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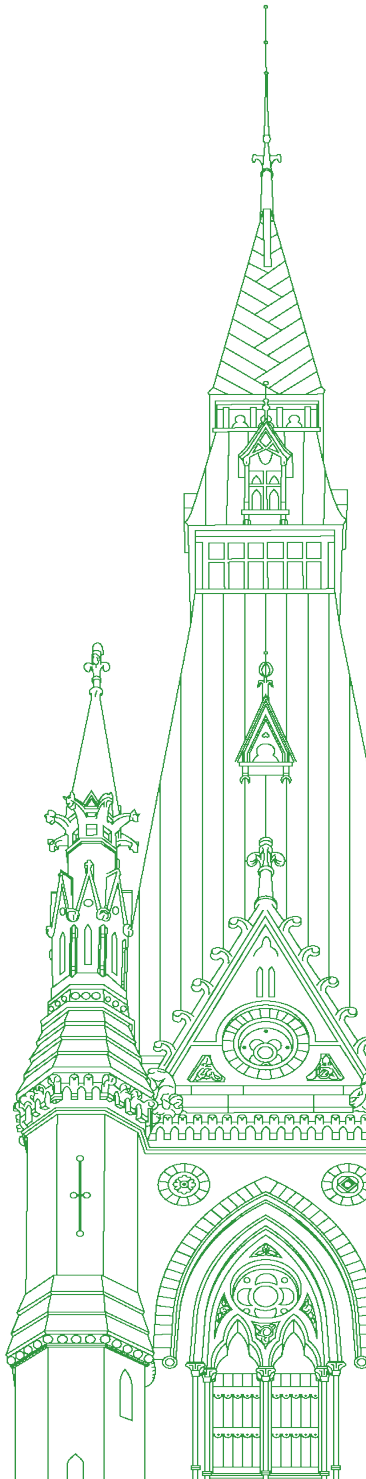

Chair: Mr. Ali Ehsassi

Standing Committee on Foreign Affairs and International Development

Thursday, March 9, 2023

● (1105)

[*English*]

The Chair (Mr. Ali Ehsassi (Willowdale, Lib.)): Welcome to meeting 53 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 would like to make a few comments for the benefit of the members and witnesses.

Please wait until I recognize you by name before you speak. 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 routine motion, as is our practice, I am informing the committee members that all witnesses have completed the required connection tests in advance of our meeting.

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

It is now my great pleasure to welcome, from the National Women's Civic Association, Ms. Maria Cristina Rodriguez Garcia, who is a research consultant with the organization. She is joining us by video conference.

Also, we have here present before us today, from Oxfam Canada, Ms. Lauren Ravon, executive director; and Ms Béatrice Vaugrante, executive director of Oxfam-Québec.

Each witness will be provided a maximum of five minutes for their remarks, after which we will proceed to a round of questions by the members.

For all the witnesses, once you have only 30 seconds remaining, either for your opening remarks or for the follow-up questions, I will signal you. I would appreciate it if you could try to wrap things up within 20 or 30 seconds once you see the sign.

Each of the witnesses will have five minutes for opening remarks. First we will go to Ms. Garcia.

Ms. Garcia, you have five minutes.

Dr. Maria Cristina Rodriguez Garcia (Research Consultant, Political Narratives and Women's Affairs, National Women's Civic Association): Thank you, Mr. Chair. Thank you for the honour of speaking to the committee.

I'm a researcher and consultant on political narratives and women's affairs. I have conducted national studies in my country about sexual harassment and international statements for the human rights systems, and I have worked at the local and national level as a woman rights defender for 10 years.

I represent the National Women's Civic Association, an organization that has almost 50 years of working for an integral development of women to promote their public participation in Mexico and internationally, and holds consultative status in the United Nations.

I will be speaking about three matters. First, I will talk about an analysis and evaluation of the framing at the edges of sexual health and reproductive rights. Second, I want to talk about what we are not talking about that was recently discovered about sexual violence and sexual and reproductive rights. Finally, I will provide some recommendations for this study based in our local and international experience.

The first point is the evolution of the framing at the edges of sexual and health reproductive rights. The sexual and health reproductive rights are based on the idea that sexuality is a fundamental aspect of human development. The framing supporting sexual health and reproductive rights relies on three keywords: access, decision and enjoyment. These three aspects are oriented towards gaining control, autonomy and a life without violence. But which are the indicators that we usually listen to in the local application of policies, programs and international statements?

First, we have indicators that focus on specific behaviours. Some examples include the use of a condom or contraception, access to abortion, and data about sexual life. This data is necessary but it has concerning limitations. As much as we need clarity in the policies and programs, we know that this conduct does not happen in isolation. Sexual health and reproductive rights place most of the measures in the genital aspect of sex. However, reality shows us that sexuality is much more than the use of genitals and includes aspects like affectivity, desire of transcendence, bonding and past experiences of trauma and abuse.

Furthermore, all this conduct happens in different stages of life, so we must not isolate conduct as if it doesn't matter when, how or why this conduct happens. In my experience in working with children and teenagers to prevent teenage pregnancy and listening to the framing of different countries and developing public policies, this focus placed solely in the sexual act overlooks the cultural expectations, emotional pressures and lack of education in recognizing healthy relationships, among other factors that hinder individuals' capacity to make choices that have a long-term effect on their well-being. For instance, neither the use of a condom nor the access to contraception prevents a woman from entering into a life of violence. This kind of autonomy that it puts forwards looks like indifference. It implies the message that we don't care who you are or what's happening to you, as long as you use a condom.

Second, about the framing, sexual health and reproductive rights focus on the internal factors: desire, consent, autonomy and identity. Without diminishing their importance, we must acknowledge that this is just at the surface. All of these factors must be seen through the glasses of cultural structures and dynamics of power, including customs, beliefs and stereotypes. We talk about control, autonomy and empowerment on a superficial level, without deepening our understanding of internal and external constraints to freedom. For example, a woman can give consent to her sexual exploitation in spite of doing that to her own detriment.

There is an extensive need for talking in the circle of reproductive rights about affectivity, healthy relationships and peaceful resolution of conflict. This is part of sexuality too, and these are the aspects of sexuality that help people make good decisions about sexuality.

● (1110)

Lastly, a focus on the result rather than the human process makes us not see which other unmet needs we need to face. For instance, there are the unmet needs of contraception, but what is the real need that is being overlooked? For example, if we dive into social media, we find thousands of testimonies from women using contraception who are disappointed. They are scared of how it changes their bodies and overall well-being, and they remain uneducated about the way their bodies work, as the study shows.

These reflections lead to the second point of this presentation.

What are we not talking about? We're not talking about trauma and fragmentation. Based on the history of survivors of sexual violence and sexual exploitation, we know that many women are born into already vulnerable conditions that can lead to a series of biased choices, which, in turn, ultimately lead to their sexual exploitation. Society fragments women. That is, it produces a separation between their bodies and minds, and then creates industries that exploit their brokenness. We have to include that in the sexual reproduction rights studies.

In summary, women don't have all the knowledge or tools. They are experiencing a lot of fragmentation, disassociation and trauma throughout their lives. We are saying they have sexual reproduction rights because they have a condom in their pocket. We need to face the fragmentation associated with their trauma and the circle of implication this generates, and link that to their vulnerability.

Do I have a little more time?

The Chair: No, you don't. You're a minute and a half over. Can you wrap it up? There will be opportunities for questions.

Dr. Maria Cristina Rodriguez Garcia: Okay, thank you very much.

The Chair: Thank you, Ms. Garcia. We're very grateful.

We next go to Oxfam-Québec.

Madame Vaugrante, you have five minutes.

[*Translation*]

Ms. Béatrice Vaugrante (Executive Director, Oxfam-Québec, Oxfam Canada): Thank you, Mr. Chair.

Thank you for inviting me and for putting the topic of sexual and reproductive health and rights on your committee's agenda.

Oxfam-Québec and Oxfam Canada are members of the Oxfam confederation, whose mission is to fight inequality to end poverty, particularly through the power of women, for sustainable solutions.

We believe that reproductive justice is linked to social justice and that gender justice cannot be achieved without bodily autonomy and sexual and reproductive rights. The numbers speak for themselves: 7 million women are hospitalized every year owing to unsafe abortion, and far too many die.

According to the World Health Organization, complications from pregnancy and childbirth are a leading cause of death for young girls. Teen pregnancy carries a higher risk than adult pregnancy. It has a significant impact on their lives, future, education and autonomy.

Oxfam-Québec and Oxfam Canada are conducting two major projects on sexual and reproductive health and rights, which are taking place in different regions of the world. Funding from Global Affairs Canada and our donors enables our organizations to implement these projects, which focus on adolescent girls and young women, especially those who are most marginalized, under the leadership of those who are on the frontline.

There are many barriers to the realization of sexual and reproductive rights, but it is discrimination against women and marginalized groups that underlies these problems. Ensuring sexual and reproductive rights is a critical pathway to not only making women's rights tangible, but also enabling women to build resilient communities and economic autonomy and to participate in crisis and conflict resolution.

