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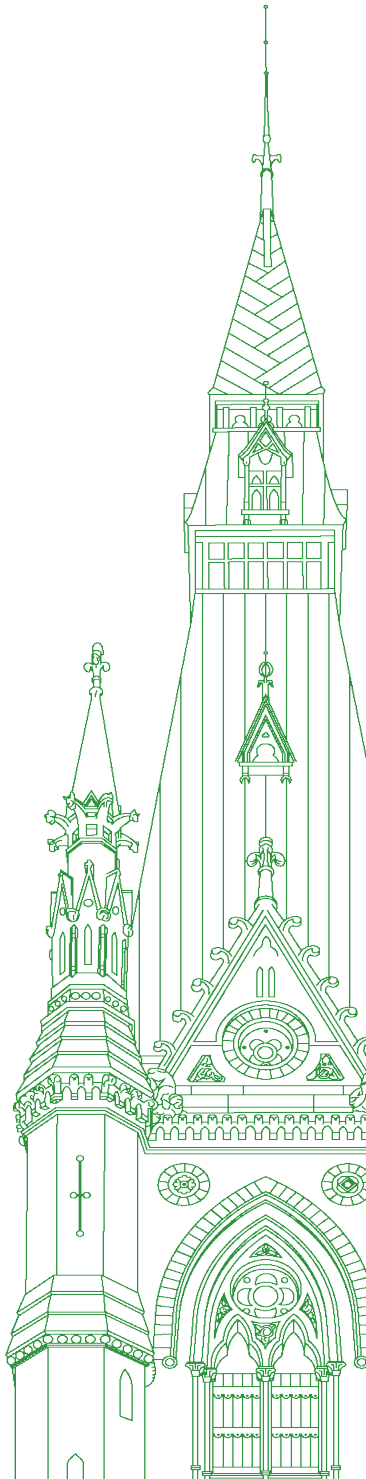

Chair: Mr. Ali Ehsassi

Standing Committee on Foreign Affairs and International Development

Tuesday, March 7, 2023

● (1105)

[*English*]

The Chair (Mr. Ali Ehsassi (Willowdale, Lib.)): Welcome to meeting number 52 of the Standing Committee on Foreign Affairs and International Development.

Today's meeting is taking place in a hybrid format pursuant to the House order of June 23, 2022. Members are attending in person in the room as well as remotely using the Zoom application.

I'd like to make a few comments for the benefit of the members as well as the witnesses.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourselves when you are not speaking. Interpretation for those on Zoom is at the bottom of your screen and you have a choice of floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

In accordance with our previous practice, I'd like to inform everyone that all witnesses have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on Monday, June 20, 2022, the committee now resumes its study of the sexual and reproductive health and rights of women globally.

It's my great pleasure to welcome to our committee, first of all, from the Guttmacher Institute, the principal research scientist, Ms. Elizabeth Sully. Also, from the International Planned Parenthood Federation, we have with us the director general, Dr. Alvaro Bermejo. Lastly, from the Parliament of the Republic of Uganda, we have with us member of Parliament the Honourable Lucy Akello.

Welcome, all of you. Thank you for being here with us today.

You will each be provided five minutes for your opening remarks, after which we will open it to the members for questions. I should say that once you have 30 seconds remaining, I will make a sign to you that you should really be in the process of wrapping up your comments. That applies not only with respect to your opening remarks but also when you're in the process of answering questions from the members.

All of that having been said, Ms. Sully, the floor is yours. You have five minutes.

Dr. Elizabeth Sully (Principal Research Scientist, Guttmacher Institute): Thank you, Mr. Chair, and good morning, members.

The Guttmacher Institute is a leading research and policy organization committed to advancing sexual and reproductive health and rights, or SRHR, worldwide.

We're at a critical juncture globally. We've achieved substantial progress over the last few decades. The number of women using modern contraception has risen, unintended pregnancy has been declining globally, maternal deaths are dropping and legal access to abortion is expanding. However, as of 2019 there were 218 million women in low- and middle-income countries with an unmet need for modern contraceptive methods. This resulted in 111 million unintended pregnancies annually and 35 million unsafe abortions. We're also at risk of backsliding on the progress that we've achieved, with a global opposition to SRHR that's emboldened by the recent overturning of Roe in the United States.

I want to highlight for the committee today two main areas where greater investment and leadership are needed to ensure SRHR globally. First, through our decades of conducting research with global partners, the data clearly shows that investing in a comprehensive package of sexual and reproductive health services is a smart and cost-savings investment that protects health and saves lives. Investing in a comprehensive package of services can result in substantial gains. For example, if all women in low- and middle-income countries wanting to avoid a pregnancy were to use modern contraception, and all pregnant women and their newborns were to receive care at international standards, we would see a two-thirds decline in unintended pregnancies, unsafe abortions, and maternal and newborn deaths, and an 88% drop in HIV infections among babies six weeks and younger.

When investments are made in a comprehensive package of services, there are also important cost savings to the health system. Every additional dollar that's invested in modern contraceptive services would save three dollars on pregnancy-related and newborn care through preventing unintended pregnancies. Investing in maternal and newborn health is essential and important, but it is insufficient on its own. A comprehensive investment is necessary to really make an impact in reducing preventable maternal deaths, ensuring bodily autonomy and reducing health systems costs.

The second point I want to make to the committee is that global leadership is needed now to protect and expand on the gains that we have achieved in safe abortion access. People around the world have and need abortions. That is not going to change. Globally, more than 60% of all unintended pregnancies end in abortion. That's 73 million abortions annually. Legal restrictions do not stop abortions from happening. We find no evidence that the abortion rate differs in countries where abortion is restricted versus where it is legally allowed. Abortion restrictions instead lead to more unsafe abortions. There are an estimated 21 million abortion complications annually in low- and middle-income countries. However, if all unsafe abortions were made safe, that would drop to two million, and there would be a 45% reduction in the health system costs of providing abortion care. Providing safe abortion care saves lives, respects rights and reduces costs.

The United States has become a global outlier by eliminating the right to abortion. This is in stark contrast to decades of progress on abortion rights, with the global trend towards liberalization of abortion laws. Nearly 60 countries have expanded the legal grounds for abortion since 1994. We need global leadership to support countries in their efforts to expand safe abortion access. Supporting safe abortion means investing and filling the evidence gaps, it means strengthening advocacy and it means expanding access to abortion services.

Canada has made a historic commitment to SRHR. My team at the Guttmacher Institute has conducted two studies estimating the impact of Canada's investment in family planning over the last few years. We find that as of fiscal year 2020-21, Canada invested $63.5 million in family planning. That resulted in 2.5 million women and couples receiving contraceptive services, preventing 1.1 million unintended pregnancies and 347,000 unsafe abortions, and resulting in 1,800 lives saved.

Canada can have similar impacts on the other neglected areas of SRHR. We're facing a global backlash, but countless allied low- and middle-income country governments and civil society organizations want to secure comprehensive SRHR in their countries. To do this they need support, and they need Canada's support. They need data and evidence to support their efforts. They need funding to expand services within their health systems. They need political support and strong and vocal global leadership.

How countries respond to sexual and reproductive health and rights is really a story about how much societies do and do not value women.

● (1110)

Canada has made its voice clear that it values women through its feminist international assistance policy and its historic new funding commitment to SRHR.

I hope that the facts and evidence I have shared today demonstrate why it's imperative that Canada continues to put these values into action on the global stage.

Thank you very much.

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

We go next to Dr. Bermejo.

You have five minutes, sir.

Dr. Alvaro Bermejo (Director General, International Planned Parenthood Federation): Thank you, Mr. Chair.

Good morning, committee members and fellow panellists. The International Planned Parenthood Federation, IPPF for short, is a global service provider and a leading advocate of sexual and reproductive health and rights for all.

Today, IPPF is a worldwide federation of 119 national member associations and 29 collaborative partners working with and for communities in 149 countries. These local member associations are nationally owned and governed civil society organizations, and leading sexual and reproductive health service providers in their respective countries. This gives IPPF a global presence unparalleled among other sexual and reproductive health and rights civil society organizations.

We defend the right of all people to enjoy their sexual lives free from ill health, unintended pregnancy, violence and discrimination. We deliver comprehensive sexuality education to young people, in and out of school, to help them both understand and claim their sexual rights, and we support a woman's right to terminate her pregnancy legally and safely.

As an international federation, IPPF provides a platform for member associations and stakeholder groups from around the world to come together. Our global presence makes IPPF a powerful advocate for sexual and reproductive health and rights at all levels. We are, in a way, a living expression of the universality of sexual and reproductive health and rights and an expression of global solidarity.

