



**HOUSE OF COMMONS  
CANADA**

## **MATERNAL AND CHILD HEALTH**

### **Report of the Standing Committee on the Status of Women**

**Hon. Hedy Fry, MP  
Chair**

**JUNE 2010**

**40th PARLIAMENT, 3rd SESSION**

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# **THE STANDING COMMITTEE ON THE STATUS OF WOMEN**

has the honour to present its

## **SECOND REPORT**

Pursuant to its mandate under Standing Order 108(2), the Committee has studied Maternal and Child Health and has agreed to report the following:



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# MATERNAL AND CHILD HEALTH

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## INTRODUCTION

Canada is chair of the G8 in 2010 and will host the G8 leaders' summit in Muskoka, Ontario on June 25 and 26. Earlier this year, the Prime Minister announced that Canada would be championing a major initiative to improve child and maternal health in the world's poorest nations as host of the Summit.

On April 12, 2010, the Standing Committee on the Status of Women unanimously adopted the following motion:

That the Committee study maternal and child health following the government's announcement to make maternal and child health a priority at the G8 in June that Canada will be hosting as long as this is done before the end of May.

The Committee held four meetings with witnesses on this study, and held a subsequent meeting with the Minister of International Cooperation and Development and the Minister for Status of Women.

The Committee has heard that between 340 000<sup>1</sup> and 500 000<sup>2</sup> women die of pregnancy-related causes each year, and almost nine million children under age five die — nearly 40% of these in the first weeks of life. Witnesses have highlighted the importance of maintaining the political will to reduce these numbers. It is the hope of the Committee that the recommendations in this report will contribute to the discussion on how Canada can play a leadership role in addressing the unacceptably high mortality rates among mothers and children in the world today.

## BACKGROUND INFORMATION: MATERNAL AND CHILD HEALTH

The Millennium Development Goals (MDGs) were established by the United Nations *Millennium Declaration* in 2000.<sup>3</sup> These eight goals identify the

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1 Margaret C. Hogan, Kyle J. Foreman, Mohsen Naghavi, Stephanie Y Ahn, Mengru Wang, Susanna M. Makela, Prof. Alan D. Lopez, Prof. Rafael Lozano MD, Prof. Christopher J. L. Murray, *Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5*, Lancet, April 12, 2010.

2 Partnership for Maternal, Newborn and Child Health, *Improving Maternal and Child Health Through Active Partnerships*. [http://www.who.int/pmnch/topics/part\\_publications/2009\\_improvingmnch.pdf](http://www.who.int/pmnch/topics/part_publications/2009_improvingmnch.pdf).

3 United Nations Millennium Declaration, Millennium Summit, September 6 to 8, 2000, <http://www.un.org/millennium/summit.htm> (accessed March 24, 2010).

internationally-agreed upon objectives to be achieved by 2015 to address the world's main development challenges. The eight MDGs are:

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat HIV/AIDS, malaria and other diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: Develop a Global Partnership for Development

Each MDG contains targets that can be measured by designated indicators. The target for reducing child mortality is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. Indicators for monitoring progress toward this target include the under-five mortality rate, infant mortality rate, and the proportion of 1 year-old children immunised against measles.

The targets for maternal health are to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio; and to achieve universal access to reproductive health by 2015. Indicators for monitoring progress include the maternal mortality ratio, the proportion of births attended by skilled health personnel, contraceptive prevalence rate, adolescent birth rate, antenatal care coverage, and unmet need for family planning.<sup>4</sup>

Some progress has been made toward achieving these MDGs, particularly those related to child health. A May 2010 article in the Lancet reports that:

Worldwide mortality in children younger than 5 years has dropped from 11.9 million deaths in 1990 to 7.7 million deaths in 2010, consisting of 3.1 million neonatal deaths,

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4 United Nations, "Official list of MDG indicators," Millennium Development Goals Indicators, <http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm> (accessed: April 27, 2010).