In the wake of a pandemic that has exacerbated inequalities, and in a global context weakened by “polycrises” and more restrictive laws for sexual and reproductive rights, this area is increasingly less of a budgetary priority for governments and donors, even though it is among the critical solutions.

Without a collective effort, we will continue to see access to sexual and reproductive health services and rights increasingly impeded, if not impossible, leading to an increase in unwanted pregnancies, deaths, unsafe abortions, cases of gender-based violence, and impacts on the physical and mental health and education of girls and young women.

Oxfam-Québec has begun implementation of power to choose, a seven-year program for reproductive and sexual rights that is supported by partners such as the Society of Obstetricians and Gynaecologists of Canada. The program has a component in Quebec and relies on partnerships with local organizations based in Honduras, Ghana, Bolivia, the Democratic Republic of Congo, Jordan, Lebanon and the occupied Palestinian territories.

● (1115)

[*English*]

Through the Her Future, Her Choice project, Oxfam Canada and its partners work to advance comprehensive approaches to sexual and reproductive rights in Ethiopia, Malawi, Mozambique, and Zambia.

Both projects respond to gender inequality and women's rights violations by directly addressing barriers that hinder access to sexual and reproductive rights in program communities and fragile, restrained civic spaces. These barriers include harmful social norms, traditional practices, taboos about gender and sexuality, lack of access to sexual and reproductive health information and education services, and a lack of meaningful decision-making power for adolescent girls and young women regarding their own health and sexuality.

Canada has made significant contributions to support sexual health and reproductive rights internationally. We must continue to be a leader among donor countries. The government should remain dedicated to ensuring that it meets its $700-million commitment for sexual and reproductive health, with a focus on the neglected areas, and to tracking its investments. As it stands, the government will need to aggressively scale up funding in these areas to meet the target by the 2024 deadline.

[*Translation*]

This investment should also cover the strengthening of universal health coverage to ensure continuity of sexual and reproductive health services, particularly in the context of health emergencies and crises, which, as we know, are increasing. It should also support and include local youth and women's organizations, as well as LGBTQ+ organizations, in decision-making spaces to ensure effective and sustainable mobilization, even in small civic spaces.

Canada must fund transformative gender programs and intersectional research related to the health of adolescents, women and people of diverse backgrounds with flexible, long-term budgeting.

Thank you for listening. We will be happy to answer your questions.

[*English*]

The Chair: Thank you very much.

We will now go to the members for questions.

We'll go first to Mrs. Kramp-Neuman for six minutes.

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

Thank you to all the witnesses for being here today. *Gracias* to the witness who's here virtually.

My first question today will be posed to Dr. Maria Cristina Rodriguez Garcia.

In the past, as we're all aware, billions of dollars were allocated for maternal, newborn and child health, as well as sexual and reproductive health and rights, including under the Muskoka initiative. Certainly, while applauding and celebrating our Prime Minister Harper's record on maternal and child health, what impact do you feel Canada is having on policy or funding decisions in relation to sexual and reproductive health and rights in your country?

● (1120)

Dr. Maria Cristina Rodriguez Garcia: Thank you very much for that interesting question.

I think Canada can extend the scope of what essential health and reproductive rights are. You can do that by enlarging the concept, the framing at the edges of what planned sexuality means. At some point, what can be done, what can be included in your study or policies, is indicators. I think we can create indicators. Canada is a country that, as you mentioned, has given a lot to development in other countries.

Some indicators can be appointed to evaluate the emotional, social and cultural contexts where the child, teenager or adult faces decisions about sexuality. They can analyze the experience of trauma, violence, disassociation and unhealthy attachments and the relationship with sexual and reproductive decisions. They can support research and unfold the criteria that young people are using to make decisions about sexuality, which may include indicators related to affectivity and emotional well-being. They could analyze whether the services and programs that countries offer are related to integral services of health and development.

I think if Canada proposed to extend the scope to a better vision of sexuality, an integral vision of sexuality, it could do a lot for countries like mine, which are facing a lot of machismo and the wounds in femininity and masculinity at a structural level.

Thank you very much.

Mrs. Shelby Kramp-Neuman: Thank you.

You mentioned during the second point of your testimony what we are not talking about, and that's sexual violence, sexual expectation and sexual exploitation. Could you speak to the most effective ways of...? What kinds of advocacy and influence are you having with adolescents, and what kinds of mediums are you engaging in to get the message across?

Dr. Maria Cristina Rodriguez Garcia: I'm sorry. Could you repeat the question, please? Thank you.

Mrs. Shelby Kramp-Neuman: I was speaking about sexual violence, sexual exploitation and sexual expectations. My question is this: How are you having dialogue and getting informed information from the adolescents, and how are you influencing them? Is it through social media? Are you getting conversations directly from adolescents?

Dr. Maria Cristina Rodriguez Garcia: I have been working, over the last years, at the local and national level with the government for the implementation of programs to achieve the aim of developing an agenda for children, teenagers and women. The way that we work and have worked is developing a diagnosis in person with all the teenagers and children. I go to the cities. I travel around the country talking and collecting data about how children and teenagers feel about all the topics related to human rights, but in the last year especially related to sexual and reproductive rights.

In that way, we collect information. We construct an agenda that is then socialized with political actors at all levels. It's followed by many processes of evaluation of these policies that include the agenda.

● (1125)

Mrs. Shelby Kramp-Neuman: Thank you.

How am I for time, Mr. Chair?

The Chair: You have 20 seconds remaining.

Mrs. Shelby Kramp-Neuman: Okay, then I'll pass it on, thanks.

The Chair: Thank you very much, Mrs. Neuman.

We now go to Ms. Bendayan.

You have six minutes.

Ms. Rachel Bendayan (Outremont, Lib.): Thank you, Mr. Chair.

Allow me to begin by thanking all of the witnesses. We are but 24 hours after International Women's Day. We are very grateful for the work that you do, both Oxfam-Québec and you, Dr. Rodriguez Garcia, on the ground in order to support women around the world.

I would like to start with you, Doctor. Can you give us a sense of whether or not you see any organized backlash against the provision of sexual and reproductive health resources to women, either in Mexico or in the research that you've done around the world?

Dr. Maria Cristina Rodriguez Garcia: I'm sorry. Can you repeat the last part of the question?

Ms. Rachel Bendayan: Yes, I apologize if there are any technical difficulties. I hope you can hear me now.

I'm concerned about, obviously, the backsliding that we have seen in the sexual and reproductive rights of women being protected around the world. I'm wondering if you have seen any organized backlash against the provision of those resources to women on the ground, either in Mexico or around the world.

Dr. Maria Cristina Rodriguez Garcia: Thank you very much.

Yes, we are facing a lot of polarization and radicalization in all of the public spaces, including the digital one. There are organizations that have led in a radical and opposite way. We have people who talk about ideology, visions and political views that are opposed to each other. They speak with a narrative that talks about the war between them. These organizations are creating an aggressive environment to dialogue and proposing constructive solutions.

Yes, there are organizations that have been increasing their narratives about war and fighting, and all these narratives that use the language of war. This is what has been provoking us, so we are not able to give solutions and to promote better regulations about sexuality and human rights, including democratic things.

Did I answer your question?

Ms. Rachel Bendayan: Yes. Thank you, Doctor.

[*Translation*]

Mr. Chair, I hope you won't take away any of my time because of these technical problems.

Oxfam witnesses, thank you for being with us and for making the trip from Montreal. I would like to ask you a similar question. In your opening remarks, you raised the issue of discrimination against women. Do you see this opposition to women's rights in the countries where you work?

Ms. Lauren Ravon (Executive Director, Oxfam Canada): Thank you for the question.

[*English*]

I think we all know that progress on women's rights isn't linear. When you make advances, it often comes with a backlash. At Oxfam, I'd say that, to some extent, the countries where we're seeing the strongest backlash are also those where feminist movements have been built up and supported and have been making progress on women's rights. That's what often has that counterpoint of backlash. Since the emboldening of anti-rights, anti-choice actors because of what has happened across the border in the States with the reversal of Roe v. Wade, I think we have seen a trickle effect across the world in terms of pushing back on some hard-won gains.

When we talk about backlash, it's not only the big picture in terms of pushing back on women's rights. It can be anything, like, at the school district level, a schoolteacher not letting a young girl come back to the classroom because either she got pregnant or it's known in the community that she had an abortion. There are backlashes at every single level, from the household up to the policy level.

● (1130)

Ms. Rachel Bendayan: Thank you for that explanation.

When you refer to the emboldening of this movement following the decision to overturn Roe v. Wade, do you feel that at a financial level? Do you see or feel that this movement has increased funding since then?

Ms. Lauren Ravon: There are definitely funding flows pushing back against women's rights. It's a very organized movement, that's for sure. If we look at the Canadian context, a country like Canada coming out and saying we're going to be funding sexual and reproductive health and rights, including areas like access to contraception, safe abortion and sex education for young people, we see that it's extremely powerful. I think if we're looking forward, it's a matter of combining money and voice. Most donor countries are not making these investments anymore. Canada has a role to play, not only in making these investments but also in showing up in diplomatic spaces and speaking out on these issues.

