Palliative Interventions:
Canadian Foreign Policy, Security, and Global Health Governance

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Colleen O'Manique
Trent University, Peterborough, Canada
comanique@trentu.ca

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Introduction

Thirty years ago, 134 representatives of member states of the World Health Organization (WHO) gathered in Alma Ata in the former Soviet Union, and drafted and unanimously adopted the Alma Ata Declaration, 'Health for All by the Year 2000.' The much publicized declaration called for "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life", and the cornerstone of achieving health for all, the implementation of a broad based primary health care vision. What happened next? Certainly some gains in some places were made. But in the three decades that followed, the governance of global health shifted away from the state and World Health Organization (WHO); first toward the World Bank, whose 1993 report *Investing in Health* signalled its growing interest in global health policy. Over the years a much broader network of state and non-state actors – civil society organizations, the G7/G8, and more recently, the new rich: global elites in the high tech and entertainment industries through their philanthropy have become major players in the governance of global health. As neo-liberal policies of structural adjustment eroded public health care systems ('short-term sacrifices' that well-fed macroeconomists insisted needed to be made) the discourse of Primary Health Care was replaced with that of economics, (cost recovery, willingness to pay, technical efficiencies, opportunity costs); single disease, vertical interventions became fashionable, and the understanding of health as a basic right gave way to health as a commodity provided by the market, poor health increasingly disengaged from its social and political roots.

Through these decades, Canada emerged as a significant actor in global health governance, active through both bilateral and multilateral channels, and as part and parcel of the G7/G8. Viewed historically as a nation that 'does the right thing', Canada provided leadership in 2001 to set up the Global Fund for HIV/AIDS, Tuberculosis and Malaria; was a major instigator of the WHO's '3 by 5 Initiative' to provide anti-retroviral treatment to 3 million people with HIV/AIDS; and in 2005 passed a bill to make less-expensive generic drugs available to developing and least developed countries. Canada's International Policy Strategy of 2005 identified health as a programming priority in Canada's development cooperation program, consistent with Canada's recent history of health related development assistance. But a closer examination challenges Canada's reputation as a leader in global health governance. Canada has deviated little from promoting a global health research and policy agenda that focuses on the global health priorities of the G8 while Canada's overarching foreign policy agenda can be shown undermine the health and security of communities outside of Canada's borders.

The HIV/AIDS pandemic, a resurgence of infectious diseases, bio-terrorist threats, tainted food scandals, and mounting controversies over trade-related intellectual property rights and access to

medicines have put public health more firmly on the foreign policy agenda.[1] Canada claims to be a leader in promoting a foreign policy that has human security as one of its pillars. Human security is a broad concept that places the individual at the centre of security, understood as 'freedom from want and freedom from fear,' shifting the focus from state-centric notions. Rosalind Irwin argues that in Canada and elsewhere, much of the human security agenda is incommensurable with national security agendas which reflect the unequal Westphalian divisions of political sovereignty and global structural inequalities in power and wealth.[2] It is in this context that Canada's role in global health can be seen as a complicated mix of national 'self-interest' (defined broadly within the parameters of neo-liberalism) and 'doing the right thing;' its role consistent with the country's self-image as a middle power state and its rhetorical commitment to human security and human rights.

This paper begins to examine some of the contradictions between Canadian foreign policy goals and Canada's role in global health governance, focusing on Canada's official development assistance (ODA) in health (including Canada's role in responding to the HIV/AIDS pandemic) and the Canadian government response to the new 'global threats' of SARS and avian influenza. I begin with a brief discussion of some of the relatively recent global forces that condition disease distribution and health system. The paper then discusses Canada's post-war foreign policy direction, and Canada's relatively recent history of global health governance. I conclude with some preliminary thoughts on the conflicts between Canada's role in global health governance and Canadian foreign policy.

Global Health Determinants

Since Alma Ata, there have been some indicators of improvement in global health: average worldwide life expectancy has increased, infant mortality has declined, the under-five mortality rate has improved, and vaccination coverage has increased. At the same time, a deeper examination complicates the positive picture that global health is improving. New pharmaceuticals and medical technologies have mainly benefited high and middle income countries, and high and middle-income citizens within those countries as well as within the global South, while reversals have followed distinct pathways, shaped by unprecedented rises in inequality, the erosion of public health care systems, and the basic constituents of health, or health's 'social determinants.' According to the most recent WHO World Health Report (2006) life expectancies have collapsed in some of the poorest countries (most in Sub-Saharan Africa) to half the level of the richest. The 2005 WHO World Health Report states that eleven million children younger than five would die in that year, more than half from hunger related causes and most of the rest from preventable and treatable infectious diseases and HIV infection. Recent reviews of research on HIV/AIDS, tuberculosis and malaria, three diseases which together account for almost six million deaths per year, identify poverty, gender inequality, development policy and health sector 'reforms' that involve user fees and reduced access to care as some of the causal factors.[3] More than four million child deaths per year are attributable to diarrhoeal disease, lower respiratory infections and vaccine-preventable diseases; causes of death that are highly infrequent in the industrialized world, and under-nutrition is an underlying cause of roughly half