2.3 million postneonatal deaths, and 2.3 million childhood deaths (deaths in children aged 1-4 years).<sup>5</sup>

The Honourable Bev Oda, Minister of International Cooperation told the Committee that “[e]very year three million babies die within the first week of their lives, and almost nine million children in the developing world die before their fifteenth birthday from largely preventable causes, such as pneumonia, diarrhea, malaria, severe acute malnutrition, measles, and HIV.”<sup>6</sup>

The Committee has heard that, although child mortality has decreased, newborn mortality has not, because it is so closely linked to maternal health.<sup>7</sup> Witnesses emphasized the strong link between maternal and newborn mortality.

In spite of progress in the area of maternal health, the United Nations reports that the MDG related to maternal health was the one “towards which there has been least progress so far.”<sup>8</sup> This conclusion was also reached in an article published by the *Lancet* in 2006, which notes that “As it stands now, the health-related MDGs will not be met by 2015.” The maternal mortality rate has decreased from 320 deaths per 100 000 live births in 1990 to 250 deaths per 100 000 live births in 2008.<sup>9</sup> While this is a notable decrease, it is not in line with achieving the MDG target of a 75% reduction by 2015.<sup>10</sup>

The United Nation’s Millennium Development Goals Report 2009 states that: “Greater political will must be mustered to reduce maternal mortality, especially in sub-Saharan Africa and Southern Asia, where negligible progress has been made so far.”<sup>11</sup> It is widely acknowledged that funding shortfalls remain a major constraint to meeting health-related goals such as the one on maternal health.<sup>12,13</sup>

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5 Knoll Rajaratnam, Julie, Jake R Marcus, Abraham D Flaxman, Haidong Wang, Alison Levin-Rector, Laura Dwyer , Megan Costa, Alan D Lopez, Christopher JL Murray . “Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970-2010: a systematic analysis of progress towards Millennium Development Goal 4”. *Lancet*. May 24, 2010 Early Online Publication, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60703-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60703-9/fulltext).

6 Standing Committee on the Status of Women, *Testimony*, Hon. Bev Oda (Minister of International Cooperation), May 26, 2010.

7 Standing Committee on the Status of Women, *Testimony*, Dr. Sharon Camp (President and Chief Executive Officer, Guttmacher Institute), May 5, 2010.

8 United Nations, *The Millennium Development Goals Report 2009*, New York: 2009.

9 In contrast to these rates, Canada’s maternal mortality rate stands at 7 deaths per 100 000 live births.

10 Margaret C Hogan, Kyle J Foreman, Mohsen Naghavi, Stephanie Y Ahn, Mengru Wang, Susanna M. Makela, Alan D Lopez, Rafael Lozano, Christopher JL Murray, “Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5”, *The Lancet*, Volume 375, Issue 9726, 8 May 2010-14 May 2010, Pages 1609-1623.

11 Ibid.

12 Guttmacher Institute. *Adding It Up: the Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*, December 2009.

In June 2009, Canada co-sponsored a landmark resolution at the U.N. Human Rights Council recognizing maternal mortality and morbidity as a pressing human rights concern. One month later, in July 2009, at the meeting of the G8 in Italy, the G8 heads of government agreed that maternal and child health was one of the world's most pressing global health problems.

### **A. The Role of the G8 in Maternal and Child Health**

The G8 includes the United States, the United Kingdom, Canada, France, Italy, Japan, Germany, and Russia. The European Union is a “non-enumerated ninth member”.<sup>14</sup> The heads of state and government of these highly-industrialized countries hold an annual summit to address the major economic, political, and security challenges facing the international system.

The G8 allows leaders of the world’s advanced economies to come together to deliberate on common international challenges and to chart a course going forward. This direct diplomacy and personalized format was intended to facilitate relationships between leaders and the adoption of a more coordinated approach to issues. G8 meeting agendas have evolved over the years from their initial economic focus in the 1970s and 1980s to include a discussion of broader issues pertaining to international security and development.<sup>15</sup>

The responsibility of the G8 chair rotates each year amongst the member states. The host country takes a leading role in driving the priority themes and agenda. At different summits G8 leaders have also been seized with immediate international events. The most important document produced by the G8 summits until 2001 had been communiqués, which were adopted on the basis of consensus. The format of a “Chair’s Summary” came into use beginning in 2002. Moreover, statements or declarations on key issues (e.g. food security; terrorism) and action plans have also featured prominently in recent summits.<sup>16</sup> These declarations represent statements of the group’s objectives and commitments, rather than formal international agreements. Several civil society groups

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13 Unicef. *Tracking Progress in Maternal, Newborn & Child Survival, The 2008 Report*, 2009. p. iv. [http://www.countdown2015mnch.org/documents/2008report/2008Countdown2015FullReport\\_2ndEdition\\_1x1.pdf](http://www.countdown2015mnch.org/documents/2008report/2008Countdown2015FullReport_2ndEdition_1x1.pdf).