We believe in the importance of the funding going to women's rights organizations on the ground. When you're a women's rights organization and you hear a government official stand up in a UN space, in their Parliament, in defence of women's rights, talking about the power of women's rights organizations, speaking up in defence of women's right to choose, it's incredibly powerful in helping you continue your struggle day to day.

Ms. Rachel Bendayan: Thank you.

Mr. Chair, do I have any more time?

The Chair: No, you have no time remaining.

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

Thank you to the witnesses.

The Chair: We will now go to MP Bergeron.

You have six minutes, sir.

[*Translation*]

Mr. Stéphane Bergeron (Montarville, BQ): Thank you, Mr. Chair.

I would first like to note that I will be sharing my time with my colleague from Shefford.

Witnesses, thank you for your introductions.

Oxfam Canada representatives, you have clearly demonstrated that lack of safe access to abortion services does not reduce the number of abortions, but increases unsafe abortions.

In 2021, the World Health Organization's website published an article about abortion. It explains the following: “Barriers to accessing safe and respectful abortion include high costs, stigma for those seeking abortions and health care workers, and the refusal of health workers to provide an abortion based on personal conscience or religious belief.”

During your presentation, we learned that, through two programs, you operate in countries such as Honduras, Bolivia, Ghana, the Democratic Republic of Congo, Jordan, Lebanon, the occupied Palestinian territories, Ethiopia, Malawi, Mozambique and Zambia. Yet this week, the committee heard from two witnesses telling us that western support for safe and respectful abortions would be a form of neo-colonialism that would run counter to the cultural values of the countries we are engaging with.

Based on your experience in all the countries I just mentioned, what kind of resistance do you encounter culturally that prevents you from doing your work properly?

Ms. Lauren Ravon: Thank you for the question. If you don't mind, I will answer it in English.

[*English*]

When we talk about what aid Canada is providing, we're providing aid to countries that are independent, that have their own social movements and have a variety of perspectives within their own community. We're not saying that every single person in any of these countries wants access to these services. What we're saying is that there is a demand for it. There is an unmet need, whether it's for family planning, contraception or safe abortion, and those who want it should be able to have access to it.

I know the first question was about how we are influencing policy in these countries and how we are influencing culture. That is not our role; our role is to support civil society actors and local governments to make choices for their own communities.

What we do see, though, is that in every single country around the world, women get pregnant when they don't want to and look for a way to have an abortion. Whether it's illegal, safe or not safe, it's happening. It's a matter of asking, “How are we making this come out of the shadows?” It's about having safe services and medical options for women in every single country in the world, without exception.

I also want to add something on the issue of safe abortion. We know that it's a critical component of a life of dignity. We know the number of women who die in unsafe abortions every year. We've talked about Canada ramping up the investment in sexual and reproductive health and rights around the world, but, in the first reporting year of Canada's new commitment, less than $2 million went to supporting safe abortion services. You know what health care costs. You can imagine that, if you trickle that around the world, it's not a whole lot of money, so this is an area where we'd like to see Canada ramping up in particular, because most donors are not investing in that.

When we talk about safe abortion, it's also postabortion care. I've worked in countries, like Kenya, where the emergency rooms are flooded with women who have had unsafe abortions, so there is a huge weight on the public health care system and on hospitals. Also, these are women whose futures are compromised. They might not be able to have children later when they want or have health problems for the rest of their lives, so this is really an area where Canada can be investing.

I would say one more thing. It's also about supporting social movements and women's rights organizations that have an important role in norm, attitude and behaviour change. These organizations are talking to communities and changing mindsets around women's sexuality and around women's agency and choice. What we would also like to see at Oxfam is more Canadian funding going directly to civil society and women's rights organizations, not exclusively to large multilateral programs and government agencies.

● (1135)

[*Translation*]

Mr. Stéphane Bergeron: Thank you.

In the same vein, you note that funding tends to focus on targeted, time-limited interventions rather than on the long-term work of building strong health systems and infrastructure, of which sexual and reproductive health and rights are an integral part.

To go back to the answer you just gave us, do you think the development assistance that Canada provides should be transformed, so as to be aimed not at supporting ad hoc interventions, but more at supporting health systems in developing countries, thus facilitating a better approach to women's reproductive health?

[*English*]

Ms. Lauren Ravon: I just want to recognize that we have seen changes in the way Canadian aid gets delivered. We're not talking so much about two- or three-year projects anymore. We now have five- or seven-year project timelines, so that's important progress.

What we'd like to see is more continuity. Sometimes I think the best innovation is just doing the same thing with more resources and for a longer time. We don't need to reinvent the wheel constantly. Building up health systems is a decades-long project, but also building up women's movements is over years. When we look at Global Affairs Canada, our preference would be to see investment in the long term in supporting social movements. We're talking not just five or seven years, but 10 or 20 years. Then, in terms of health care systems, there's building up things like a national sexual education curriculum. These are things that are not done in five-year horizons. It's the same when supporting midwives across the country, building up midwifery programs and safe abortion services in rural health clinics. These are things that can't be done on a short timeline.

If we look at Canadian funding right now, about two-thirds goes to government or multilaterals, and less than a third to civil society initiatives. That's where we would like to see a better balance, because we know—and you're all politicians, so you know this—politicians act when they feel that there's public interest, public pressure, public demand. It's civil society that holds up that demand, so it means having strong civil society speaking up for rights and making sure there's that counterweight. We can see government investing in family planning and contraception one day, and then not doing it the next because they don't feel that need, that demand on the ground. It's civil society organizations, in particular women's rights organizations, local grassroots organizations—

The Chair: I'm sorry, Ms. Ravon, but you're considerably over.

Ms. Lauren Ravon: Thank you.

The Chair: Thank you.

We next go to MP McPherson.

You have six minutes.

Ms. Heather McPherson (Edmonton Strathcona, NDP): Thank you, Mr. Chair, and thank you to the witnesses. These are things that, as somebody who's worked in the sector, I know we've been calling for for a very long time. It's very good to hear this and to know this is getting on the record.

For me, this study is so very important because we know that women—because of conflicts, because of COVID-19, because of climate change—are disproportionately burdened right now and are feeling many of the effects of those things. As my colleague Ms. Bendayan pointed out, it is a day past International Women's Day, and it seems like a very good time to be asking questions about how Canada can do more to support women around the world.

What I'm going to focus all my questions on is what we need to see from the Government of Canada. What are the recommendations you want to see in this report for the Government of Canada?

To start with, can you talk to me a little bit about the Global Affairs Canada accountability framework, how you feel about that, how you feel about the first report that came out, and how you feel about the fact that we have a commitment to $700 million for SRHR, yet we haven't gotten anywhere close to that, to date, and time is running out? Could you explain that a little bit?

● (1140)

Ms. Lauren Ravon: Sure. I'm happy to speak about the accountability report.

First, I'd say the commitment that was made was historic. It was fantastic, and now it's a matter of getting it right. Also, the commitment to having this accountability reporting is a wonderful thing, not only because we can keep track of things, but also because we can readjust as we go along, so I really applaud the government for that.

I think the first year might have been to some extent a test run, so we have an opportunity to shape things differently. I think there's clearly an underinvestment in the four neglected areas of sexual and reproductive health and rights that we want to see more investments in. For everyone to know, they are safe abortions; contraception and access to comprehensive contraception; sex education, especially adolescent and youth; and advocacy for SRHR. If you look at those four areas, two areas in particular, sexual education and abortion, have received virtually no funding in the first year. We think it's in part because there hasn't been sufficient funding being directed to civil society partners and women's rights organizations. That can help balance it out.

I feel hopeful that we can get on the right trend, but it also means ramping up different kinds of partnerships. If you always work with the same actors in the same way, you don't get new results, so this is a real shift in Canadian aid funding. It's building on the work on maternal and newborn child health, but it's a new approach, so you need new partnerships. More partnerships with progressive women's rights actors can help increase those numbers.

I think something that's been encouraging is on advocacy. There have been investments in advocacy work. This is something that's a promising trend in the report and that we would like to see more of.

[*Translation*]

Ms. Béatrice Vaugrante: I want to add something about funding. We want Canada to be much more supportive of organizations, which are sometimes working in increasingly difficult contexts in terms of democracy and freedom of expression. Some organizations are becoming increasingly informal, but we still need to be able to support them.

So that occasionally requires flexibility or a review of budgeting or funding methods, which are sometimes a bit too rigid for this unfortunately increasingly common context.

[*English*]

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

We've said many times in this room that the best development funding is long-term, predictable and, of course, increasing, but I take your point that the flexibility to be responsive is also very important.

Oxfam is one of the 77 groups that wrote to Minister Chrystia Freeland asking the government to ensure that it lived up to its own commitment to produce increases in our official development assistance.

Can you tell me a little bit about what it means to organizations like Oxfam and other Canadian-based civil society organizations when we have these ups and downs? We see it more in the U.S. when there is a change of government and there's a real gap in funding, but it does happen here as well. Could you talk about that a little bit as well, please?

Ms. Lauren Ravon: We're asking for more funding, in particular because we're facing a situation that we didn't have in the past, where we have development challenges, but then we have major climate emergencies and then humanitarian crises, so it's making our work more expensive and more difficult.

Inflation touches everything, including good development, so this has an impact. Even a Canadian aid budget that remains steady is one that is declining globally. That's why, obviously, we're asking for more.