I want to endorse everything that my colleague Elizabeth Sully from the Guttmacher Institute has said, and maybe just spend a couple of minutes looking at what she has called the "backlash". From where I sit, [*Technical difficulty—Editor*].

● (1115)

The Chair: Mr. Bermejo, we can't hear you. We're having some technical difficulties.

We'll suspend for a few minutes.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Chair, can we just go to the next witness and then go back to him?

The Clerk of the Committee (Ms. Ariane Gagné-Frégeau): No, we have to suspend.

Mr. Garnett Genuis: Okay.

The Chair: Thank you.

● (1115)

(Pause)

● (1135)

The Chair: Dr. Bermejo, we're back. We're terribly sorry for the technical challenges we were experiencing. We will reset the clock for you, and you can commence from the very beginning, if you so wish.

Is that your intention?

Dr. Alvaro Bermejo: No, I will aim to be a bit shorter and not repeat everything from the beginning. Thank you, Mr. Chair.

Good morning, again, everybody. You have my apologies for the interruption.

I am speaking on behalf of the International Planned Parenthood Federation, IPPF, which is a federation of 119 member associations and national civil society organizations that provide sexual and reproductive health services. We provided 200 million services last year through our 40,000 clinics around the world—

The Chair: Mr. Bermejo, I'm sorry. Interpretation is not working. We'll try to work on it on our end to make sure your remarks are translated properly. In the interim, I presume the best route forward would be for us to go to Ms. Akello.

Ms. Akello, if you're ready, we will hear from you for five minutes, and then circle back to Dr. Bermejo.

Welcome MP Akello, the floor is yours.

● (1140)

Hon. Lucy Akello (Member of Parliament, Parliament of the Republic of Uganda): I bring you greetings from Uganda, Mr. Chairman and your committee members.

As you rightly said, I am Lucy Akello, a member of Parliament from Uganda.

Africa has a long history of colonization—just like Canada—and of people, foreign governments and foreign-led organizations telling us what is good for us or what our priorities should be.

I will speak from the context of an African woman, a mother and a legislator. I speak not just for myself but for the constituents who have asked me to speak on their behalf about their priorities and concerns. Clear polling data shows that what I will tell you is overwhelmingly in line with public opinion throughout Africa. I pray that my submission is as candid as you would like it to be.

I'll speak first about abortion.

Our people are still loyal to religious truths and cultures. Canada, too, has its beautiful cultures. It seems that no matter how much money is spent on making abortion look good, our people still see through the money, marketing and mass education. The women I represent are able to see through this. We believe life starts from conception, and where I come from, once conception takes place, it is life. Even when you have a miscarriage, that life is given a decent burial, irrespective of the sex.

Africa generally finds abortion repugnant. A survey of 2014 by Ipsos Synovate, for example, found that 87% of Kenyans oppose the thought of killing an unborn child. This nationwide Kenyan survey echoed the findings of a 2013 global study by Pew Research Center that asked 40,117 respondents in 40 countries what they thought about various moral issues, including abortion. The overwhelming majority of Africans said that abortion was morally unacceptable, with 92% of Ghanaians, 88% of Ugandans, 82% of Kenyans, 80% of Nigerians and 77% of Tunisians saying they considered abortion to be morally wrong.

Almost 80% of African countries have some sort of law prohibiting and restricting abortion, and it is predicated on a widely held belief that unborn babies have a right to live and deserve to be protected by law. With this prevalent view of the issue of abortion, most people are satisfied with these laws. There are hardly any locally organized complaints, demonstrations or protests calling for the legalization of abortion. On the contrary, there have been many pro-life rallies, marches and conferences in various countries, expressing the people's desire for the continued protection of the unborn.

Globally, crisis pregnancy facilities are vilified as misinformation or disinformation centres. Postabortion recovery programs for women who have been wounded by abortion, or who would like to find emotional and psychological healing are not a common occurrence in Africa. The result is that the trauma they have suffered follows them because there's no one who tells them before they carry out the abortion.

On family planning, to the women I represent, the term “family planning” is synonymous with contraception. This is how it has been sold to them. When one says they are on family planning, they mean they are on contraception. However, women are hurting from the side effects of hormonal contraception, and they talk about it with each other. Contraceptive side effects are a major deterrent to the consistent use of contraception, and women who experience bleeding-specific side effects are most likely to make a choice of contraceptive discontinuation and switching.

● (1145)

On the issue of comprehensive sexuality education, the parents I represent see this as an assault to the health and innocence of children.

Mr. Chairman, in the interest of time, I recommend that the Canadian government and this Parliament look more at keeping the girl child at school as opposed to giving them contraceptives. Where I come from there is a push to put girls even as young as 13 or 14 onto contraception. What does this do to a young girl?

I also recommend that you respect Uganda's sovereignty.

Thank you so much.

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

Have we sorted out the technical problems? Okay, we'll call him.

Are the members okay with going to questions?

Some hon. members: Agreed.

The Chair: Once the previous witness is good to go, then we'll revert back to that.

For our first round of questioning, we have Mr. Genuis.

Mr. Genuis, you have four minutes.

Mr. Garnett Genuis: Thank you, Chair.

I'd like to move forward with my first question here. Before that I want to thank all of our witnesses. All of you have made an effort to be here, in particular Mrs. Akello flying all the way from Uganda to be with us in person. Sometimes we have public servants who don't want to come from their offices to be with us in person. I look forward to the continuing discussion here.

I'm the shadow minister for international development. A big concept in international development right now is the issue of localization—listening to and responding to the needs of local people and applying those without bringing in predetermined western priorities.

What are the development priorities of the local women you represent in Uganda? How can we ensure that our development assistance relates to local priorities instead of bringing in predetermined western priorities?

Hon. Lucy Akello: Thank you so much. I chose to fly here after two days of thinking. I've just witnessed it here—systems can actually fail. I would have failed to represent the voices that would have told me to come here. I think I made the right choice.

I will go back now to your question on development priorities.

For a long time I worked with civil society before joining politics. One thing that was so good at that time was that, when the donors would come to us, they would ask us what our values were. What does our culture say about this, this and this? They would say that they would fit into our culture.

Now things have changed. What is now happening is that you must fit in with the donors. The donors come and tell you that you must fit into their values. You must fit into their culture. This is really, for me, wrong. If you want to help me, come build what I have as opposed to making me fit into your priorities.

Right now, like I say, our priority is to keep the girl at school. Studies have shown that when a girl stays at school she will definitely stay out of unwanted pregnancy. We will not need abortion for her. We will not need contraceptives for her. That is for me the development priority that I think we need.

We need more functional health centres for our women and children as opposed to more money for contraceptives, family planning and abortion.

● (1150)

Mr. Garnett Genuis: Thank you, Madam.

In 2018, Prime Minister Justin Trudeau met with President Museveni, the President of Uganda. He was widely criticized at the time for not raising the issue of LGBTQ rights in particular, given that your president has taken positions on that issue. Our party joined in that criticism of the Prime Minister at the time. I just raise this, because there are issues where people want to see us raise issues that reflect widely held opinions here, but those may differ from opinions or perceptions on the ground and with our partners.

On the issue of abortion, how do you suggest we navigate those areas where there are sincerely held disagreements, deeply held, among governments, among parliamentarians? How do we navigate those areas relating to abortion, family planning, in a way that is true to our convictions but also sincere and respectful?

Hon. Lucy Akello: Thank you.

My president has always said that Uganda is a sovereign nation, just like Canada and just like any other country. If we all respected our sovereignties, then we wouldn't have many problems. You have laws here in Canada. We also have laws in Uganda. Those are the things that should get us going.

Thank you.

The Chair: Thank you.

We next go to Mr. Oliphant for four minutes.

Hon. Robert Oliphant (Don Valley West, Lib.): Thank you, Mr. Chair.

I'd like to take a moment of privilege to raise one name at the committee. It's the name Bonnie Bean.

Bonnie was a friend of mine and a parishioner in the church where I was the pastor. She died on February 21 after a lifetime with Planned Parenthood in the Toronto office and after a lifetime of sexual education for young people and advocating for women's rights. She had a profound influence on me for all my life. I just want to raise her name and get it in our record today as someone who has made a difference in our country. Her death is a loss to our community.

I wanted to raise Bonnie's name and also thank Ms. Sully for her presentation and very factual understanding. I also want to thank the witness from Planned Parenthood, who raised some important issues.

I am going to address some issues with respect to Member of Parliament Akello's presentation today.

With all due respect, and fully understanding the sovereignty issue, the world community has decided that human rights are universal. They transcend political boundaries. They're indivisible and they're interdependent.

I understand that you are a co-chair of the women's caucus in your Parliament—or you have been co-chair of the women's caucus, with the Minister Sarah Opendi—and you have worked on women's issues.