[1] David P. Fidler and Nick Drager 'Health and Foreign Policy', *Bulletin of the WHO*, Sept 2006, 84 (9) p.687.
[2] Rosalind Irwin (ed) *Ethics and Security in Canadian Foreign Policy* Vancouver: UBC Press, 2001.
[3] I. Bates, C. Fenton, J. Gruber, D. Lalloo, L.A. Medina, S.B. Squire et al. "Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part II: determinants operating at the environmental and institutional level. *Lancet Infectious Diseases* 2004:4 (June 2004):368-75; I. Bates, C. Fenton, J. Gruber, D. Lalloo, L.A. Medina, S.B. Squire et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part I: determinants operating at individual and household level. *Lancet Infectious Diseases* 2004, 4(May 2004):267-77.

these deaths.[4] 850 million people on the planet suffer from chronic hunger, consuming less than the minimum needed for sound health.[5] Close to one-half of the population in the global south are suffering from one or more of the main diseases associated with inadequate provision of water and sanitation services, diseases that kill approximately two million children yearly and more than a billion around the world lack access to safe drinking water. [6]

An understanding is beginning to emerge, in part sparked by the threat of new viral pandemics, that improved access to public health care is critically important. (cite most recent WHO report on health security). After years of erosion related to fiscal restraint and privatization, the general consensus is that health sector reforms instituted to increase 'efficiency' have been largely detrimental to the health conditions of the poorest, and have instigated a massive skills drain from south to north, from greatest to least need. Many national health systems today are unsafe, unresponsive, and inequitable, disease surveillance systems in some parts of the world close to non-existent. Prevailing orthodoxies that inform health policy and approaches to disease management focus on technical innovations and single- disease campaigns (such as vaccines, pesticide impregnated bed nets, oral re-hydration therapy, micronutrient supplementation, ARV scale up). Though they might save lives an improve health outcomes, they are palliative and system maintaining to the extent that they leave intact the structural drivers shaping huge disparities in global health.

Disease distribution today follows pathways that are significantly shaped by forces that are 'global' in nature such as climate change, economic restructuring and trade policy, and military conflict. The consequences to human health are not democratically distributed, but follow asymmetries in power and wealth along the lines of geography, race and ethnicity, class and gender. The costs of global climate change are borne by those with the smallest environmental footprint, have the least capacity to respond, and are the most reliant on their local environment for their livelihoods and sustenance. 97 percent of deaths from what are understood to be natural disasters are in the global South.[7] Increased floods, droughts, water- and vector- borne diseases, crop failures, and diminishing livestock and reduced biodiversity disproportionately affect the poor, and disproportionately women and children. While many countries in the global South continue to deal with the problems of infectious disease and under-nutrition, at the same time there has been a rapid upsurge in chronic disease risk factors such as obesity and overweight, particularly in urban settings in South and South East Asia and the Americas. Many low and middle income countries are now facing a 'double burden of disease': under-nutrition and obesity existing side-by-side, fostered by inadequate pre-natal, infant and young child nutrition followed by exposure to high-fat, energy-dense, micronutrient-poor foods and lack of physical activity (WHO 2006 Global Dietary changes). The paradox of obesity and starvation existing in close quarters is not unrelated to the consolidation of a global agro-industrial model in which a handful of conglomerates monopolize the processing, marketing, and distribution of food, at the expense of local markets, the nutritional needs of human bodies, long established local food cultures and economies, and local ecosystems. The effects of environmental instability, ecological crisis, increased commodification of biological necessities, and military policy, are manifested in the body.

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[4] WHO, *World Health Report* 2003.

[5] Food and Agricultural Organization, 2005.

[6] Loren Becker, Ruth Levine, Jessica Wolf, 2006. *Measuring Commitment to Health.* Global Health Indicators Working Group Consultation Report: Centre for Global Development. p. 22

[7] DFID White Paper, 2006, *Making Governance Work for the Poor.* p.94.