On what it means in terms of disruptions for our partners, one thing we've seen, and this is not specific to Canada, is that the aid community has a hard time keeping its attention on core anti-poverty work and core humanitarian work. For example, in the response to the war in Ukraine, we have seen much-needed support in that context, obviously, but it has definitely disrupted aid investments in many other countries. We speak to colleagues in the Horn of Africa, in eastern Africa, who are facing extreme hunger but also health systems that are really at their knees. We're talking about women's maternal health in these contexts being very difficult. These countries are seeing the whole world's attention turn elsewhere when they are facing one of the biggest crises of the century.

Canada has a role to play in keeping a steady ship and saying that we've made commitments to a feminist international assistance policy. We've made commitments to helping certain communities that are the hardest hit by climate change. Let's stick with it, even if we can show our solidarity when an earthquake hits somewhere else or when a war breaks out somewhere. Let's keep a steady ship, because organizations having their funding pulled from one day to the next because there are no development dollars left means literally life and death in certain circumstances.

● (1145)

Ms. Heather McPherson: Of course. Thank you so much for your work.

The Chair: Thank you very much.

Now for the second round, we first go to Mr. Genuis.

You have four minutes, Mr. Genuis.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you, Chair.

I just want to comment at the outset, in response to what was just said, that our focus on Ukraine is extremely important, in part because hunger crises in other parts of the world are impacted by the flow of essential food that's been disrupted as a result of the invasion, but I won't go too long on that, because I know it's not the main point today.

Ms. Garcia, you've had your hand up for a little while wanting to come in on some of the points that were made in the last 15 minutes, so I'll give the floor to you, if you'd like to do that first off.

Dr. Maria Cristina Rodriguez Garcia: Thank you very much.

Yes, I want to talk about how to deal with legislation on abortion that some of you were talking about. In my country, the discussion about abortion leaves no space to address all the issues about the vulnerability and exploitation that women are facing. In my country, women are barred, because of years of poverty and violence. We just find the solutions that many of the funds...and the actions that some organizations do are just a political resignation to violence. Why? There is that connection to the trauma of women that provokes this dissociation. The dissociation leads to their vulnerability, and their vulnerability is like green grass for exploitation. These vulnerabilities that women are facing have been creating industries of exploitation, even in abortion.

I say that because in my country, we have no accountability, for example, about why women are having an abortion. We have no accountability about which of these women are being trafficked or living in violence. We definitely have no accountability if these women come back to the same environments that generate trauma and disassociation.

We have a circle of political affirmation of vulnerability that makes the most vulnerable women invisible in all the programs and all the policies. With the limited interpretation of their autonomy, we are not seeing the exploitation, pain, suffering and trauma that women are facing, which affects all their decisions. Sometimes they will decide on the side of the trafficker and the violence—

Mr. Garnett Genuis: Thank you. I did want to get one more question in.

We have in our next hour the United Nations Population Fund appearing before the committee. I wanted to ask a question about an issue that has arisen in Mexico specifically. The National Human Rights Commission in Mexico has done a report on the issue of coercive family planning and population control. The report says that public health servants have imposed methods of family planning on the native population without their consent and without informing them of the risks. The National Human Rights Commission further alleges the complicity and involvement of UNFPA, and this follows a series of allegations about UNFPA complicity in population control around the world.

Dr. Garcia, do you have any observations or comments on the activity of UNFPA in Mexico and suggestions for us in that regard?

Dr. Maria Cristina Rodriguez Garcia: Yes. Thank you very much.

In the last year, we have been facing an aggressive imposition of some of the agenda that doesn't correspond with the reality that Mexican women and girls are facing. These interventions have become the main part of the discussion and the main part of the regulations. They don't let us talk about the real problems that women are facing, like the separation of women, the femicides we are facing, and how women are being sold among the narco groups.

The denouncements of these interventions that some groups have made are because these interventions absorb all the resources but don't leave us the space to talk and decide about the huge problems that we are facing in our countries.

Thank you very much.

● (1150)

Mr. Garnett Genuis: Can I just ask if there is a sense of public or political response to the UNFPA as it relates to their involvement? What has been the popular response to that?

The Chair: You have 20 seconds.

Dr. Maria Cristina Rodriguez Garcia: The popular response is that people are really worried, because of the war against narco that we are leading. We are generally angry and desperate. We feel they are not listening to our necessities and they are talking about things that don't relate to our reality.

Thank you very much.

The Chair: Thank you.

We next go to MP Sarai. You have four minutes.

Mr. Randeep Sarai (Surrey Centre, Lib.): Thank you, Chair.

I saw you paying attention to this, Ms. Ravon. Maybe you want to comment on that study that's being done. Do agencies, like Oxfam or others, go in and try to influence culture, or do they focus on the rights of women and the availability of those services? Can you enlighten us really quickly?

Ms. Lauren Ravon: Sure. Maybe I can respond in two points.

One is that an organization like Oxfam does not make decisions here in Ottawa and then tell local communities what to do. All of our work is with local partners and communities. We work with women's rights organizations in countries like Mexico and around the world. They are the ones leading the agenda. We have the privilege of being a conduit between the Canadian government and public funding and their work to support their communities, so we're not leading the agenda. That being said, there are strong women's rights organizations in every single country we work with. There's no lack of community organizations to work with on the ground.

On the previous question, if I may, I won't comment on UNFPA in particular, but what we do know is that, if you look at Mexico—I'll comment on this personally because my family lives in southern Mexico—indigenous women led the charge for abortion to be legalized in the poorest provinces of Mexico, with Oaxaca being first. Indigenous women led the green wave around abortion, because they know that they are suffering the consequences of unsafe abortion and lack of public services.

This is certainly not something that has been imposed by any foreign agent or the UN. This is very grassroots mobilizing and really impressive mobilizing that has led a country with very restrictive abortion laws to change because of grassroots, rural, indigenous women's movements, so I think we look to them as the leaders we can support. It's not driven from the outside.

Mr. Randeep Sarai: My second question into that is this: How do you deal with cultural norms in a society? How does Oxfam or similar organizations, when they go to South America, Latin America, India, the Middle East, etc., work with those? Are you there to work with the culture norms? What's a general practice, just in 60 seconds or so, as to how Oxfam works in that kind of environment?

Ms. Lauren Ravon: A lot of our work is precisely on behaviour, norm, attitude and belief change with local organizations. I can give you an example of Bangladesh, where the partners we work with have developed a very popular television series that talks about women's role in the household, gender dynamics and gender norms around decisions, around sexuality decisions and around who has household chores. They're trying to shake things up.

Our partners in Bangladesh have decided that using these kinds of very popular TV stations—the word that comes to mind is "telenovela"—is the best way to access people and start raising different ways of thinking about gender norms in their countries. In other contexts, we support groups that do public radio stations in rural communities. In others, we support street theatre and community theatre.

It's very much context-specific how you shift attitudes and norms, but the best way is to be closest to the communities you're working with. It's never from the capital down.

● (1155)

Mr. Randeep Sarai: Just switching back to North America and the reversal of Roe v. Wade, have you seen the impact in states that do not allow access to abortion or have very restrictive access to abortions? What is the effect on women getting illegal abortions, or is it generally still accessible because neighbouring states usually have access to it?

Can you enlighten us? Even though it has been a short window, what has been the effect of Roe v. Wade on women and women's reproductive rights and the dangers to women in the United States?

The Chair: Keep your answer within 30 seconds, please.

Ms. Lauren Ravon: Oxfam America works very closely with organizations across the country in the United States. They have seen that the biggest impact has been on marginalized communities. Black women in particular have seen a harder access to abortion. There's a direct correlation between poverty and being able to fly, take a train or take a car to get to safe abortion.

Communities that are in poverty have less access to take the three days off work. That would mean getting into the car, driving across the border to another state and having access to health care to begin with. Poverty is really the intersecting factor here, so it's not only a crackdown on women; it's a crackdown on poor people.

Mr. Randeep Sarai: Thank you.

The Chair: We next go for two minutes to Madame Larouche.

[*Translation*]

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

Ms. Ravon and Ms. Vaugrante, thank you for joining us today on this day after March 8, International Women's Day, when we talked about the important need to stand up, again and again, for women's rights. What stands out for me this year is that, according to UN Women, it would take another 300 years at the current rate to achieve equality between men and women. It's a number that sets off alarm bells for me and reminds me that the fight must continue.

Ms. Vaugrante, in your presentation, you spoke about the issue of sexual violence against women. Could you tell us more about the link between, on the one hand, that gender-based violence and, on the other hand, all the health issues such as abortion and unwanted pregnancies?

In international cooperation, it is important to improve health systems, but could you talk about the work that needs to be done to decrease gender-based violence and violence against women in particular?

Ms. Béatrice Vaugrante: I will begin to answer your question, and I will let Ms. Ravon continue.

We have talked about this in answering different questions. Our interventions are never technical. The primary goal is to support groups that are already on the ground. When it comes to training on sexual and reproductive health, we talk about comprehensive training. So our approach is never just about the technical part of health. It's comprehensive, and it's about the full range of women's sexual and reproductive rights and ways to combat the violence they experience.