I want to know how you address the human rights, the health and the well-being of lesbians in your country.

Hon. Lucy Akello: Thank you.

Just for the record, the Honourable Sarah Opendi is the chair of the Uganda women's parliamentarians. I am nowhere in the executive. I am actually the vice-chair of an accountability committee, PAC, and I sit on the foreign affairs committee of Parliament. I'm just a member of the Uganda women's parliamentarians. I thought I needed to set this record very clear.

Hon. Robert Oliphant: Sometimes the Internet is wrong.

Hon. Lucy Akello: Now you're getting it from the right person. It's the reason why I needed to be here.

Yes, you're right. Human rights are universal, but with the UN declaration—the original one—if you look through how everything has changed, we now make definitions of what human rights are based on what we now want. Even today I can wake up and decide to define “human rights” the way I want. If you look through the definition of “human rights”, it has changed over the period from the original definition of what we knew as human rights.

● (1155)

Hon. Robert Oliphant: I would still argue they're universal and they transcend sovereignty.

Hon. Lucy Akello: Yes, they do.

Hon. Robert Oliphant: There is a bill called the Anti-Homosexuality Bill that was presented in your Parliament. Are you supportive of that bill?

Hon. Lucy Akello: That bill came in Parliament. I've yet to read it because when it came, I was away. At the right time, I will make my decision. It is still very premature.

Hon. Robert Oliphant: This bill allows for the extradition of gay people from other countries—people who are living their lives with the protection of human rights in Canada. It would allow for their extradition and for them to be punished and serve up to 10 years for simply being a lesbian, a gay man or a bisexual person.

It also has definitions of homosexuality that are outdated and have no bearing in science, in religion or in law. As a Christian pastor, it is an offensive bill.

I would hope you read it very carefully to understand that it would isolate Uganda from the rest of the world. In Africa, 22 countries are now moving towards full rights for lesbian women and gay men. I am wondering what your caucus could do to do that.

Mr. Garnett Genuis: I have a point of order.

I share Mr. Oliphant's views on this particular bill. However, this is not on the topic of the issue we're here to raise. Even in a person's time, there is an expectation that they stay on topic. I have been chastised for that from time to time in the past—and successfully chastised, as Ms. Bendayan points out. What's good for the goose is good for the gander, so to speak.

With respect, this is an important issue—

Hon. Robert Oliphant: The bill is very clear that it limits lesbians' rights—their health and human rights. Our study is on sexual and reproductive health and the rights of women globally. That includes the rights of lesbian women who are being discriminated against in this bill.

My hope is that this bill doesn't pass and Uganda chooses to be with the world community and recognize human rights—certainly, the rights of Ugandans who live outside their country and have the right to live under the laws of Canada and not face extradition.

The Chair: Ms. Akello, you have approximately 20 seconds to respond.

Hon. Lucy Akello: Thank you.

I was invited here to talk about the topic of sexual reproductive health for women, globally, and I have done that. If you want to talk about the Anti-Homosexuality Bill, we will talk about it when my sovereign nation of Uganda has made a decision on it. Rest assured that no one is going to be killed, because every life matters.

Hon. Robert Oliphant: Thank you, Mr. Chair.

The Chair: The clerk has asked to do a sound check for the floor.

Dr. Alvaro Bermejo: Is it any better? I can hear you well.

I'm so sorry I'm not there face to face. It would have been much easier if I were there with Elizabeth and Lucy. I'm sorry about that.

The Clerk: Your sound is all right.

Thank you, sir. You'll be able to answer questions.

The Chair: Thank you very much for that.

We will now go to Mr. Bergeron.

Mr. Bergeron, you have four minutes.

[*Translation*]

Mr. Stéphane Bergeron (Montarville, BQ): Thank you, Mr. Chair. I want to point out that I'll be sharing my time with my colleague from Shefford.

Good morning, ladies and gentleman. Thank you so much for joining us today and providing your insight.

Ms. Sully, you touched on this in your presentation, but I feel that given the testimony we've heard today, you must be more explicit about the consequences people face when they don't have easy access to adequate contraception or suitable abortion services.

Could you enlighten the committee as to what your organization has observed with respect to these consequences around the world?

● (1200)

[*English*]

Dr. Elizabeth Sully: Thank you for the question. As I understood it, you want to understand what we're doing to address gaps in access to sexual and reproductive health services and, in particular, to family planning.

We are a research and policy organization. All of our work is through partnerships. We are always following the lead of our country partners, whether they be researchers or advocates. What do they see as the priorities for evidence generation, policy and advocacy within their own countries? We follow a country-led approach.

What we see is this: The countries that have the highest rates of unintended pregnancy are often also those that restrict contraceptive access and have higher rates of abortion. The restriction of abortion often goes hand in hand with lack of access to family planning services. Make those available, so people can prevent those pregnancies.

One thing I want to touch on is this: It's not just about access alone. I thought Lucy Akello touched on an important point around contraceptive side effects. We see women reporting that as one of the reasons for not using methods of contraception. It's about access and the methods available to them. They always need to have free and informed choice on a range of methods available at a place near them, in their communities.

That should always be how we put forward contraceptive programming. We often interpret the gaps as being just about access. Access is a huge part of it. Financing is a huge part of it, but it's also about information. That's where comprehensive sexuality education comes in. People need to understand what is available to them and what those services are.

There's a range of steps we need to take. Where Canada can step in is on the financing side to support advocates who are pushing, within their countries, to expand access to services in order to ensure there is comprehensive sexuality education with the full comprehensive package of services provided.

[*Translation*]

Mr. Stéphane Bergeron: Thank you.

As you may know, the Ethiopian government has signed a peace agreement with the Tigray People's Liberation Front. However, based on reports that have reached the BBC, women continue to be sexually assaulted, particularly in Tigray.

Do you have any information about the situation in Tigray right now?

[*English*]

Dr. Elizabeth Sully: Thank you for that question.

We don't have great data, because it is hardest to collect data where there are humanitarian emergencies and fragile contexts. Over the period in which the most recent conflict erupted in Tigray, we were actually collecting data in Ethiopia on a national study. We were not able to get evidence from the Tigray region to understand what was happening—both in terms of provision of SRH services and health facilities and in women's needs and use of contraceptive methods and other SRH services—at that time.

I think we know broadly that during humanitarian emergencies the SRH needs are greatest and that SRH services should be part of primary care. They are often forgotten and not included as part of the humanitarian response, yet the needs are greater. There are high levels of sexual violence. We know that is the case. People have their access to health facilities and to services interrupted, so we need to be including SRH services as part of the humanitarian response.

The Inter-Agency Working Group on Reproductive Health in Crises has put forward a minimum initial service package that really lays out how, in that moment of responding in a humanitarian emergency, to put forward a full package of SRH services to meet those needs.

I think we need to stop neglecting this as part of a humanitarian response in Tigray as well as in other conflicts and fragile contexts.

[*Translation*]

Mr. Stéphane Bergeron: Thank you.

[*English*]

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

We now go to Ms. McPherson.

You have four minutes.

Ms. Heather McPherson (Edmonton Strathcona, NDP): Thank you very much, Mr. Chair.

Thank you to our witnesses for your testimony.

Mr. Alvaro Bermejo, it's nice to see you. I had the opportunity to meet with you last summer. I'm sad that we weren't able to hear your testimony. I'm curious to know if you would be able to send to the analysts the testimony that you had planned, so that they have it to add to the report that we'll be preparing at this committee.

I want to start with a question for Ms. Sully, if I could.

We spoke to our SRHR experts in Poland, which is one of the countries that has very restrictive access to SRHR for women. There has been a massive movement within the community to push back on that. I think we all can be very proud of that.

What I would like to hear about from you is how we see more countries liberalizing their abortion laws over the past few decades. From your perspective, what factors have been driving this change?

● (1205)

Dr. Elizabeth Sully: Thank you.

Yes, I mentioned that there have been 60 countries that have liberalized their laws to some extent or another since the ICBD conference in 1994.

To talk about the African context, there, the Maputo protocol was signed in 2003. Article 14(2)(c) lays out the legal grounds on which the African Union member states have agreed that they want abortion to be accessible within the African Union. We've seen 21 countries in the region liberalize their laws to some extent to meet the Maputo protocol, with seven of those countries going beyond the conditions outlined within that protocol.

There, we're looking at African country-led efforts to protect lives, expand rights and reduce the maternal mortality crisis that is happening across sub-Saharan Africa. Within the countries, those efforts often are being led by politicians, clinicians and bureaucrats who understand the health consequences of unsafe abortion. The latest law to pass was in Benin. There were two members of Parliament who were OB/GYNs and who saw first-hand the consequences of unsafe abortion.

