends—and between now and June has been removed, so the timeline has gone.

Mr. Dreeshen, you had your hand up. Did you wish to add anything further to that?

Mr. Earl Dreeshen: Well, this is your committee and what you might wish to study. Coming in here new, I'm not going to suggest I know where you wish to go with it. But I do know that with the overall discussions we've had we've certainly talked about the Aboriginal Healing Foundation, the types of things being done in the community, and the fact that it was a sunsetted clause for the healing foundations. So I think it's significant that we have taken it on in aboriginal affairs to study that. Where you wish to go beyond that is up to you.

The Chair: Thank you.

Madame Deschamps.

[*Translation*]

Ms. Johanne Deschamps: I would just like to make a clarification.

We know that the foundation no longer exists. Actually, we are asking the minister to come here to address the concerns of the groups who supported the foundation. What will happen with the groups that received the foundation's support for a number of years, now that it is no longer funded? What are their concerns about that? Women's groups especially are worried about what the minister will now do with the funding that no longer goes to the foundation. They are wondering how this will be managed and whether we will continue to support them. That is why we are asking the minister to come here.

[*English*]

The Chair: Thank you.

Ms. Brown.

Ms. Lois Brown: Madam Chair, if I may, I was in the House the night there was the emergency debate on this issue. It lasted for five hours in the House.

Would it not be prudent for us, first of all, to get the material from the Indian and northern affairs committee and from the Hansard? Would that not be prudent to get, so we have that before we bring in the minister? It would seem to be prudent, because so much of the debate has already taken place.

The Chair: We've heard from three people who were at the aboriginal committee, and two said they were not satisfied with what they heard, that the questions were not answered with regard to what was going to happen to the funding for those groups who will no longer be funded.

Of course Hansard is something you can get whether you agree to this motion or not. It doesn't preclude getting Hansard to help to inform you so you can ask clear pertinent questions of the minister. I don't think those two things are necessarily contradictory.

I'm going to call the question on Madame Demers' motion with regard to the Minister of Health.

There is a tie vote. The chair will have to break the tie.

I will ask the Minister of Health to come, purely because I have heard two-to-one that the question Madame Demers is asking was not answered there.

(Motion agreed to)

The Chair: Madam Neville made a comment, and before I speak to her comment in a broader context, Ms. Simson has something to say.

Mrs. Michelle Simson: Well, no, it's not really something to say; it relates to this matter and it's a question. If you look at the schedule, have we received, or have you as the chair received, any response from either Minister Oda or Minister Ambrose as per our request that they appear before our committee? That's only the one concern. I certainly support this. It's getting a response that concerns me, any kind of response.

● (1725)

The Chair: We have not as of today heard from Minister Oda and Minister Ambrose whether they can come here before the end of May. These questions were asked of these ministers. There was a lot of leeway offered to them, as long as it happened before the end of May. We know the parliamentary secretary, Madame Boucher, had said she would speak to the minister with regard to this.

Mrs. Sylvie Boucher (Beauport—Limoilou, CPC): I will speak to her again.

The Chair: I must say that as the chair my comment is simply that we have asked a minister who is particularly responsible to this committee and we have not even heard from her. I have not had a simple response of any kind—a yes, no, don't bother me, or anything. I've just had nothing.

Minister Oda had said she couldn't come on the dates that we had suggested, and we have since sent back to ask her if she could come on May 26, which would be before the end of May. We have not heard a response to that.

We're now asking two ministers to come. I would just like to comment that in the past, when we were looking at other issues, such as EI, we had asked the minister of HRSDC to come. We had asked the minister of the Treasury Board to come with regard to pay equity. Ministers do not have to appear before a committee. I guess that's their executive prerogative not to do so. However, as chair of the committee, I might suggest that when a committee asks for information and asks for clarification because we need to understand the issue better, I really think.... I have been here for 17 years, and it's the first time I have seen ministers completely not responding. It's not just not coming, but it's not responding to chairs of committees and committees who request their presence. That concerns me a little bit. It is something I think Ms. Simson is alluding to.

I know the parliamentary secretary can only do what the parliamentary secretary can do, which is ask. If the parliamentary secretary doesn't get an answer, she's being considered to be not as important as the committee is either. A committee of the House is an important body. You've heard the Speaker speak to this issue. A committee of the House is here, in a non-partisan way, to gather information, to understand the issues, and to speak to them, to report on them, to make recommendations, if they believe that Parliament does not have the answers it requires. That's how you get answers, through committees. So I am concerned, and I want the concern to be on the record in this instance.