Contexts are increasingly made fragile by conflict and natural disasters, which are increasing the danger of violence against women and girls. There is evidence that contexts where democratic spaces are increasingly constrained and conflict is on the rise can lead to sexual violence.

So we work with community leaders and we also talk about the benefits of having women who are not experiencing sexual violence and are enjoying their rights, and are therefore able to participate in the community economy and contribute to solutions. That's important.

I will yield the floor to Ms. Ravon.

[*English*]

The Chair: Thank you.

For the last two minutes, we go to MP McPherson.

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

Thank you very much for your testimony, again. You spoke about how you work with women partners. I was in Nicaragua and met with Oxfam there and with the partners on the ground.

I want to give you an opportunity to talk about two things very quickly. First is the fact that you work so closely with partners and that you are in fact enabling the people on the ground, the women on the ground, to do what they need. You're providing that support to them. One thing that was brought up was the ability of the Canadian aid sector to switch its focus. Obviously, the horrendous earthquake in Syria and Turkey and the horrible war that's happening in Ukraine have diverted a lot of our attention. Obviously, Canada needs to do absolutely everything it can for the people of Turkey, Syria and Ukraine—the women of Ukraine, who we know have suffered quite a bit of sexual violence.

Could you talk a little bit about how that support needs to be in addition to the development dollars, not in exchange for them?

Ms. Lauren Ravon: If it is not, ultimately we're going to see a backslide. If we invest only in repeated humanitarian crises, we're not investing in long-term resilience building, whether it's health systems, women's education, movement building or civil society. We're going to be in a yo-yo effect where you invest one moment, and then the investment leaves because the humanitarian community looks elsewhere. That's not how we're going to build long-term resilience. While this is not specific to sexual and reproductive health and rights, in a world where climate change is going to disrupt pretty much everything and we know there are going to be increased flows of migration and conflict related to climate, we need to be building that long-term capacity for communities to be resilient, to adapt and to build up their national infrastructure, in particular their national safety nets, because we know crises are coming.

● (1200)

Ms. Heather McPherson: We need real solutions instead of just band-aid solutions.

[*Translation*]

Ms. Béatrice Vaugrante: It even makes humanitarian aid more effective. I see our partners from Oxfam KEDV, in Turkey, who have been working for decades with women's cooperatives. They are close to those women; they are there. So working in international development for a long time makes humanitarian aid and response much more effective.

[*English*]

Ms. Heather McPherson: Thank you.

The Chair: Thank you very much, MP McPherson.

That concludes this first panel for us. I'm incredibly grateful to Ms. Vaugrante, Ms. Ravon and Ms. Garcia. I'm very grateful to you for sharing your perspectives with us.

On that point—

Mr. Garnett Genuis: Chair, can I raise a brief point of order?

I think one of our witnesses had her hand up for a while. I think witnesses are able to submit follow-up information in writing to the committee, and that is considered as part of the evidence.

I don't know if you want to allow an opportunity for her to speak further or not, but I would encourage people who have further comments to submit them in writing.

The Chair: Thank you, Mr. Genuis.

Ms. Garcia, at this point, a witness can't make any further submissions, but if there is anything further that you would like us to consider, please feel free to send us any written submissions that you think would assist our members in coming up with their recommendations.

Thank you for that.

On that point, let me thank you all for your time and for your perspectives.

We will need a few minutes to get to the second panel. For those on Zoom, you don't have to do anything. We will reconvene in two minutes.

Thank you.

● (1200)

_____(Pause)_____

● (1210)

The Chair: Welcome back, everyone.

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

It is now my great pleasure to welcome, from the United Nations Population Fund, Dr. Natalia Kanem, the executive director and under-secretary-general of the United Nations.

We also have equally distinguished witnesses from the Society of Obstetricians and Gynaecologists of Canada. We welcome Dr. Diane Francoeur and Dr. Jocelynn Cook.

For the benefit of the witnesses and the members, please ensure that you're recognized by me before you speak. For each of the witnesses, we are providing five minutes of opening remarks before we open it up to questions from the members. When you're getting towards the end and you have only 30 seconds remaining, I will give you a sign. I would be grateful if you could wrap up your comments. This goes for both your opening statements and the questions posed by the members.

That having been explained, allow me to welcome Dr. Kanem.

Dr. Kanem, you have five minutes.

Dr. Natalia Kanem (Under-Secretary-General of the United Nations and Executive Director, United Nations Population Fund): Thank you, Mr. Chair, vice-chairs and honourable committee members.

Thank you for inviting UNFPA, the United Nations sexual and reproductive health agency, to address you today, and thank you for Canada's continued, generous support to UNFPA. We are delighted to have Canada back as a member of the UNFPA executive board through the year 2024, and we look forward to your guidance during this period. It's the support of partners that spells the difference between life and death for millions of women and girls around the world each year.

There can be moments of great joy amidst tremendous suffering, as we saw in the wake of last month's devastating earthquake, when Khawla Hassan Al-Ali was able to give birth safely to four healthy babies, quadruplets, delivered by Caesarean section at a UNFPA-supported clinic in northwest Syria.

Nasreen Faroug Balla, a young Sudanese woman, was in critical condition when she finally reached a UNFPA field hospital in a settlement for Ethiopian refugees, after being carried three kilometres through rain and mud and suffering from pre-eclampsia. Nasreen's blood pressure spiked dramatically and she lost consciousness. Fortunately, the doctors were able to perform an emergency Caesarean section, and both she and her baby boy survived and received the care they needed to recover.

Of course, not every story has such a happy ending. Every two minutes, a woman dies during pregnancy and childbirth—an estimated 287,000 women in 2020, according to a new report by UNFPA and our United Nations partners. Very often, this woman is an underage girl.

Most of these deaths are preventable. One of the most cost-effective ways to prevent maternal deaths is to educate and deploy midwives. Midwives can deliver 90% of all essential sexual, reproductive, maternal and newborn health services. However, currently the world faces a global shortage of 900,000 midwives. With support from Canada and other partners, UNFPA works to close the gap and to create a well-trained midwifery workforce.

Also very critical is reducing unintended pregnancy that so often ends in unsafe abortion, which is among the leading causes of maternal death. UNFPA research shows that nearly half of all pregnancies are unintended. Our research also shows what works to address this: increasing access to a range of quality contraceptives, improving comprehensive sexuality education for young people, and protecting a woman's right to decide whether, when and with whom she wishes to have children.

We will also need to tackle harmful norms and practices that undermine women and girls' human rights, their bodily autonomy and their access to life-giving health care. Why? The figures speak for themselves. One in three women experiences physical or sexual violence in her lifetime. One in five girls is married or in a union before the age of 18. More than four million girls are at risk of female genital mutilation this year. Just 56% of partnered women are able to make their own decisions about whether to have sex, use contraception or seek health care.

We know that changing this will require partnerships, first and foremost with communities, with civil society organizations, with traditional and religious leaders and, critically, with men and boys.

The benefits for both individuals and their societies are enormous. According to UNFPA research, every dollar invested in ending preventable maternal deaths and unmet family planning needs by the year 2030 would yield $8.4 back in economic benefits by 2050.

UNFPA certainly welcomes Canada's feminist approach to international assistance. Your leadership is a beacon of hope at a time when push-back on gender equality and women and girls' rights is intensifying.

● (1215)

UNFPA looks to Canada as a strong ally in advancing gender-transformative change, rooting out disparities, discrimination and inequalities, and defending the rights and choices of all people in all their diversities.

I'll end by saying that we look forward to continuing our work together toward a world where every pregnancy is intended, every childbirth will be safe and every woman and every young person can choose the direction their life will take, transform their community and help build a more equitable, prosperous and sustainable future.

Thank you very much.

● (1220)

The Chair: Thank you very much, Madam Under-Secretary.

Next, we will go to the Society of Obstetricians and Gynaecologists of Canada.

Ms. Francoeur, you have five minutes.

[*Translation*]

Dr. Diane Francoeur (Chief Executive Officer, Society of Obstetricians and Gynaecologists of Canada): Ladies and gentlemen, good afternoon.

My name is Diane Francoeur and I am the chief executive officer of the Society of Obstetricians and Gynaecologists of Canada, or SOGC. With me today is Dr. Jocelynn Cook, who is our chief scientific officer.

We thank you for this opportunity today to speak with you about sexual and reproductive health and rights of women globally. The SOGC has over 4,000 members, including obstetricians, gynaecologists, family physicians, nurses, midwives, researchers and other health care professionals working in our field. Our mission is to lead the advancement of women's health through excellence and collaborative professional practice. Our vision is: healthy women, healthy professionals and excellent care.

Our organization and our members are very committed to the sexual and reproductive health and rights of women, both in Canada and around the world. The SOGC has distinguished itself for many years as the go-to organization for health care professionals and women when it comes to quickly finding the latest evidence-based recommendations. Our members, who are involved in the development of guidelines, are among the best experts in Canada and, unusually for a country with 17 medical schools, are able to speak with one voice when it comes to changing our practices to improve care for women.

Today, we will share our recommendations, as well as some thoughts on science-based solutions to meet the current needs of women and those who care for them, as they too deserve our support and attention to do a better job.