Where we're seeing the laws change, it is from people who understand the reality on the ground. Sometimes it is against their own moral beliefs, but it is what they think should be policy and law because they understand what the implications are of limiting access to abortion.

Ms. Heather McPherson: Thank you.

That's one of the questions that I wanted to get some clarity on from you. You talked about the fact that putting legislation in place doesn't reduce abortion: It reduces safe abortion.

Disproportionately, the people who are impacted by that tend to be poor, and they tend to be from racialized communities. It impacts different people differently. Can you talk a bit about what that looks like?

Dr. Elizabeth Sully: Yes. I mean, I think we see that in the United States, where I live right now as a Canadian.

I live in the United States and, with the abortion restrictions there, we see that who it harms the most are those who don't have the means to travel, to go and pay for services and access them in other places. That happens internationally. People find access to safe abortion services if they have the means and resources to do so. It is poor women who are struggling to meet their service needs who are most impacted by these laws.

When you look at who is having abortions, you see that these are married women: mothers who have children and cannot afford to have additional children in their houses. There are a lot of reasons why people have abortions. I think it's those who are struggling the most and need access to these services who have the hardest time reaching them.

Ms. Heather McPherson: I have very little time, but could you talk a little bit about the impacts on school-age women and girls who are not able to access reproductive rights and health care?

Dr. Elizabeth Sully: Yes. Often they are forced to leave school. When they become pregnant, they can't remain in school. Often, adolescents may not have control over if and when they have sex. I think that's just a reality. Also, contraceptive methods fail. They work great—a lot of them work very well—but they all fail at some point or another. Therefore, we need a second line of defence, and that's safe abortion.

We did a study in Uganda among adolescent girls, and we found that sexually active adolescent girls had the highest rate of abortion, as well as abortion complications. They're showing up in health facilities, and this is impacting their long-term health.

Ms. Heather McPherson: Thank you very much for that testimony.

The Chair: Thank you, Ms. Sully.

We now move to the second round, and the first question goes to Mr. Genuis.

Mr. Genuis, you have three minutes.

Mr. Garnett Genuis: Thank you, Mr. Chair.

I'll come back to Mrs. Akello.

I do wish the committee had given you more time in general, but I'm grateful again for your being here.

I want to follow up on the issue of sovereignty and ask you about the violation of local laws. My view is that if the Government of Canada is involved in supporting activities that are illegal in the country where they're happening, it should at least be transparent about that fact. Then we can have the conversation, as a country, about whether that's something that we want to do.

In African countries, are you seeing abortions being performed that violate local laws with the facilitation of international NGOs or foreign governments? Could you share information you have about that, please?

Hon. Lucy Akello: Thank you.

The fact that we haven't legalized abortion in Uganda doesn't mean it's not going on. It's going on, even under the watch of most of these big organizations.

I want to give an example. We have a facility called Marie Stopes. It hides in the name of doing family planning, but at the end of the day, it actually is doing what it calls safe abortions.

We have Reproductive Health Uganda, which is directly linked to International Planned Parenthood, and it's actually doing a lot of these. I remember last year I raised a question in Parliament regarding the involvement of Reproductive Health Uganda in teaching our children—as young as nine and 10—that it is actually okay to do abortions as a way of family planning. Secondly, a family planning method like tubal ligation.... Why would a child as young as 10 years be learning about, knowing or appreciating using tubal ligation for family planning?

● (1210)

Mr. Garnett Genuis: Yes.

Just because of the time constraints, I want to make sure that the committee has heard what you said precisely. Are you saying that Marie Stopes and the International Planned Parenthood Federation are, in your view, involved in performing abortions that are violating local laws in Uganda?

Hon. Lucy Akello: Yes. Marie Stopes, yes, and Reproductive Health Uganda, which works directly with this organization.

Mr. Garnett Genuis: Thank you.

Is that sort of widely known? Is that widely discussed? What is the local government's response to that? What should our response be, given that Canada's government has funded both of these organizations?

Hon. Lucy Akello: Actually, it's widely known. Everybody knows this fact, but what they cannot come out to do.... They hide behind the name of providing family planning services to the people. That's why in countries like Kenya there was actually a demonstration for Marie Stopes to be closed down because of that.

Mr. Garnett Genuis: Am I...?

The Chair: You're over time.

Mr. Garnett Genuis: Yes. I'll happily take more if it's available.

The Chair: No, that's fine. We'll move on.

Mr. Garnett Genuis: Thank you.

The Chair: Next we go to Dr. Fry.

Dr. Fry, you have three minutes.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Chair.

I just want to thank everyone.

I'm so sorry, Mr. Bermejo, that we couldn't hear you, because I think this is such an important issue. Rob Oliphant earlier on pointed out that you cannot pick and choose what are human rights. Some human beings are not more important than others. No human beings are more equal than others, so human rights are a universal issue. I just wanted to say that because I feel strongly about that.

I have a question for Dr. Sully from the Guttmacher Institute. Can you tell me what happens? Do you have data that tells us what happens when a young person in a conflict situation is raped—because rape is now a tactic of war—and they cannot have access to abortion? What happens to that young person? What do they do? How can they cope with that and is there any way...? We see it happening in Ukraine right now, and when someone goes into Poland or into Hungary, they don't have access to abortion. That's the first question I have.

Second, if you don't have access to legal abortion, you're going to have to go and get an illegal abortion. That has been done since the dawn of history, and we know that causes extreme illness. The reproductive organs of many young people are harmed because they have unsafe abortions, and many young people around the world die from having unsafe abortions.

My question to you is this: It seems that everyone wants to focus on abortion. I would like to make sure that's not all we are focused on. The point is what happens to people when they're stuck in a conflict situation or in areas where they're pregnant and don't want to be and they're very young? What happens to them if they have no access to legal abortion?

Dr. Elizabeth Sully: Thank you for those questions. I have to admit that our data is not great on fragile contexts to begin with, let alone on adolescent girls in those settings, and that's something in which we need to invest more funding to generate evidence to really understand those needs.

What we do know is that, when adolescents and all women in these contexts have unintended pregnancies and they are unable to access safe abortion services and they go and have unsafe abortions, they are having the least-safe abortions. Unsafe abortion is a very broad category, but there are extremely dangerous unsafe abortions that are part of that category. When we've done research in refugee camps and in humanitarian settings, we've seen that those in those camps have worse and more severe complications from unsafe abortions compared to people in the surrounding communities. They aren't even able to access the same services as those in the same geographic area.

They're having more severe complications from unsafe abortions, and that's impacting their long-term health.

● (1215)

Hon. Hedy Fry: Thank you. One quick question I want to ask is about access to contraception. We know that about 400,000 women in Uganda between 15 and 49 do not have access to contraception. We heard that it's because there are side effects. Women in other parts of the world take birth control pills. They have other forms of contraception. We know the IUDs can be unsafe and can cause problems, but why is it that there is no access to safe abortion in some of these countries? What is the problem here, and what can we do to fix it?

The Chair: You're out of time, so we will allow a 20-second response.

Dr. Elizabeth Sully: I would say side effects are a very small piece and are not the most common thing for adolescents. For adolescents, it's often a question of access. It's providers who are biased and unwilling to provide those services, to give them the full range of options that are available. It's discrimination. It's stigma. There is a range of factors that adolescents in particular face when trying to access services for contraception in particular.

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

We now go to MP Larouche.

You have a minute and a half.

[*Translation*]

Ms. Andréanne Larouche (Shefford, BQ): Thank you, Mr. Chair.

I'd like to remind everyone that today is March 7 and March 8 is International Women's Day. Despite the fact that women have a right to sexual and reproductive health, we must keep up the fight to protect that right.

Dr. Bermejo, knowing that the number of conflicts in the world will only continue to rise, and that sexual and gender-based violence is pervasive and gets worse in humanitarian emergencies, why do you think that addressing sexual and gender-based violence is not considered a priority when crises occur?

[*English*]

Dr. Alvaro Bermejo: Thank you.

I hope you can hear me now.

The Chair: We sure can.

Dr. Alvaro Bermejo: Okay.

Thank you for that question. I'll speak not just as IPPF but also as having spent 10 years as part of the humanitarian system and for the last five as the health director of the International Federation of Red Cross and Red Crescent Societies.

I would argue that the main reason this happens is that our feminist foreign policy and approach do not cover humanitarian assistance and our humanitarian response. The humanitarian response remains, probably after the oil industry, the most macho industry that I've ever worked in. People come back from missions in Yemen or in Afghanistan or in Iran or wherever and say that women didn't come to them to talk about their reproductive health needs. I always say, “No, women didn't come to you, full stop, and certainly, if they did come, they wouldn't have talked to you about their reproductive health needs.”