14 Stephanie Lee, “The Group of Eight (G8) Industrialized Nations,” *Council on Foreign Relations Background*, March 27, 2009, <http://www.cfr.org/publication/10647/>.

15 Ibid., p. 3.

16 Hajnal, *The G8 System and the G20: Evolution, Role and Documentation*, pp. 179-187. For a full listing of links to summit outcome documents, see University of Toronto, G8 Information Centre, “G7/8 Summits,” <http://www.g8.utoronto.ca/summit/index.htm>.

and academics monitor each country's compliance with the objectives set by the group in an effort to hold states accountable for the commitments that have been made.<sup>17</sup>

Recognizing that there had been a lack of progress with respect to the child and maternal health MDGs,<sup>18</sup> leaders of the G8 countries have discussed maternal and child health at their annual Summits over the past two years. At last year's Summit in Italy, a paragraph in the G8 leaders Declaration, "Responsible Leadership from a Sustainable Future", stated the following on these issues:

We promote a comprehensive and integrated approach to the achievement of the health-related [Millennium Development Goals] MDGs, also maximizing synergies between global health initiatives and health systems. We will accelerate progress on combating child mortality, including through intensifying support for immunization and micronutrient supplementation, and on maternal health, including through sexual and reproductive health care and services and voluntary family planning.<sup>19</sup>

The Declaration went on to describe the group's strategy for tackling these issues:

We warmly support building a global consensus on maternal, newborn and child health as a way to accelerate progress on the Millennium Development Goals for both maternal and child health through (i) political and community leadership and engagement; (ii) a quality package of evidence-based interventions through effective health systems; (iii) the removal of barriers to access for all women and children, free at the point of use where countries chose to provide it; (iv) skilled health workers; (v) accountability for results.

No funding levels were committed to this strategy at the 2009 G8 meeting.

Earlier this year, Prime Minister Stephen Harper announced that Canada would be championing a major initiative to improve child and maternal health in the world's poorest nations as host of the G8 Summit.

## WHAT THE COMMITTEE HEARD

The Committee heard that, in Canada, the lifetime risk of maternal death is one in 11,000. In comparison, in Ethiopia, the risk is one in 27; in Angola and Liberia, the risk is one in 12; and in Niger, one in seven. Of the 10 million women who have died in pregnancy and childbirth since 1990, three-quarters of the deaths were preventable. Millions of other women have been left with crippling injuries or illnesses as a result of

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17 The University of Toronto's G8 Information Centre provides one example of such compliance-monitoring. Their reports may be viewed here: <http://www.g7.utoronto.ca/evaluations/index.html>.

18 G8 Summit, *G8 Leaders Declaration: Responsible Leadership for Sustainable Future*, para. 120, [http://www.g8italia2009.it/static/G8\\_Allegato/G8\\_Declaration\\_08\\_07\\_09\\_final.0.pdf](http://www.g8italia2009.it/static/G8_Allegato/G8_Declaration_08_07_09_final.0.pdf) (accessed March 24, 2010).

19 *Ibid.*, para. 122.

poor care during childbirth.<sup>20</sup> The Committee has also heard that “the most dangerous time in a child’s life is during birth and shortly thereafter. Newborn babies — those in their first four weeks of life — account for over 40 percent of deaths among children under age 5.”<sup>21</sup>

The case for action is compelling.

There were many more areas of consensus among witnesses than areas of division. Witnesses emphasized the importance of providing a comprehensive package of services along the continuum of care, of strengthening health systems, and of supporting locally-driven initiatives. Witnesses agreed that new financial commitments are required to make progress on meeting MDGs 4 and 5.