The pandemic has left us with a shortage of human resources that is undermining our health care system. It is clear that this shortage has had a direct impact on women's health by creating a bottleneck, especially for under-served populations. New immigrant women, indigenous women and people of diverse gender identities are finding it harder than ever to navigate our overburdened system. Because it is difficult to get access to the specialty clinics and health services they need in a timely manner, the consequences and impact of delayed care on their medical condition will be even more significant and sometimes, unfortunately, irreversible.

One example is the appearance of HIV-positive newborns when medication was started late for the mother. No one can ignore all the pregnant women who are crossing the United States and arriving via Roxham Road in Canada as refugees. Even if they have medical coverage through the interim federal health program, they do not know how to navigate our system and often have to rely on their children or friends to translate their medical problems when interpreters are not available. How do we explain to them that their sexual rights will be respected when we are unable to have a private conversation free from influence?

Overcrowded clinics are not the best place to welcome immigrants and assess their medical and social risks. As health care professionals, we need time to be able to build a trusting relationship to help those women make the best possible decisions about their medical and social issues. Unfortunately, their complicated medical condition often dictates the speed of necessary interventions before these women even have time to realize that they now live in a country where they will have the right to choose.

Issues of access to safe or illegal abortion, access to contraception without financial constraint and special care for the LGBTQ+ community, including the multicultural aspects of health and managing the trauma experienced by each woman, are even more complex issues and problems in situations of conflict, pandemic and war for these under-served populations. Women around the world experience the consequences of those problems, and we need to be able to understand the trends, gaps and opportunities to improve their lives when they arrive here.

Sexual and reproductive health and rights must be a priority for all women and their unborn children. In this regard, Canada must stand out for its commitment to all its women, whether they were born here or are newcomers.

● (1225)

This way, we will be able to back up every dollar invested internationally with our credibility in our actions, and not the other way around.

Canada lacks reliable and accurate data on the health of its women when it comes to monitoring indicators and producing reports to guide investments and decision-making. We see some aberrations on the ground, such as the fact that women of colour, indigenous women and new Canadians appear to be more likely to die during childbirth in Canada. However, we have no data to support these observations, as these data are not measured or reported.

However, the SOGC is confident in developing training tools to prevent these deaths. Mental health and opioids are issues seen in rich countries, but unfortunately they are also very closely linked to limited access to available services.

For more than 80 years, the SOGC has been advocating for improvements to women’s health, providing training and education, leading research and producing evidence-based guidelines. We have worked in partnership with countries around the world to develop training programs on sexual health and reproductive rights for their professionals, with their learned societies and governments. We have trained over 10,000 health care professionals in low-resource countries to optimize emergency obstetric care based on the philosophy of and respect for everyone's rights.

We would like to leave you with a few recommendations.

We have to support our health care teams with innovative models of care and think outside the box to improve access, decrease stigma and improve patients' experiences and health indicators. The shortage of human resources is unfortunately here to stay. Therefore, we must find solutions that are not based solely on the magical thinking of seeking professional resources from other countries, especially those in the developing world.

We have to reach the public and our patients with the right information, in the right language, to help them make decisions about their health. We have to share the same science and recommendations with women and physicians, so that they can speak the same language.

Finally, we have to continue to work with federal, provincial and territorial data to ensure that we can identify issues and trends, so as to be able to measure the impact before it's too late to act.

Thank you again for your invitation today—

[*English*]

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

[*Translation*]

Dr. Diane Francoeur: —and we hope to be able to answer your questions.

[*English*]

Mr. Garnett Genuis: I'm sure you have important things going on, but it's been over eight minutes that the witness has been speaking. Thanks.

The Chair: Yes, absolutely. That's fair enough.

Mr. Garnett Genuis: I appreciate the testimony, but I wanted to flag that it's our question time.

The Chair: As you know, I do let it slide. I allowed it to slide when it was your slot to speak as well.

Mr. Garnett Genuis: It's been eight minutes, though.

The Chair: Thank you.

We will open it to members for questions. The first question goes to Mr. Genuis.

You have six minutes.

Mr. Garnett Genuis: Thank you, Chair.

I hope you'll be as liberal with my time as you've been thus far.

I want to start by asking Dr. Kanem from the UNFPA whether the UNFPA believes that human rights are universal and indivisible.

Dr. Natalia Kanem: Mr. Chair, am I directed to respond?

Mr. Garnett Genuis: Yes, you can just go back and forth. You don't need the chair to step in.

Dr. Natalia Kanem: Okay. Thank you very much.

Yes, indeed, the UNFPA has that belief.

Thank you.

Mr. Garnett Genuis: Thank you.

Does the UNFPA believe that the one-child policy implemented in China by the Communist Party constituted a violation of fundamental human rights?

Dr. Natalia Kanem: Typically, as a member agency of the UN, we do not comment on member states' internal decisions. However, speaking for the platform of UNFPA, we are very clear that we stand behind voluntary decisions by women and couples regarding their reproductive decisions.

● (1230)

Mr. Garnett Genuis: Thank you, Doctor.

Respectfully, I think it will be pretty clear to the folks listening that you didn't answer my question. My question was, do you believe that the one-child policy was a violation of fundamental human rights?

Dr. Natalia Kanem: From the perspective of UNFPA's position—and actually, this is a United Nations position—that women and couples have the right to decide the number and spacing of their children, this is what we espouse in every country where we work.

Mr. Garnett Genuis: Is it correct to infer from that statement that you do believe that the one-child policy and any policies that cap the number of children a family can have constitute a violation of fundamental human rights?

Dr. Natalia Kanem: It is, in fact, our belief that these decisions are made by couples. However, it is not the United Nations Population Fund that ascertains this term “violation” that you're using. Within our mandate, we actually fall under.... It's the Office of the High Commissioner for Human Rights that determines violations. We are a reproductive health and rights service agency. We are not mandated to decide on violations.

Mr. Garnett Genuis: Okay, so if I understood that answer—

Dr. Natalia Kanem: I was trying to be as comprehensive and direct as possible.

Mr. Garnett Genuis: Okay.

If I understand that answer, then, you're saying that determining whether or not the one-child policy was a violation of human rights is outside of the competency of your organization, and I should direct that question to a different agency. Is that a fair synopsis of what you just said?

Dr. Natalia Kanem: It is, indeed.

Mr. Garnett Genuis: Okay. Thank you.

Of course, in determining the partners you work with and the organizations and governments you work with, I hope you keep in mind human rights considerations when you're determining those points of co-operation. UNFPA has been criticized for working with actors who are clearly involved in coercive population control policies in China, but also in Mexico and India.

What is your response to the allegations that your organization has collaborated in substantial and meaningful ways with organizations that are implementing coercive population control policies?

Dr. Natalia Kanem: I thank you for this question, because UNFPA is pained by these allegations, and where investigated, they have consistently been found not to be the case.

In particular, as I alluded to earlier, our mandate is based on principles that are long-standing over the 53-odd years that we have been working. The term “voluntary” is there precisely because the rights issue comes down to individual choice.

UNFPA does not co-operate with, nor do we uphold any coercive practices.

Mr. Garnett Genuis: Doctor, there are a couple of data points I'd appreciate your response to. Is it true or not true that in 1983 the UN Population Fund gave an award of over $12,000 to China's family planning chief? Is it true or not true that the UNFPA was involved in creating an information-gathering system that facilitated China's one-child policy?

I have a BBC article from 2014 that talks about the involvement of the UN Population Fund in funding an “ambitious population control programme” that had coercive elements during the 1975 Emergency in India.

There was a recent report by the National Human Rights Commission in Mexico that points a finger at the National Population Council of Mexico working with the collaboration and support of UNFPA on coercive family planning, including involuntary sterilization.

Are those reports from those various organizations inaccurate, in your view?

● (1235)

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

Mr. Garnett Genuis: Okay, thank you.

The Chair: Thank you.

Next we go to MP Bendayan.

You have six minutes.

[*Translation*]

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

Thank you all, respected witnesses. As it was mentioned earlier in this meeting, this is the day after International Women's Day. We want to tell you how grateful we are for the work you are doing on the ground to support women.

Dr. Francoeur, I am very interested in the recommendations you will have for the federal government. We all know that health care falls under provincial jurisdiction, but I would like to hear your comments on improving access, which you mentioned, as well as on the importance of communicating the right information to the public in the right language.

Are you suggesting that more information be published in multiple languages to address different communities in Canada? Can you elaborate on what should be communicated to women here in Canada?

Dr. Diane Francoeur: Thank you for your question.

Let me clarify that I am not just a chief executive officer. I am also an obstetrician-gynecologist and I work in your constituency at the Sainte-Justine university hospital centre, the mother and child university hospital centre.

In the past year, a very large number of immigrant women who do not speak English or French have arrived in Canada. When we see those women in the hospital, we have access to interpretation services, but when we see them in a clinic or in an office, it's sometimes impossible to get those services. It's really problematic.

Pregnancy is not an illness, but when pregnant women are sick, it is important that they be able to understand in their native tongue the issues that we are trying to explain to them.