I think it has something do to with how the system works. I think we saw in Ukraine very clearly, for everybody who wanted to see it, the massive impact of the conflict on women's rights and their bodily autonomy. It wasn't just about the use of rape as a form of war, which of course is there. It was also about women who were pregnant, whose husbands were going to war, and who now didn't want to continue with their pregnancies. It was also about many other things. People continue to have sex during wars as well.

There is no doubt in our minds, and there shouldn't be doubt in anybody's mind, that sexual and reproductive health services are life-saving services that need to be provided in conflict situations.

I say this also, in responding to another question, as an organization that has 40,000 clinics and service delivery points, including on the Sudan-Ethiopia border. I was there in the refugee camps just a week before the peace settlement was signed. You saw an incredible amount of sexual and reproductive health violence there. You saw it there, and at the same time—

The Chair: Dr. Bermejo, you're considerably over time. Thank you ever so much.

Dr. Alvaro Bermejo: I'm sorry. I took my last chance to say something.

The Chair: Absolutely.

For the final minute and a half, we will go to MP McPherson.

Ms. Heather McPherson: Thank you very much, Mr. Chair.

It wasn't your last time to speak, Mr. Bermejo. I have some questions for you.

My concern is always around access to SRHR for women. Of course, one thing I'm quite proud of is that one of the provinces in Canada just recently made contraception products free for all the people living in that province. I know that when I spoke with you, we spoke a little about pharmaceutical abortion and how that has made access easier. It made it easier for women to access the health care they require.

Could you talk a bit about that, a bit about access and a bit about how much we have to lose if we don't get this right in Canada and around the world?

● (1220)

Dr. Alvaro Bermejo: Thank you so much for that question.

Medical abortion, or pharmaceutical abortion as you're calling it, is increasing everywhere as the preferred method for many women, even though we still have to keep traditional methods available as well. That is because it responds to two things. I think it's a good response to the operational challenge of increasing access to safe abortion in countries where it's difficult. It's also a response to the political challenge, the global opposition that is making access more and more difficult in clinics by either picketing the clinics and embarrassing and discriminating against women when they try to access abortions or threatening the providers.

In a way, medical abortion provides a response to both those situations. I would argue that it is a very important tool in our tool box to guarantee access to safe abortion to the women and pregnant people who need it.

Ms. Heather McPherson: Thanks very much.

Mr. Garnett Genuis: I have a point of order, Chair.

The gentleman from Planned Parenthood made some very critical comments about the oil industry. I just wonder if he can clarify whether those comments were his own opinion or on behalf of his organization.

The Chair: We're out of time, Mr. Genuis.

At this particular point, I'd like to thank Ms. Sully, Ms. Akello and Dr. Bermejo. I'm terribly sorry for the technical challenges. We will ensure that your remarks are translated into French and distributed to all the members. Thank you very much, all three of you, for your perspective and your expertise.

We will suspend for approximately three or four minutes so that we can go to the next panel.

For those who are online, you can remain on your current link. You don't have to go out and come back in again.

Go ahead, Ms. Bendayan.

Ms. Rachel Bendayan (Outremont, Lib.): On a point of order, Mr. Chair, would it be possible to extend the meeting, given that we are past 12:20?

The Chair: We can extend by, maybe, 10 minutes.

Thank you.

● (1220)

_____(Pause)_____

● (1230)

The Chair: Pursuant to Standing Order 108(2) and the motion adopted by the committee on Monday, June 20, 2022, the committee is resuming its study of sexual and reproductive health and rights of women globally.

It is my pleasure to welcome to the committee three witnesses. First, we have Ms. Krystyna Kacpura, who is with the Foundation for Women and Family Planning. Second, we have Ms. Julie Théroux-Séguin, who is with the Centre for International Studies and Cooperation. Last, we have Dr. Theresa Okafor, who is with the Foundation for African Cultural Heritage.

Welcome to all three of you.

I'd like to make a few comments for the benefit of the witnesses who are joining us by video conference today. Please wait until I recognize you by name before speaking. You should be clicking on the microphone icon to activate your mike, and please mute yourselves when you are not speaking. Interpretation for those on Zoom is at the bottom of your screen, and you have the choice of floor, English or French. For those in the room, you can use the earpiece and select the desired channel. This is a reminder to all three witnesses that all comments should be addressed through the chair. You will each be provided five minutes. After the five minutes for all three are over, we will go to the members for questions. Should I put this sign up, that means you should be wrapping up either your comments or your response to questions within 30 seconds.

First, we will go to Ms. Kacpura. You have five minutes.

● (1235)

Ms. Krystyna Kacpura (President, Foundation for Women and Family Planning): Thank you, Mr. Chair.

I am president of the Foundation for Women and Family Planning, which is the very first Polish NGO leading the process of advancement of sexual and reproductive health and rights in Poland. It was established in 1991. Since then, we have been monitoring the implementation of the law and advocating for the liberalization and decriminalization of abortion.

Since the outbreak of the war in Ukraine, FEDERA—which is the short form for our organization—has provided help accessing SRHR for women and girls from Ukraine. Moreover, we take part in various advocacy initiatives, along with the international NGOs and partners, ensuring a SRHR and GBV response for the refugees.

The very purpose for the creation of FEDERA was the existence and counterbalance of the consequences of Polish women's gradual loss of autonomy in access to legal abortion care. For almost 30 years, the law allowed access to abortion under three minimum grounds, as stipulated in the act of January 1993 on family planning, human embryo protection and conditions of legal pregnancy termination.

In October 2020, things got worse by means of the political Constitutional Tribunal's ruling. The Constitutional Tribunal found that certain provisions of the act that provide for the legality of women's access to abortion care are unconstitutional, specifically on the grounds of fetal abnormalities. The tribunal's decision came into effect in January 2021. It has severely rolled back the already severely limited protection for women's access to legal abortion in Poland, and resulted in a near total ban on abortion.

Apart from almost no access to legal abortion, there is limited access to contraception, especially emergency contraception. Polish teenagers suffer from a lack of comprehensive sexuality education.

We cannot look at what is happening in Poland with regard to SRHR backsliding without considering the impact of the transnational antigender movement, which is quite powerful in Poland and operates in synergy with the current ultra-conservative government.

The regressive ruling is contrary to Poland's obligations under international human rights treaties and the European Convention on Human Rights. As a state party to seven international human rights treaties, Poland is obliged to ensure that abortion is legal, at a minimum, when a woman's life or health is at risk, when the pregnancy involves a severe or fatal fetal impairment or when the pregnancy results from sexual assault.

Furthermore, by removing a pre-existing legal entitlement to accessing abortion, Poland acted contrary to the international law principle of non-retrogression, which prohibits states from taking steps that undermine, restrict or remove existing rights or entitlements. Moreover, the ruling prevents Poland from complying with the above-mentioned judgments from the European Court of Human Rights and, as such, further undermines respect for the rule of law.

The regressive legal change has exposed women's health and lives to serious harm by forcing them to carry pregnancies to term against their will, by forcing them to travel to other European countries to obtain safe and legal abortion care or by forcing them to seek clandestine abortion care outside of the scope of the law in Poland.

The CT's ruling has had fatal consequences. Women die as a result of this ruling and its chilling effect on doctors, who are afraid of activities that could be qualified as abortion. They wait too long to induce stillbirths. They procrastinate in removing a dead fetus in time, and they hesitate to remove an ectopic pregnancy.

Hear their names: Justyna died in December 2020. Izabela, Anna from Świdnica and Dominika died in 2021. Agnieszka and Marta both died in 2022.

● (1240)

The ruling has significantly decreased access to antenatal tests. We hear from women contacting FEDERA that the doctors don't refer for antenatal testing or don't provide sufficient explanation of the results. There are more children born with severe and fatal defects who die shortly after birth. There is almost no institutional support for families who decide to take care of an ill child.

FEDERA and other women's rights organizations organized to provide information on access to medical abortion, abortion abroad and in some narrow cases—

The Chair: Ms. Kacpura, I would ask that you conclude your remarks in the next 20 seconds or so.

Ms. Krystyna Kacpura: Okay.

Obviously, abortions do happen. The very restrictive law didn't stop women from getting abortions, but the process to get one might be burdensome and costly and generate distress.

This is also a kind of reproductive injustice, especially because this law beats on the poorest.

Thank you very much.

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

We next go to Ms. Théroux-Séguin.

You similarly have five minutes.

[*Translation*]

Ms. Julie Théroux-Séguin (Global Thematic Leader, Women and Girls Rights, Centre for International Studies and Cooperation): Thank you so much for the opportunity to meet with you today.