## **COMPREHENSIVE PACKAGE OF SERVICES ALONG THE CONTINUUM OF CARE**

Most experts advocate that, to reduce mortality during childbirth and in newborns, programming efforts must focus on the effective and integrated delivery of interventions and approaches. In its brief to the Committee, the Partnership for Maternal, Newborn and Child Health outlined the continuum of care required in a health system which can effectively address maternal and child health as follows:<sup>22</sup>

- Comprehensive family planning—advice, services and supplies.
- Quality, skilled care for women and newborns during and after pregnancy and childbirth, including antenatal care, quality delivery care in a health facility, emergency care for complications, postnatal care, and essential newborn care.

The literature around maternal and child health consistently highlights that many single interventions are available, but none alone can reduce the rate of maternal and newborn mortality in a population.<sup>23</sup> As Robert Fox, Executive Director of Oxfam Canada told the Committee:

We need to understand that in taking on this issue, there's no quick fix. It's not a little thing here; it's not a little thing there. It is a comprehensive, integrated response that is

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20 Standing Committee on the Status of Women. *Testimony*, Ms. Janet Hatcher Roberts (Executive Director, Canadian Society for International Health), May 3, 2010.

21 Save the Children, *State of the World's Mothers 2010*, May 2010, p. 5.

22 Brief submitted by Dr. Dorothy Shaw, the Partnership for Maternal, Newborn and Child Health. *Improving Maternal Newborn and Child Health: Providing Solutions—The G8 and Its Role*, May 3, 2010.

23 Ronsmans, Carine, Wendy J Graham, on behalf of The Lancet Maternal Survival Series Steering Group “Maternal mortality: who, when, where, and why”. *Lancet*. 2006 Sep 30;368(9542):1189-200.

required to deal with the full range of health and human services to ensure that people can secure their sexual and reproductive rights, but that also situates that in the broader context.<sup>24</sup>

Witnesses suggested that a doubling of investments in both family planning and maternal and newborn health would “reduce maternal mortality by 70%, cut nearly in half newborn deaths, and generate a range of other development benefits.”<sup>25</sup>

## A. Family Planning

More than half of women in developing countries want to delay or prevent pregnancy, yet a quarter of them are not using modern contraceptives, usually because of poverty, lack of education or lack of services.<sup>26</sup> There are 215 million women in the world who would like to delay or avoid child-bearing but do not have access to modern contraception.

Several witnesses told the Committee that “[e]vidence shows that access to family planning alone could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unsafe abortions, and stop childbearing when they have reached their desired family size. After giving birth, family planning can help women wait a healthy period of time (at least two years) before trying to become pregnant again, thereby reducing newborn, infant and child deaths significantly.”<sup>27</sup>

Witnesses referred to the research of the Guttmacher Institute and the United Nations Population Fund to demonstrate that investments in family planning as part of the comprehensive package of maternal health would save more lives for less money. The Guttmacher Institute study estimated cost and benefits of three alternative investment strategies for reducing maternal deaths:

- 1) In the first scenario, they calculated the cost-effectiveness of increasing investments in family planning alone to a level sufficient to address 100% of the unmet need for modern contraception.

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24 Standing Committee on the Status of Women, *Testimony*, Mr. Robert Fox (Executive Director, Oxfam Canada), May 5, 2010.

25 Standing Committee on the Status of Women, *Testimony*, Dr. Sharon Camp (President and Chief Executive Officer, Guttmacher Institute), May 5, 2010.

26 Brief submitted by the Canadian Society for International Health. *Improving Maternal Health: A Health Systems Response Evidence for Global Action*.

27 Singh, S., Darroch, J., Ashford, I., Vlassoff, M., “Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health”. April, 2010. In a brief submitted by Canadian Society for International Health, *Improving Maternal Health: A Health Systems Response Evidence for Global Action*.

- 2) In the second scenario, they calculated the cost-effectiveness of making new investments only in maternal newborn health to a level sufficient to provide the WHO-recommended package of basic maternal newborn care to all those women and newborns needing it.
- 3) In the third scenario, they calculated the cost-effectiveness of combining both the additional investments in family planning and those in maternal newborn care.