I sent a third letter to the ministers last week, personally sending them the motion, reminding them that this has to be done before the end of June, and we have not heard anything back. Not even to acknowledge is not a good thing, I think. It's not particularly respectful of committees.

That's speaking to the issue of Ms. Simson's question.

Now, we have another question we need to ask. Ms. Neville had put forward a motion in the last meeting that the committee hold a special meeting to examine the manner in which funding is distributed by Status of Women Canada, etc. She had said that this was a special meeting. The point is, if it's a special meeting, I asked everyone to think about it, because it means it is outside of the two meetings a week that we have. Have you got a date, as a committee, that we will stay one evening and get this done? We have all passed this motion—it was passed by the committee—to hold a special meeting. “Special” means outside the normal meetings. It's for one meeting. We've asked for this to come to the clerk and the analyst, but we have not had a response from the committee on this. We need to make that decision.

Ms. Neville.

Hon. Anita Neville: Madam Chair, I wonder if I could suggest possibly doing what we've done in the aboriginal affairs committee, extending the regular meeting by an hour, or an hour and a bit.

The Chair: That's a good suggestion, except I would like the committee to note that on a Monday evening and a Thursday evening, I would say that at nine out of every ten meetings, we've had a vote. But if you wish to come back after the vote, and there could be a meal provided, that would be one way of following up on Ms. Neville's comment. Wednesday nights seem to be particularly free, if people wanted to stay on a Wednesday. We could start again at six o'clock and have a dinner and spend a few hours on this, the normal time of any committee, which is going to be two hours.

● (1730)

The Clerk of the Committee (Ms. Danielle Bélisle): Do you have a consensus for it?

The Chair: Do you all have this? We keep giving it every time.

Yes, this will be after the break week. The break week is the 17th to the 22nd, so we could look at either after this committee on the 25th, and the—

The Clerk: On the 25th, you don't sit.

The Chair: Sorry, that's right. So it's going to be the 26th.

Mrs. Sylvie Boucher: On the 26th after what time?

The Chair: Well, we would have to stay and let this committee be a continuing committee. It could be the 26th. It could be the second. It could be the ninth.

The Clerk: Well, on the second you might be travelling, if you get your budget approved.

The Chair: The 26th is soon. It's quick. We may be into travelling in June, so the 26th seems like a practical solution.

Mrs. Sylvie Boucher: Yes.

The Chair: I'm putting it to everyone. You're the ones who have to make the decision.

Mrs. Sylvie Boucher: I don't have a problem with the 26th.

The Chair: All right. Does someone want to make that proposal for the 26th? Ms. Neville.

Hon. Anita Neville: If you want to ask the clerk to set it up, that's fine.

The Chair: No, but we have to have an agreement. The clerk can't set up a meeting if no one can come. We have Ms. Boucher agreeing to it. So what I'm doing is asking the committee if the 26th is acceptable to everyone, after committee to continue for an extra two hours. We will supply food. And if there's a vote, come back after the vote.

Mrs. Sylvie Boucher: Okay, after the vote.

The Chair: On the 26th of May.

Do I hear no dissenting voices? Then the clerk will set this up. That's agreed.

Good. Thank you.

Now, what do we have here as time?

It's 17:33. We have this budget I want to take next week, Tuesday. I only need you to say yea. We have made the budget as we said. I think you all have it with you.

Actually, instead of the two trips we talked about, we broke off Maniwaki as one trip, because it's cheaper if we do Maniwaki as one trip—it will cost us $2,500—than if we attach it to Brantford, Quebec City, and Montreal, because that would add a night in a hotel, which would mean more money.

I don't know if you've looked at this, but basically we have a total cost of $157,635 for the first half of our committee.

Hon. Anita Neville: So moved, Madam Chair.

The Chair: You move that the budget is accepted?

(Motion agreed to) [See *Minutes of Proceedings*]

The Chair: I will take the budget in.

Mr. Paul Calandra: I am opposed.

The Chair: Yes. It will be noted that Mr. Calandra is opposed.

Mr. Paul Calandra: Since many of us are in Toronto, to come to Ottawa and then fly back to Brantford seems to make very little sense to me.

The Chair: Remember, it is not the full committee travelling. We will figure it out, because we've already decided we will travel and we've already decided to split the travel, etc.

So that's it. Is there a motion to adjourn?

Ms. Lois Brown: I so move.

The Chair: Thank you, Ms. Brown.

The meeting is adjourned.

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