I'm speaking to you on behalf of CECI, the Centre for International Studies and Cooperation, a Canadian organization founded in 1958 and headquartered in Montreal. CECI is active in over 15 countries, in Africa, Latin America, the Caribbean—mainly in Haiti—and Asia.

CECI's mission is to fight poverty, exclusion and inequality, through such means as women's rights programs, economic empowerment and adaptation to climate change, and work in communities living in fragile environments.

CECI has been carrying out sexual and reproductive health projects for over 35 years, advocating for equal access to health care and quality health services for mothers and children, and reducing violence against women and girls. In the past decade or so, it has completed projects of this kind in Haiti, Mali, Rwanda, the Democratic Republic of Congo and Burundi, among other countries.

We're currently seeing a decline in sexual and reproductive health rights. Various factors are to blame, but some appear to us to be predominant and recurring in a number of countries around the globe. I will address just four of them for now.

The first factor is the decline in public and international funding for sexual and reproductive health care, comprehensive sexuality education and outreach. This has led to a reduction in counselling services, outreach to rural areas and decentralized services. It's also had an impact on conflict-affected areas. Systems are becoming less efficient, and the use of technology for things like teleconsultations is relatively rare.

The second factor is the rise of a global narrative that is resistant and sometimes hostile to women's and girls' rights, gender equality, family planning, methods of contraception and comprehensive sexuality education, and this has set back sexual and reproductive health rights, especially for the most marginalized people.

The third factor is the disparity between women's and girls' needs and clinical training or training that promotes more egalitarian approaches. For example, in countries where abortion is illegal, medical staff lack knowledge about postabortion care, even in cases of involuntary termination. This staff also lacks the counselling skills to address women's needs or the difficulties women may face.

The final factor is the fact that sexual and gender-based violence continues to happen. The lack of skilled attendance among health care providers to assist victims and survivors of sexual and gender-based violence leads to fewer women seeking help, which may cause them to take health risks like unsafe pregnancy termination.

A few of the witnesses before me have said it, and I would also like to point out that, according to the World Health Organization, 13.2% of maternal deaths each year can be attributed to unsafe abortion. The WHO also says that restricting access to abortion does nothing to reduce the number of abortions, but it does affect their safety and the mothers' dignity.

Based on this experience and best practices from our various projects, CECI recommends that Canada take several steps.

First, it should increase funding for sexual and reproductive health, with a special focus on recognizing and building the capacity of Canadian expertise, including that of non-governmental organizations and universities that work internationally to support people around the world. In particular, these institutions help support collaborative initiatives to harmonize the work of health care services stakeholders with that of civil society organizations, particularly women's groups and decentralized communities.

Next, it should urge local civil society organizations to get involved. I'm making a connection with the localization of assistance in particular. This work needs to be done specifically with women's organizations that can connect with official health services. This has proven to be particularly effective in encouraging victims of gender-based violence to seek help, and in ensuring adequate follow-up.

● (1245)

Support should also be provided for the use of new technologies and approaches that enable health care coverage in remote, underserved or prolonged crisis areas.

Lastly, formal medical education should be provided, with university curricula that are egalitarian and address sexual and reproductive health issues, including abortion, as public health rather than cultural issues. In addition, clinical knowledge would be paired with gender-sensitive coaching skills.

In closing, I'd like to make a recommendation regarding the political and legislative impact Canada can have legislatively. Either directly or through multilateral institutions, Canada can encourage amendments to discriminatory legislation in some countries or advocate for stronger legal mechanisms through new legislation or implementation laws.

For example, Mali passed sexual and reproductive health legislation 20 years ago—

[*English*]

The Chair: Ms. Théroux-Séguin, you're considerably over time. Could I ask that you wrap up your comments in the next 20 seconds, please?

Ms. Julie Théroux-Séguin: Sure. I will do that.

[*Translation*]

Finally, we recommend that Canada support legal mechanisms, which could be done through the United Nations Human Rights Council's Universal Periodic Review, and promote recommendations to improve sexual and reproductive health.

Thank you very much.

● (1250)

The Chair: Thank you very much, Ms. Théroux-Séguin.

[*English*]

We will now go to Ms. Okafor.

You, similarly, have five minutes. The floor is yours. Thank you.

Dr. Theresa Okafor (Director, Foundation for African Cultural Heritage): Thank you, Mr. Chair.

Good afternoon, everyone.

It's an honour and a privilege for me to address you on this motion calling on the Standing Committee on Foreign Affairs to undertake a comprehensive study of the sexual and reproductive health and rights of women globally.

These rights in question do not represent the governments nor the citizens of African countries, except for four countries. It is pressure groups pursuing special interests without being mindful of the impact this can have. As one who has represented my government as a delegate of the United Nations in New York for four years and one who has worked closely with the African Group, I can say that we have been deeply concerned by the paternalism that interferes in another person's affairs coercively or through incentives motivated by claims that the person will be better off. This hand-out approach is what continues to perpetrate beggary, hunger, illnesses, oppression and modern-day slavery in Africa.

Support for the African woman should not be one that strips her of a right to family stability, a right to raise her intellectual tone and moral compass, or a right to economic empowerment and social inclusivity, a.k.a. equity and proper health care. These rights are largely ignored and are substituted with unsolicited rights to abortion, safe abortion—whatever that means—contraception, and comprehensive sexuality education, to mention a few

I am aware that Canada has committed to increase funding to an average of $1.4 billion per year by 2023-24. Canada has also committed to maintain this level of funding until 2030. Of this total funding, $700 million is to promote global sexual and reproductive health and rights, which includes contraception, abortion and comprehensive sexuality education.

I was shocked and scandalized by the language used by members of the committee, representatives of Global Affairs Canada and other witnesses, who have demonstrated an imperialistic approach to helping underdeveloped nations. Advocacy to liberalize laws in countries that oppose abortion amounts to undermining the legislative and democratic processes of sovereign states and to subverting the deep values and good cultural traditions of these nations.

It is increasingly clear that foreign funding and the feminist international assistance policy are becoming less about aid, empowerment, health care and poverty reduction, and more about ideological colonization.

If this is about rights, then I'm wondering if any government has a right to impose its belief in abortion on other nations that continue to reject it. The majority of African countries continue to protect life in all its stages and prefer to prioritize genuine health care that achieves best outcomes for women, mothers, their children and families. I sincerely hope we can all agree that these are the priorities we should be focusing on.

By way of conclusion, please note the following four points. There is no international right to abortion and comprehensive sexuality education, which is a key component of SRHR, because too many United Nations member states are strongly opposed to establishing such rights. On the contrary, United Nations consensus language indicates that member states have agreed to help women avoid abortion. Even the United Nations agencies are prohibited from promoting abortion as a method of family planning.

In Africa, the reproductive health care is maternal health care. It's suicidal to import practices and lifestyles that are alien to Africa. In 1994, the International Conference on Population and Development's outcomes document instructed that “Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning”.

Let me say, with your permission, Mr. Chair, that I am aware that many African countries are overflowing with condoms and contraception from the west sent to us to fulfill a fictitious, unmet need for contraception, when what we really need is water, food, housing, employment and quality education that can break the intergenerational cycle of poverty and employability, that can make education an equal playing field, regardless of the circumstances surrounding one's birth. The true unmet needs are in the maternal health care provision, which should set up blood banks to provide blood to prevent death caused by bleeding, which contributes a whopping 33.9% to maternal mortality.

● (1255)

Another unmet need is the hygienic—

The Chair: Ms. Okafor, you're considerably over your allotted time.

Mr. Garnett Genuis: On a point of order, Chair, I've been timing the witnesses, and you allowed Ms. Kacpura to go to six minutes and fifteen seconds. You just told the currently speaking witness that she's considerably over her time at the five minutes and one second mark. I think given—

The Chair: No, it's six minutes according to my—

Mr. Garnett Genuis: Mr. Chair, I think given that there are different views being expressed, you should ensure that witnesses with different perspectives on this topic are afforded equal time to present those perspectives—

The Chair: You can rest assured, Mr. Genuis, that will be the case.

Mr. Garnett Genuis: —rather than cutting off a witness who has a different perspective early.

The Chair: You can rest assured of that, Mr. Genuis.

Mr. Garnett Genuis: I'm not so sure.

The Chair: Excuse me? You're not so sure.

Dr. Theresa Okafor: Mr. Chair, may I be allowed to conclude?

The Chair: Yes, you can conclude, but I would ask that you conclude in the next 20 to 30 seconds, please, so that we have some time left for questions.

Thank you.