Their study concluded that “[d]oubling investments in both family planning and maternal/newborn health from the current level of under \$12 billion U.S. a year to roughly \$24.6 billion would cut maternal deaths by at least 70% and newborn deaths by 44%. The combined investment strategy would save more lives. It is also \$1.5 billion a year less expensive than investing in maternal and newborn health alone.”<sup>28</sup>

As Jolanta Scott-Parker of the Canadian Federation for Sexual Health told the Committee, “[t]here is strong evidence to show that family planning saves lives. The World Bank estimates that 40% of maternal deaths could be prevented by a wider uptake of reliable contraceptive methods.”<sup>29</sup>

Many witnesses referred to the issue of unsafe abortion. The Committee heard that:

approximately 70,000 women die each year due to unsafe abortions...Five million women are hospitalized because of complications resulting from unsafe abortion and this number does not even include the other three million women who do not have access to a hospital. The complications those women are experiencing can have short-term and long-term consequences that would cost their governments more money than funding safe abortion services.<sup>30</sup>

In developing countries, children under one year old have an 80% risk of dying within two years after their mother’s death, and 50% of children under 5 will not reach adulthood.

Regarding the health impact of unsafe abortion, the Programme of Action of the International Conference on Population and Development states that:

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28 Standing Committee on the Status of Women, *Testimony*, Dr. Sharon Camp (President and Chief Executive Officer, Guttmacher Institute), May 5, 2010.

29 Standing Committee on the Status of Women, *Testimony*, Ms. Jolanta Scott-Parker (Executive Director, Canadian Federation for Sexual Health), May 10, 2010.

30 Standing Committee on the Status of Women, *Testimony*, Ms. Ainsley Jenicek (Project Manager, Fédération du Québec pour le planning des naissances), May 10, 2010.

abortion in no way should be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services.<sup>31</sup>

Witnesses suggested that “while we will never completely reduce the need for abortion, we can bring it down very substantially if we meet women's need for modern contraception.”<sup>32</sup> Mr. Robert Fox of Oxfam Canada told the Committee:

We clearly need an integrated approach. We need to deal with the reality of people's lives. Abortions are going to happen, but that isn't the question. The question is whether they are going to happen in hospitals or with medical attention for women who are not wealthy. We need to ensure that the system understands that this is one integral element of a broader approach and that to the extent that we deal with it properly, we will, in fact, minimize how often it happens and when it happens. And we will ensure that when it happens, it happens with the best possible outcome for everyone involved.<sup>33</sup>

## **STRENGTHENING HEALTH SYSTEMS**

We have seen in the discussion above that a comprehensive approach to maternal and child health is more effective. One aspect of a comprehensive approach is the strengthening of the health system. This includes investing in the health care workforce and reinforcing national health care systems.

### **1. Investing in the Health Care Workforce**

Witnesses highlighted the importance of providing skilled care to mothers and babies during pregnancy, childbirth, and in the minutes, days and weeks following birth.<sup>34</sup> Despite this, 40% of the world's women deliver without skilled attendants. This rate is considerably higher in Africa. For example, over 90% of women in Ethiopia give birth without skilled help.

Witnesses told the Committee that “[s]killed and motivated health workers... in the right place at the right time with the necessary infrastructure, drugs and equipment are an

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31 United Nations, Programme of Action adopted at the International Conference on Population and Development, Cairo, September 5 to 13, 1994, paragraph 8.25.

32 Standing Committee on the Status of Women, *Testimony*, Dr. Sharon Camp (President and Chief Executive Officer, Guttmacher Institute), May 5, 2010.

33 Standing Committee on the Status of Women, *Testimony*, Mr. Robert Fox (Executive Director, Oxfam Canada), May 5, 2010.

34 Save the Children, *State of the World's Mothers 2010*, May 2010, p. 5.

essential part of the solution.”<sup>35</sup> They identified the importance of increasing the number of front-line health workers who are supported, trained, equipped and motivated to deliver essential services to mothers and children at the community level close to home.

Developing countries have too few health care workers to address the needs of mothers, their babies and young children. The international development agency, Save the Children, has documented that “there are 57 countries with critical health workforce shortages, meaning that they have fewer than 23 doctors, nurses and midwives per 10,000 people. Thirty-six of these countries are in sub-Saharan Africa.”<sup>36</sup> They report that there is a global need for an additional 4.3 million health workers if we are to meet the Millennium Development Goals by 2015.