The Sainte-Justine mother and child university hospital centre is a hospital that deals with high-risk pregnancies. During the past year, we have seen very sick women, many of whom are from Haiti. These women may have transited through Chile or Brazil and had a caesarean section. They don't have a record, they don't understand what happened, and they arrive in a country where they suddenly have to make choices without really understanding that they now have rights that will be respected. In this kind of clinical situation, newcomers are still not able to make those decisions.

It is very difficult when there is a language barrier, in addition to a cultural barrier. Newcomers have often crossed the entire the United States and don't have a record. We try to help them see the real risks, but a pregnancy has a time limit: after 40 weeks, the baby has to come out. So sometimes we don't have a lot of time to help these women navigate all of this.

Ms. Rachel Bendayan: You also talked about the importance of collecting reliable data. Right now, if I understand your testimony correctly, we don't have data on vulnerable women who have health problems during pregnancy.

Dr. Diane Francoeur: I will ask Dr. Cook, who is in charge of our wonderful maternal mortality reduction project, to tell you about the data, because it's a real problem.

[*English*]

Dr. Jocelynn Cook (Chief Scientific Officer, Society of Obstetricians and Gynaecologists of Canada): Thank you. I will speak in English, because that will be much better for all of you.

I think that's a really key point. Right now we're at a real turning point where the federal, provincial and territorial governments are working together to talk about data. We learned things from COVID. We had to learn. We were in a situation where we were forced to do new things that from a scientific point of view we don't really have good evaluation data on, but intuitively we know that they worked and they helped.

Now what we're trying to do in our field, I think, is take a breath, take a step back and really be thoughtful about what the outcomes are, what the trends are and where we need to be on top of things, for lack of a better word, so that we can understand what's happening. If we understand what's happening from a true evidence and data perspective, then we can start to plan and anticipate and identify where we need more education for the public—in what languages, for example—and more education for health care providers who are dealing with very different circumstances and contexts and even patient populations. Then we can work together and see where we can have points of intervention and prevention.

As an organization and nationally and provincially, we are working together to try to do this around severe maternal morbidity and maternal mortality, which we've already spoken about and you've spoken about at previous meetings, and also some of those really critical factors that will emerge soon in Canadian data, because some of the provinces have the data around mental health and the consequences in terms of outcomes.

Thank you for that. I love data, so I get really excited.

● (1240)

Ms. Rachel Bendayan: I do, too.

Thank you very much, Dr. Cook. I think it speaks to the importance of the work that we're doing now in partnership with the provinces to ensure better data collection.

The Chair: MP Bendayan, you're out of time. Thank you.

We'll next go to MP Larouche. You have six minutes.

[*Translation*]

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

I thank the witnesses for being with us today for this important study on the sexual and reproductive health and rights of women around the world.

Yesterday, March 8, we had the opportunity to reflect on how far we have come, but also on the setbacks that many women's rights have suffered in recent years, including sexual and reproductive rights. One only has to think about what is happening south of the border, in particular, where the setbacks that have occurred in recent months are really concerning.

Ms. Kanem, in 2019, the Government of Canada committed to provide an average of $1.4 billion per year over 10 years, starting in 2023, to support the health of women, children and adolescents around the world. Of this amount, $700 million is to be spent on sexual and reproductive health and rights. This is a worthwhile commitment, but it should not obscure the fact that, in 2021, Canada spent only 0.32% of its gross national income on official development assistance.

Can you remind us what target countries should aim for in providing development assistance as a percentage of their gross national income?

[*English*]

Dr. Natalia Kanem: Thank you very much for the question. It underscores the importance of being able to plan predictably for the needs of women, who are the most vulnerable in so many circumstances around the world, including in humanitarian circumstances.

I will note that last year, in 2022, Canada, indeed, was the 10th-largest donor to UNFPA core resources and our fourth-largest donor to non-core resources. This allowed us to accelerate implementation in development and humanitarian contexts, especially post-COVID, when we're trying to regain ground and, as you have already expressed, when there seems to be a retrenchment in upholding the minimum floor of overseas development assistance, which is so invaluable in terms of capacity to deliver on the ground. I'm speaking of places that may be hard to reach because of geography—small island nations or a place like Afghanistan, because of the terrain—but also because of the political landscapes.

The fixed and predictable core funding from member states is what equips UNFPA to get in there, in the over 120 countries where we're located, to address a growing number of crises in the lives of women and girls.

Thank you.

[*Translation*]

Ms. Andréanne Larouche: That's interesting. Are you having any discussions with Canada to see if the country could invest even more in development?

[*English*]

Dr. Natalia Kanem: Canada has been an extremely close partner. As mentioned, back on our executive board, we've taken a lot of guidance in terms of the strategic planning, which I've insisted should be finite. We work on three transformative results: contraception, because it's empowering for women; ending maternal mortality, which is so symbolic of a health system that doesn't work; and, lastly, ending the scourge of gender-based violence, which is erupting in greater numbers, including online violence.

We consistently make the case to Canada, and I believe Canada has been responsive in that regard.

Thank you.

● (1245)

[*Translation*]

Ms. Andréanne Larouche: Thank you very much, Ms. Kanem. I may come back to you if I have time.

Ms. Francoeur, in your opening remarks, you mentioned the issue of the human immunodeficiency virus, HIV. While doing my research, I saw a piece of information that really shocked me: worldwide, HIV is still the leading cause of death among women of reproductive age in 2023. In recent years, have these poor outcomes been getting worse or, on the contrary, improving?

Dr. Diane Francoeur: First of all, it is important to remember that we are privileged in Canada and that free medication is available to women. That being said, we still need to see those women.

I work at the Sainte-Justine university hospital centre, the main mother-child AIDS centre in Quebec. For years, the transmission rate was zero. However, during the pandemic, delays surrounding immigration documents caused delays in specialty clinic consultations, which require proper documentation because HIV medication is so expensive.

As a result, we unfortunately started seeing newborns being born with HIV again. This is a disaster in a country like Canada, as these infections are preventable. For those women who come to Canada and find out they are HIV positive after being tested, it is catastrophic. We have often had to perform caesarean sections when we were too late, to try to protect the little baby.

All of these problems are problems that we got rid of in the years before the pandemic. So we need to quickly get the early care of all immigrant women back on track so that the existence and results of these tests, which are often ignored for months, would be known.

[*English*]

The Chair: Thank you very much.

We next go to MP McPherson.

You have six minutes.

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

Thank you to all the witnesses for being here today and sharing their expertise with us.

This is a very important study. I'm hearing about the importance of data and how important it is for us to have access to it. I'm also hearing about the importance of long-term, predictable and flexible funding.

I will start with you, Ms. Kanem, if I could.

According to the United Nations Population Fund, access to family planning is a human right. It is "central to gender equality and women's empowerment, and it is a key factor in reducing poverty."

Could you spend some time telling us why there are still an estimated 257 million women around the world who have unmet needs for family planning, please?

Dr. Natalia Kanem: It's true that we know that nearly one-third of women in low- and middle-income countries begin child-bearing in their adolescence, age 19 and younger. This has implications in terms of consent and in terms of how a girl navigates her adolescence safely, often in the absence of comprehensive sexuality education that would be protective to her. Every year, there are an estimated 21 million pregnancies among girls aged 15 to 19 in low- and middle-income countries, nearly half of these being unintended. A significant number end up in abortion, and the majority of those abortions are in unsafe conditions.

The correlation with the difficulty of providing modern contraception to meet the unmet need is partly an adolescent issue. It's also an issue of prioritization, because studies have repeatedly shown the value of women who understand very well the costs of raising children and who want to space their children appropriately. Still, the ability to provide contraception in a regular way means that, in a biological process, you have to have a guarantee that logistics systems will be there to support the women, as well as cost and affordability.

I'm not sure if I'm out of time, but I just want to quickly add that the other issue is that the budgeting domestically for contraception is an area that UNFPA works avidly on, because this is of import in a place like Niger, for example, with an average fertility rate of seven children per woman. There is political will there in that government, and there is also strong leadership by traditional systems, including the religious chiefs, to feature family planning as a life-saving manoeuver because of the prevalence of death during childbirth in the least developed countries.

Thank you.

● (1250)

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

We've seen in British Columbia, in Canada, just this week, in fact, that free contraceptives have become law. There is a push for that to happen in Alberta, too, so I'm very excited about that for women across this country, certainly in British Columbia and Alberta.

I think it's useful to hear. We've heard this multiple times during this study, but it's useful to repeat that the failure to provide services does not result in fewer abortions. It does not result in fewer pregnancies. In fact, it results in less safe pregnancy and causes incredible damage to individuals.

Can you talk a little bit about the damage to individuals and perhaps bring in some data for those of us in the room who are data hounds?

Dr. Natalia Kanem: In fact, the latest "State of World Population" report by UNFPA dealt with the issue of unintended pregnancy and covered the circumstances under which lack of access can be lethal, literally, in the sense that women lose their lives. We also featured, as I mentioned earlier, that the woman who dies during many of these occurrences is not a woman at all. She is an adolescent girl who, whether through ignorance or through lack of access, or sometimes through coercion, became pregnant and there was no support.