Dr. Theresa Okafor: Another unmet need is the hygienic birthing environment to prevent infection, which contributes 9.7% to the deaths in Africa. Africa needs emergency obstetrics care and adequate nutrition and to manage eclampsia, obstructed labour and anaemia.

The overflow of condoms and contraception are evidence of sexual and socio-cultural colonialism. Many Africans are aware that sexual and reproductive health and rights are a proverbial “cockroach in the ice cream” of aid in kind to Africa. Can there be a shift from a deficit model that thinks that Africa exists because problems exist to a model that conceptualizes the African woman as a person and a protagonist in the story of development and one that has the moral capacity to change her life through the choices she makes?

Thank you so much.

The Chair: Thank you, Ms. Okafor.

We now go to questions from the members. The first question goes to Ms. Shelby Kramp-Neuman.

You have three minutes.

Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC): Thank you.

I'd like to start by acknowledging and thanking all of our witnesses for not being with us in person but being with us virtually. Championing the cause of sexual and reproductive health and the rights of women is definitely imperative, and welcoming ideas and ensuring that the rights and voices are respected is extremely critical.

I'd like to start by suggesting that in sub-Saharan Africa, many adolescents lack knowledge about menstruation and sexually transmitted diseases. To best educate our adolescents on sexual reproductive health is key. I understand that HIV is widespread. Knowledge of HIV is widespread but knowledge of others things with regard more specifically to menstruation and sexually transmitted infections is not. In order to gain insight on how we can best help these adolescents make informed decisions to lead to more positive experiences and to protect them from risk, I think education is the key.

My first question is for Ms. Okafor. Our previous witness mentioned that a focus on clinics and education is the best use of external dollars. Could you speak to how we can best fund the reproductive health rights of women through health care and education funding?

Thank you.

Dr. Theresa Okafor: Thank you for your question.

I'll reiterate the point that I made that the most important health care we need is health care that can prevent maternal mortality. The kind of education our youth need is education on values, education that can cultivate human values, moral values that can lift the intellectual toll of society. We don't want imposed values that actually prioritize sexuality in our continent.

Our continent can only be uplifted from poverty when priority is given to the areas that need to be prioritized, and these areas have to do with employability, employment in a labour market that is saturated with young people looking for jobs. We need information on how to make education an equal playing field for everyone regardless of the circumstances of their birth.

We need what can help mothers and children, who are key and central to everything that takes a nation to develop. They're the building blocks of a nation. We need what can help them develop and not necessarily prioritizing sex all the time, because I see that there is an obsession with sexualizing our continent. That is the problem we're having at the United Nations. When arguments should be focused on good governance, employability, quality education, food and clean water, and adequate nutrition, they're often derailed and sidetracked by other discussions that are undermining the continent.

Thank you.

● (1300)

The Chair: Thank you.

We next go to MP Bendayan for three minutes.

[*Translation*]

Ms. Rachel Bendayan: Thank you, Mr. Chair.

Ms. Théroux-Séguin, I'd like to begin by thanking you for the work you do with your organization, which has been active in Montreal since 1958.

Several witnesses have said that restricting access to abortion does not bring down the number of abortions. I'd like to hear your perspective on this. Do you have any statistics or additional information you can provide to the committee in writing, either now or later?

Ms. Julie Théroux-Séguin: The data I submitted to you came from the World Health Organization, so it's in the public domain. It shows that globally, unsafe abortions cause about 30% of all maternal deaths and that the numbers are higher in some regions. I can give you information on that.

Ms. Rachel Bendayan: More specifically, we would appreciate if you could send us the data you have that demonstrates that restricting access to abortion doesn't result in fewer abortions.

Ms. Julie Théroux-Séguin: Restricting access to abortion doesn't bring down the number of abortions, it makes the abortions that are performed more unsafe. So restricting access puts women's lives at greater risk. It's a documented fact.

Ms. Rachel Bendayan: Thank you very much, Ms. Théroux-Séguin.

[*English*]

Ms. Kacpura, I would like to address a question to you, with the time I have remaining.

Do you believe that women's sexual and reproductive rights, including the right to abortion, are human rights?

Ms. Krystyna Kacpura: Thank you for this question.

Of course. We strongly believe that these are basic human rights.

Ms. Rachel Bendayan: You spent some time detailing the 2020 Constitutional Tribunal ruling in Poland and described it as effectively creating a near total ban on legal abortions in Poland. You also mentioned that women die as a result of this ruling.

I wonder if you could expand a little on the principle of non-retrogression, which you also mentioned in your introduction. In its purest form, I understand this principle to mean that a government—

The Chair: Ms. Bendayan, you're over your time.

We can provide her with 20 or 30 seconds to respond.

Ms. Rachel Bendayan: Perhaps respond on the principle of non-retrogression, Ms. Kacpura.

Ms. Krystyna Kacpura: It's difficult to say that this is retrogression because these restrictive laws have lasted for over 30 years. We've managed somehow. Yearly, we have over 120,000 abortions, which are mostly done at home with pills. Some of them are done in our neighbouring countries in the EU.

We are a democratic country in the centre of Europe, so it's not difficult to get access to safe abortion services, but you have to know the language, you have to live in a big city and you have to have access to the Internet. You have to have money for this.

● (1305)

The Chair: Thank you, Ms. Kacpura. I'm sorry. You're considerably out of time.

We next go to Ms. Larouche.

You have three minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you, Mr. Chair.

I'd like to thank the witnesses for being here today, on March 7. I am repeating the date because tomorrow, March 8, is International Women's Day, and the majority of the witnesses have clearly demonstrated that women's sexual and reproductive health rights are in decline around the world.

That strikes me. We can no longer call ourselves feminists and contribute to a rollback of these rights. We can't keep standing still either. We must move forward and work to continuously reinforce these rights. Let's keep that in mind tomorrow, March 8, as we celebrate that day. I feel it's imperative.

Ms. Théroux-Séguin, I will address you first. I join my predecessor in congratulating you on the international cooperation work you've done for such a long time.

In 2019, the Liberal government had announced that, as of 2023, it would increase its funding to support women's and girls' health around the world to $1.4 billion per year for 10 years. That represents an annual investment of $723 million to support sexual and reproductive health rights.

Is $700 million enough? If not, what would the ideal amount be, in your and CECI's opinion?

Ms. Julie Théroux-Séguin: Recently at International Development Week, we were able to show that funding for international development is not at its highest level right now. Quite the contrary, it's at 0.32% of Canada's gross domestic product, while there is a call for this funding to be increased gradually to reach $10 billion by 2025.

The request concerns funding for all international aid, not just sexual and reproductive health. I believe several areas need to be funded. As I said earlier, in addition to sexual and reproductive health, women's organizations and the women's movement also need support. They are on the front lines of sexual and reproductive health education and awareness.

Ms. Andréanne Larouche: They say that 97% of unsafe abortions occur in developing nations, and that abortions cause 4.7% to 13.2% of all maternal deaths worldwide. Those numbers are critical.

You stated that this needs to be treated not as a cultural issue, but as a public health issue. How could and should Canada, which prides itself on having a feminist international policy, act on this study and continue to work to improve sexual and reproductive health rights around the world?

Ms. Julie Théroux-Séguin: It should work to make community services, health care services, academic curricula here at home and legislation intersect.

Legislation is already in place. I gave the example of Mali, which passed a sexual and reproductive health law in its Parliament 20 years ago. However, there's been no implementation law. Sometimes movements block implementation right before the law is set to come into force. Civil society is very strong, but it will lack funding and will no longer be able to oppose or counter these other narratives.

So I feel it's important to support a constant dialogue based on facts, not on a situation imposed by cultural perceptions.

When abortions are banned and countries don't provide enough sexual and reproductive health awareness, that puts the health of women and girls at risk.

The Chair: Thank you.

● (1310)

[*English*]

We next go for the last question for three minutes to MP McPherson.

Ms. Heather McPherson: Thank you very much. Thank you to all the witnesses for the testimony today. It's very important.

I'd like to start with Ms. Kacpura. Thank you, Ms. Kacpura, for being with us today. I know you were generous with your time when the foreign affairs committee was in Poland. You talked to us about the impact on Ukrainians fleeing violence and the impacts for women and girls fleeing violence in their country. You told some pretty horrific stories about what some of these women have to go through and how they have no access to SRHR, to reproductive health supports.

I'm wondering if you could share that with the entire committee.

Ms. Krystyna Kacpura: From the very beginning of the war, we were sure that FEDERA had to help and assist Ukrainian refugees, women and girls, because our government would not provide them with access to reproductive health services. We established a hotline for women in the Ukrainian language. We printed a special brochure and guide for them. We especially helped, at the very beginning of the war, many young—not only young—girls and women who were raped.