## 2. Strengthening Health Systems

The Committee repeatedly heard that there are important variations in needs between regions and countries, and that there is no one-size-fits-all approach to improve maternal health and to reduce maternal and child mortality. Interventions have to respond to the local needs, capacities, laws and cultural norms.

Witnesses emphasized the importance of strengthening national health systems in a comprehensive fashion. This includes providing equitable access to health care and responding to community needs. Equitable access requires removing barriers to access, with services for women and children being free at the point of use.

The Committee heard that “[t]he more things are harmonized at a country level, at a national level, the more ability people have to implement programs that are comprehensive and represent a continuum of care.”<sup>37</sup> Witnesses reminded the Committee that, as a signatory to the Paris Declaration on Aid Effectiveness, Canada has agreed to be directed by individual countries in terms of what they need for their health systems and for their development dollars. It heard evidence that the fragmentation of foreign aid makes it difficult to develop a coherent, concerted, international response.

The Committee has also heard that the majority of countries have already developed national plans for maternal and newborn health. For example, African leaders developed the Maputo Plan of Action on sexual and reproductive health and rights.

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35 Standing Committee on the Status of Women, *Testimony*, Ms. Christina Dendys (Executive Director, Results Canada), May 12, 2010.

36 Save the Children, *State of the World's Mothers 2010*, May 2010, p. 5.

37 Standing Committee on the Status of Women, *Testimony*, Ms. Janet Hatcher Roberts (Executive Director, Canadian Society for International Health), May 3, 2010.

## FINANCIAL COMMITMENTS ARE NEEDED

All witnesses who addressed funding for MDGs 4 and 5 noted that additional funding would be required to reach the MDG targets on time. This financial investment must be shared between the developing countries and donor countries. The Committee has heard that the developing countries have done a much better job than donors in meeting these financial investments:

In the budget and the agreement on how to meet the cost of the Cairo plan of action, developing countries said they would contribute two-thirds of the cost and donor governments said they would pick up the remaining third. Fifteen years after Cairo, who has lived up to their commitment? It's the developing countries themselves, because they saw what a difference it made.<sup>38</sup>

The Committee heard that, with an adequate funding commitment, it is possible to save the lives of up to a million women from pregnancy and childbirth complications, to save the lives of 4.5 million newborns, 6.5 million children, and 1.5 stillbirths. And there would be a significant decrease in the global number of unwanted pregnancies and unsafe abortions.<sup>39</sup> Witnesses recommended that funding be new funding, and not detract from other development assistance.

Witnesses were united in wanting to improve the lives of mothers and children around the world. In the words of Jill Wilkinson Sheffield, President of Women Deliver:

Global consensus has been achieved before; we can do it again. In fact, we have to do it again for the sake of the women and the girls and our futures worldwide.<sup>40</sup>

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38 Standing Committee on the Status of Women, *Testimony*, Ms. Jill Wilkinson Sheffield (President, Women Deliver), May 3, 2010.

39 Standing Committee on the Status of Women, *Testimony*, Dr. Dorothy Shaw (Canada Spokesperson, Partnership for Maternal, Newborn and Child Health (PMNCH)), May 3, 2010.

40 Standing Committee on the Status of Women, *Testimony*, Ms. Jill Wilkinson Sheffield (President, Women Deliver), May 3, 2010.



## **LIST OF RECOMMENDATIONS**

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The Committee was united in wanting to improve the lives of mothers and children around the world. The Committee recommends:

- 1. That the Prime Minister encourage his G8 counterparts, other countries, and public and private sector donors to collectively and adequately fund the maternal health commitments undertaken at the 2009 G8 Summit. In order to achieve this objective, the Committee further recommends that the level of funding committed at the upcoming G8 Summit in Canada be sufficient to close the gap that exists in international financing between current levels and what is needed to achieve the Millennium Development Goals (MDGs) on child and maternal health by 2015, estimated at \$30 billion over the next five years. All development commitments should be time bound, with clear start and end dates; they should be explicit about whether funding is additional or inclusive of previous commitments; and they should also be clear about how much each donor and partner country is contributing.**
- 2. That the Government of Canada play a strong leadership role at the upcoming G8 Summit in Muskoka by making a firm commitment to realize its share of the G8 funding that will be needed to meet the MDGs on child and maternal health by 2015, an amount which is estimated to be \$1.4 billion over the next five years. This commitment should represent new funding and should not be allocated at the expense of existing programs.**
- 3. That the Government of Canada ensure that the financial support provided to developing countries to improve maternal and child health is delivered in a way that is consistent with the commitments undertaken in the Paris Declaration on Aid Effectiveness, by working within national plans for maternal and newborn health, where these exist.**
- 4. That the Government of Canada's financial commitment to the G8 maternal and child health initiative include funding for all evidence-based interventions across the continuum of care for both mothers and children, as called for by the Maputo Plan of Action and the Cairo Plan of Action. This comprehensive plan should include, but not be limited to: training and support for frontline health workers; better nutrition and provision of micronutrients; treatment and prevention of diseases such as**

**pneumonia, diarrhea, malaria and sepsis; screening and treatment for sexually transmitted diseases, including HIV/AIDS; proper medication; immunization; clean water and sanitation; dissemination of reproductive health and family planning advice, services and supplies; access to safe abortion services where abortion is legal; quality emergency care for complications from unsafe abortions; skilled care for women and newborns during and after their pregnancy; access to emergency obstetric care; and births attended by trained personnel. The Committee recommends that Canada encourage its G8 counterparts to follow suit.**

- 5. That the G8 encourage a policy environment that permits appropriate community based delivery of treatments for the main childhood illnesses and injuries with an emphasis on pneumonia, diarrhea, malaria, measles, mumps and rubella, and newborn care for sepsis.**

## APPENDIX A LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
<b>Canadian Society for International Health</b> Janet Hatcher Roberts, Executive Director	2010/05/03	15
<b>Partnership for Maternal, Newborn and Child Health (PMNCH)</b> Dorothy Shaw, Canada Spokesperson		
<b>Women Deliver</b> Jill Wilkinson Sheffield, President		
<b>Action Canada for Population and Development</b> Katherine McDonald, Executive Director	2010/05/05	16
<b>Gutmacher Institute</b> Sharon Camp, President and Chief Executive Officer		
<b>Oxfam Canada</b> Robert Fox, Executive Director		
<b>White Ribbon Alliance for Safe Motherhood</b> Maureen McTeer, Canadian Representative		
<b>Canadian Federation for Sexual Health</b> Jolanta Scott-Parker, Executive Director	2010/05/10	17
<b>Fédération du Québec pour le planning des naissances</b> Ainsley Jenicek, Project Manager		
<b>International Confederation of Midwives</b> Bridget Lynch, President		
<b>International Planned Parenthood Federation</b> Pierre La Ramée, Director, Development and Public Affairs, Western Hemisphere Region		
<b>Regroupement Naissance-Renaissance</b> Lorraine Fontaine, Coordinator, Political Issues		
<b>AUTO21</b> Anne Snowdon, Researcher	2010/05/12	18
<b>Results Canada</b> Christina Dendys, Executive Director		
<b>Safe Kids Canada</b> Pamela Fuselli, Executive Director		

Organizations and Individuals	Date	Meeting
<b>Save the Children Canada</b>	2010/05/12	18
Cicely McWilliam, Coordinator, EVERY ONE Campaign		
<b>Canadian International Development Agency</b>	2010/05/26	19
Margaret Biggs, President		
Hon. Bev Oda, Minister		
<b>Status of Women Canada</b>		
Hon. Rona Ambrose, Minister		
Suzanne Clément, Coordinator, Head of Agency, Office of the Coordinator		
Suzanne Cooper, Research Analyst		

## **APPENDIX B LIST OF BRIEFS**

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### **Organizations and Individuals**

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**Canadian Society for International Health**

**Partnership for Maternal, Newborn and Child Health (PMNCH)**



# REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings ([Meetings Nos. 15, 16, 17, 18, 19, 22, 23 and 26](#)) is tabled.

Respectfully submitted,

Hon. Hedy Fry, MP

Chair