I also believe in the link in terms of the empowerment of women to be able to fulfill their aspirations, whether that is through employment or entrepreneurship, or through motherhood. The intention makes a lot of difference, and the ability to plan your life is going to be more and more acutely necessary in a rapidly evolving technological world.

The fact is that contraception has been proven to be not only lifesaving but also very cost-effective in terms of the value returned in community productivity and economic productivity. For me, the real value is that an educated girl has an unlimited wealth of opportunities in front of her, and a girl who lacks an education is not only condemned to poverty herself, but the next generations also have been shown, by data, to fare worse.

The empowerment terminology mustn't disguise that we are actually talking about individuals who would like to conduct their lives in ways that make things better for themselves, for their communities and additively for countries and the planet.

Ms. Heather McPherson: Thank you for that compelling testimony.

The Chair: Thank you.

We now move to the second round.

For the second round, we have very little time remaining. Each member will be provided two minutes.

We start off with Mr. Genuis. You have two minutes.

Mr. Garnett Genuis: Thank you, Chair.

I was struck by your testimony in the previous round, Dr. Kanem. You said that determining whether China's one-child policy was a violation of human rights was not a competency of UNFPA. It would seem that determining that these kinds of policies are a violation of fundamental human rights is in the competency of all human beings.

We're living through a time when this Parliament has recognized the Uighur genocide, a genocide that involves forced abortion, forced sterilization and systemic sexual violence against women, so we need to talk about issues of coercive population control and we need to talk about ending complicity—complicity by corporations that may have investments that are enabling the Uighur genocide, and complicity by organizations that are failing to call out coercive population policies and the targeting of women associated with it.

We ran out of time in my last round, but I raised a number of issues at the time, concerns raised by the National Human Rights Commission in Mexico around UNFPA's complicity in coercive population policies, and a BBC article containing certain allegations involving UNFPA's activity in India, as well as some further information about UNFPA's activity in China. If it's your position that it's not your role to make human rights determinations, certainly you have to make a determination as it relates to your own participation and complicity in that.

I would welcome your response. Thank you.

● (1255)

Dr. Natalia Kanem: Thank you very much, indeed, Mr. Vice-Chair.

I would like to emphasize that UNFPA is against any form of coercion. When it comes to reproductive health and rights, we are foremost in upholding the rights and choices of women everywhere.

Mr. Garnett Genuis: How do you respond to these specific allegations, though?

Dr. Natalia Kanem: In particular, because I wish to be precise—

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

Dr. Natalia Kanem: Certain things that you mentioned I am not in a position to comment on. It is our member states, for example, that decide who receives the population award. This is not something that the agency decides. It is, in fact, the countries of the United Nations.

Nevertheless, I do wish to assert very clearly that in China, and in every country, UNFPA works in ways that uphold and address issues of rights founded in the 1994 Cairo mandate, which is how we operate now. I will mention that some of the cases you alluded to may have preceded the 1994 Cairo mandate. That platform of action is exceedingly clear that UNFPA is to focus on people-centred development, women-centred development specifically. The allegations against UNFPA, where investigated, have always been found to be unfounded. That includes in China as well.

The primary focus of what we do is to reduce inequality, reduce inequity and in fact reject coercion. We believe that rights-based, gender-sensitive and comprehensive sexual and reproductive health programming is protective for women, who may or may not be able to express in certain circumstances because of government rules and regulations, which UNFPA is obliged to operate under.... Even in Afghanistan, we have been able to maintain life-saving care by working very carefully with midwives on the ground, with women and civil society—

The Chair: Madam Under-Secretary, I'm terribly sorry to do this. Please conclude your remarks, if you could.

Dr. Natalia Kanem: Just to emphasize that we stand for the rights and the choices—

Mr. Garnett Genuis: You say it's rights-based, but you can't make rights-based determinations.

The Chair: Mr. Genuis, I have already warned you—

Mr. Garnett Genuis: I don't know how you can say it's right-based but it's not—

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

Mr. Garnett Genuis: Either I have time or I don't, Mr. Chair.

The Chair: How many times do you need me to warn you, Mr. Genuis? You are out of time.

Mr. Garnett Genuis: The witness was still talking, so either it's my time or it isn't, Mr. Chair.

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

Mr. Garnett Genuis: Okay, but if the witness is talking, it's either her time or mine.

The Chair: Mr. Genuis, please.

We now go to Mr. Sorbara.

Mr. Sorbara, you have two minutes.

Mr. Francesco Sorbara (Vaughan—Woodbridge, Lib.): Thank you, Chair.

Welcome to the witnesses.

If I could just address two aspects that are connected, one being maternal health, and the second one.... Dr. Francoeur, you said that women's sexual and reproductive rights need to be respected. I want to start off with those two.

The reason I touch upon maternal health to the three witnesses is that I am blessed with three daughters. The first one was born in a hospital under the circumstances of code pink. I know you would both understand what code pink means. She's very healthy, and she's one of the loves of my life. Not everyone throughout the world has the ability to call code pink.

May I ask about the importance of maternal health for women, not only here in Canada, and the benefits of investing monies for maternal health, whether it's here in Canada or across the world, please?

If I could, I would go to Dr. Kanem first and then to Dr. Francoeur, for 30 seconds each, please.

Dr. Natalia Kanem: Thank you so much.

You underscored that maternal mortality can be a tragedy, but it can also be averted. Preventable maternal death is what we focus on. Maternal mortality reduction progress has been considerable, yet over 280,000 women globally still die yearly since 2020 from preventable causes. I hasten to say that approximately 70% of global maternal deaths occur in sub-Saharan Africa alone, followed by central and southern Asia, which account for almost 17%.

Midwives are part of the answer to that conundrum. A midwife is capable of calling the local code pink, if you will, even in a small clinic, and she does this very well. That's why it's a focus of our training.

Thank you.

● (1300)

Mr. Francesco Sorbara: I would say that all three of our daughters were born via the midwifery system.

The Chair: You're out of time, sorry. Thank you.

We go to Mr. Bergeron next.

Mr. Bergeron, you have one minute.

[*Translation*]

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

I thank the witnesses for being here.

Ms. Kanem, you are an under-secretary-general of the United Nations and executive director of the United Nations Population Fund, UNFPA. According to UNFPA, Afghanistan is one of the most dangerous places to give birth in the world. On average, a woman dies there every two hours from pregnancy and childbirth.

What can be done? What can Canada do to try to reverse this trend?

[*English*]

Dr. Natalia Kanem: Thank you.

UNFPA stands in solidarity with the women of Afghanistan. We remain deeply concerned about the de facto authority's decision to ban female aid workers from working in humanitarian NGOs. In Afghanistan, UNFPA's work includes the provision of maternal reproductive health and psychosocial support services. To date, we have been able to keep over 1,400 female service providers, as the health sector has been exempted from that recent decree banning female aid workers.

Our delivery points are functional; however, the overarching issue of the insistence on equal treatment and equality for women is the fundamental issue there. We also work through microsystems of clinics, which may be small, household-based clinics, and also mobile clinics because the terrain is so challenging. Ultimately, the women and girls of Afghanistan need tremendous amounts of support during a season of hunger and cold. Protection during childbirth is one of the aims that we do share.

Thank you.

The Chair: Thank you.

For the last question, we go to MP McPherson.

You have one minute.

Ms. Heather McPherson: I'm going to pass it back to our guests in the room and ask if they could share any more information on access, in Canada and around the world, to abortion and SRHR.

Dr. Jocelynn Cook: I was just writing notes to put into your notes, which we'll send later.

We've partnered with UNFPA on a number of global health projects. Because we are a health professional organization with high standards of clinical practice, there's also educating health care providers across different professions. We do have a lot of international projects. We work with countries—sometimes the governments, sometimes the leadership of their own organizations—to figure out what they want. How can we work together to bring our clinical expertise so that we can develop curricula and basically build capacity to train the trainer? We have a great system, and I'm a really good helper there in terms of doing that.

Again, it's creating WhatsApp groups, so they can come back and ask questions of our volunteers who have that technical expertise. There's that piece, in terms of delivery of the care and working directly with the folks on the ground. There's also working with the health professional organizations and sometimes the CEOs of hospitals to figure out how they can foster an environment that's supportive of women and their reproductive rights. Sometimes it's just putting screens around the beds, for example.

I'm happy to elaborate, but I know I don't have any time.

● (1305)

Ms. Heather McPherson: Any notes that you can share with the committee would be fantastic.

Dr. Jocelynn Cook: Absolutely, they will be coming.

Ms. Heather McPherson: Thank you very much.

The Chair: Thank you very much, Madam Under-Secretary, Dr. Francoeur and Dr. Cook. We are very grateful for your insights and your time. It will certainly help us as we prepare the report on the reproductive health and rights of women globally. Thank you.

Friends, before I adjourn the meeting, I want to say that we sent you a detailed budget for the travel proposal for the period of April to June 2023.

[*Translation*]

Mr. Stéphane Bergeron: Mr. Chair, I would like to know if the time period covered can be extended to cover the summer period?

[*English*]

The Chair: As I have been advised by the clerk, it could conceivably be extended until September.

Is it the will of the committee to adopt the budget?

Some hon. members: Agreed.

The Chair: Okay. Thank you.

The meeting stands adjourned.