It was very difficult to get testimony from women who were raped, because they didn't want to speak about this. They wanted to forget as soon as possible. During the end of one of these conversation, which I had many times, she said to me, “You know, I was raped by four, and after the fourth man I don't remember, because I fainted. The first thing I would like is to keep this top secret. It is only my problem and my issue. Just help me to take this out of me. Help me access an abortion, because I discovered that I am pregnant, and this is the eighth week of pregnancy.” Of course, we helped her.

It is very difficult to identify testimonies from women who were raped, because they just want access to abortion services. They don't want to speak. They don't want to go to the prosecutor or the police. In Poland, abortion for pregnancies resulting from rape is still legal, but the procedure is very complicated. We did many advocacy efforts to our government's ministry of health, just to treat these kinds of abortions.

For raped women, there's a special way and procedure, because this is a war crime. We also appealed to the European Union, to the Parliament, to treat this in a special way. Don't ask women about names and events, because they don't want to speak about this. They are afraid that somebody else could find out that they were raped. One of these women told me, “Could you imagine my life after the war? Could you imagine my husband and my family? If he knows that I was raped by several Russian soldiers, our greatest enemy, he will not touch me. I will not be his wife any longer.”

It's not easy.

The Chair: Thank you, Ms. Kacpura.

Ms. Heather McPherson: Thank you very much.

The Chair: Do members want to have one more round of two minutes?

Okay, we'll go to the next round,

Mr. Genuis, you have two minutes.

Mr. Garnett Genuis: Thank you, Chair.

My question is about illegal abortions. I wanted to ask Dr. Okafor, are foreign governments and international organizations involved in performing or supporting illegal abortions in African countries? Who is funding them? Help us understand the dynamics on that, please.

Dr. Theresa Okafor: Unfortunately, foreign governments have been supporting abortions in African states where abortion is illegal. This is intrusive, to be honest with you. It does not protect the mental health of such women, because postabortion syndrome is real.

It's also intrusive in the sense that it goes against the perennial values of African countries.

● (1315)

Mr. Garnett Genuis: Thank you. Because of time constraints, could you name specific organizations that you're aware of, or specific governments that are funding it? Any of those details in the 45 seconds I have left would be very helpful.

Dr. Theresa Okafor: It's International Planned Parenthood.

Mr. Garnett Genuis: Thank you.

Did you have more to add?

Dr. Theresa Okafor: It's International Planned Parenthood. I can also add that the feminist international assistance policy is behind most of it—Global Affairs Canada.

Mr. Garnett Genuis: Thank you.

Could you provide further information on that in writing, please? Any additional evidence or names can be provided in writing to the committee after the fact.

Some legislatures in Africa have far greater representation of women than our own legislature here in Canada. What are you hearing from African women, specifically, on these issues?

Dr. Theresa Okafor: African women are crying out and saying we need to prioritize what really matters in the countries. What really matters to African women are economic empowerment and social inclusion—equity. There are a lot of inequalities. COVID, in particular, has brought a disproportionate burden on African women.

We're talking about war in Ukraine, but in many African countries we also have refugee camps. Their priority, in these refugee camps, is employability—skills training, IT training, digital literacy and bridging the digital divide. It's not about prioritizing sex, because that's not of any benefit to the country. We have our ways of taking care of moral values. Family stability is important to Africa, because family is a safety net in Africa.

Thank you for this platform, which lends me a voice on what we really need in Africa.

Ms. Rachel Bendayan: Mr. Chair, I was cut off at exactly three minutes.

Dr. Theresa Okafor: Thank you.

The Chair: Thank you, Dr. Okafor.

We'll go to Mr. Zuberi.

You have two minutes, Mr. Zuberi.

Mr. Sameer Zuberi (Pierrefonds—Dollard, Lib.): I'll give my time to my colleague Dr. Fry.

The Chair: Dr. Fry, you have two minutes.

Hon. Hedy Fry: Thank you very much, Mr. Zuberi. I appreciate it.

I want to ask a question of Ms. Kacpura.

I am very well aware of what is happening in Ukraine. When we studied what is going on in Ukraine, we heard about the number of rapes. We also know these women, as you so movingly told us, need access to abortion. Let's imagine: If one is a refugee in your country, Poland, what happens? One can't, as a refugee, just move from Poland to another European country to get access.

What is happening? Are there any humanitarian or compassionate grounds under which the Polish government would help Ukrainian women in these desperate situations?

Ms. Krystyna Kacpura: Thank you very much, Dr. Fry, for this question.

No, there is no humanitarian exception where you can get access to reproductive health services, especially abortion services.

However, we have many informal initiatives—women's initiatives, above all. My foundation provides all refugees who contact us with access to safe abortion. This is not only through the use of pills, which we order from the Netherlands. In some cases, we do this in Polish hospitals. We have a group of friendly gynecologists and hospitals, so we use the exception for legal abortion in Poland: cases where there is a threat to a woman's health or life.

In such situations, we use mental health. We have organized a network of psychiatrists who consult women, and then issue them a special statement that continuing this pregnancy will threaten their mental health. These abortions are done in Polish hospitals. Not by all, of course, because, additionally, there is a conscience clause used by many gynecologists. However, in some hospitals, it's accessible with this certificate.

● (1320)

Hon. Hedy Fry: Thank you very much, Ms. Kacpura. This is an extremely important issue for the women from Ukraine and in other—

The Chair: Dr. Fry, you're out of time.

Hon. Hedy Fry: Thank you.

The Chair: We will go to Mr. Bergeron.

Mr. Bergeron, you have one minute, sir—one question, essentially.

[*Translation*]

Mr. Stéphane Bergeron: Thank you, Mr. Chair.

Ms. Théroux-Séguin, I'd like to continue on in the same vein as my colleague from Shefford. Some witnesses today have suggested that there are parts of the world, particularly in Africa, where abortion is completely alien to local cultures. Based on your observations, is the practice of abortion, whether official or clandestine, less common in African countries?

Ms. Julie Théroux-Séguin: No. As was said earlier, banning them doesn't stop them from happening. In Latin America and in Africa, the majority of abortions, about three out of four, are unsafe. In Africa, nearly half of all abortions are performed in the most unsafe conditions. So it isn't true that there are no abortions: there are some.

As mentioned earlier, 36 African nations signed the Maputo protocol in 2006, which allows for medical abortion in cases of sexual assault, rape or incest, or when the pregnancy endangers the mother's health.

So the answer is no. We've found that abortions are performed, but not in conditions conducive to the health of women and girls.

Mr. Stéphane Bergeron: Thank you very much.

The Chair: Thank you.

[*English*]

We now go for the last minute to MP McPherson. You have a minute.

Ms. Heather McPherson: Thank you, Mr. Chair.

I'm going to ask Ms. Kacpura this question again.

We've heard multiple times today and in previous testimony that stopping access to abortion does not stop abortion. It stops safe abortion. It stops the ability for women to access health care safely and it risks their lives. Could you perhaps talk a bit about who is most impacted by this? What women are least likely to be able to access health care when access to abortion is restricted?

Ms. Kacpura, that was for you.

Ms. Krystyna Kacpura: Thank you very much.

Yes, of course, as I told you before, this is reproductive injustice, because this is a draconian, really restrictive law for the poorest underserved people with no privilege, living in small towns and villages, and with no money, because, as you know, there's easy access to abortion for those who are educated, live in big towns and have money.

The most difficult access right now is for women in difficult pregnancies. These women are dying in Poland, because of course these are wanted pregnancies. After a prenatal test, a woman discovers that her fetus is seriously damaged, that it has fetal impairments. She is not aware of this fact until the doctor translates the result of the test. Usually, she doesn't want to continue that pregnancy, and these exceptions for legal abortion were excluded from the Polish law. We have in Poland—

The Chair: Thank you, Ms. Kacpura. I'm afraid we're out of time.

Ms. Krystyna Kacpura: [*Inaudible—Editor*] 98% of the legal abortions because of fetal impairments.

Thank you.

The Chair: Thank you very much.

On that note, let me say thank you very much, Ms. Kacpura. It's good to see you again.

Thank you to Ms. Théroux-Séguin and Ms. Okafor. We're very grateful for your time and perspectives. They will certainly be reflected in our report. Thank you.

Members, before we adjourn, there are two quick matters.

First of all, the budget for the study of sexual and reproductive health has been sent to all the members. Is it the will of the committee to adopt the budget?

Some hon. members: Agreed.

The Chair: Thank you.

With respect to Bill C-281 and consideration of that particular bill, is it the will of the committee to submit their witness lists by this Friday at 5 p.m.?

Some hon. members: Agreed.

The Chair: That's excellent. Thank you ever so much.

We're adjourned.