Canadian Foreign Policy

Mainstream accounts circulating in policy circles give an uncritical view of Canada as a 'moral leader' on the international stage, our foreign policy fostering the conditions for human security abroad while ensuring the security of Canadians at home. Canada's post-war foreign policy has been shaped, at least in part, by an ambiguous and shifting concept of human security. Prior to the Second World War, Canadian Foreign Policy (CFP) closely mirrored Britain's but Canada's post-war engagement with the creation of international institutions cemented its reputation (at least in the eyes of the Canadian public) as an enlightened and able middle power. In the post war years CFP has been conditioned by Canada's proximity to the United States and the country's heavy dependence on foreign investment, Laura Macdonald and others arguing that its history has been to a large extent, the story of successive attempts to manage economic integration with the United States while maintaining some degree of independence.[8] The deliberate strategy of strengthening Canada's middle power status was a means of establishing a degree of autonomy from the superpower next door; it was not radical, and while criticisms of US foreign policy existed, they tended to be muted. The emergence of Canada as an able middle power may well have been shaped by the vision and ideals of its political leaders and a Canadian public who were forming a national identity as 'the world's helpful fixer,' a vision of their country more perceived than real, in Chapnick's view. [9] The active attainment of middle power leadership was also strategy of preventing Canada's legacy as a British colony from falling into its destiny as an American one.

In Canada, the notion that state security rests with broader peace and prosperity outside of its borders is not new, its antecedents going back to 1944 and Mackenzie King. In his words, "Security from war is indeed essential, but real security requires international action and organization in many other fields – in social welfare, in trade, in technical progress, in transportation, and in economic development."[10] But it was Lester Pearson who has been largely credited with solidifying Canada's image as a state that promotes human security on the world stage. Pearson's reputation as an international peace broker and peace keeper emerged from his instrumental role in the formation of the UN, tenure as President of the UN General Assembly, and his Nobel Peace Prize in 1957 for his proposal to create a peacekeeping force during the 1956 Suez Crisis. Political leaders have since linked human security to national security as a principle of Canadian foreign policy. Former Prime Minister Pierre Trudeau stated in a 1969 speech that "It is in our national interest to reduce the tensions in the world, tensions which spring from the two-thirds of the world's population who are poor whereas the other third is rich and the tensions which spring from this great ideological struggle between the East and the West." Lloyd Axworthy's time as minister of foreign affairs (beginning in 1996) under Jean Chretien's tenure as Prime Minister, marks Canada's central roles in the campaign to ban Anti-personnel landmines, the creation of the International Criminal Court, Canada's chair-ship of the Kimberly Process in 2004 and more recently, in the drafting of the blueprint for the 'responsibility to protect' forged out an international commission established by the Canadian government. Axworthy was an active campaigner against the use of child soldiers and the international trade in light weapons.

During the decade of the 90s the concept of human security became more popular in the discourses of global development, promoted by civil society organizations, policy and research

[8] Laura MacDonald, 1997. "Going Global: The Politics in Canada's Foreign Economic Relations" in *Understanding Canada: Building on the New Canadian Political Economy*. Ed. Wallace Clement. Montreal: McGill-Queen's University Press. P.175

[9] Adam Chapnick, 2005. *The Middle Power Project.* Vancouver: UBC Press. p.152

[10] Adam Chapnick, 2006. "UN Security Council Reform and Canadian Foreign Policy: Then and Now" in *Canadian Foreign Policy* vol. 13: 1 p.84

institutes and western governments alike. Strong civil society organizations in Canada have been instrumental in pushing the human security agenda, a logical extension of 'Canadian values' that are said to be reflected, for example, in Canada's universal health care system and welfare state policies of redistribution. With regard to ODA, Cranford Pratt has argued that an important determinant between 1966 and 1975 was the government's increased responsiveness to poverty at home, this responsiveness a result of the strong and active campaigning of human rights, social justice and church groups. But he adds that the government's central preoccupation with advancing Canadian international economic and political interests has historically diluted the humanitarian focus on Canadian aid, reversing an earlier trend that suggested increasing government responsiveness to human values.[11] Other critical commentators view Canada's high profile activities on the international stage as 'quick wins' that have served to increase Canada's status and prestige both at home and abroad. David Black characterizes the discourse of human security as palliative and system- maintaining; although Canada's iteration of human security encompassed both 'freedom from fear' and 'freedom from want' that was encapsulated in the UNDP's discourse-shifting global report of 1995, by 1999 DFAIT had dropped 'freedom from want' in favour of a narrower 'freedom from fear' approach.[12] In the same year, Canada adopted 'projecting Canada's values and culture' as one of the three pillars of its foreign policy platform; the other two, ensuring global security and the security of Canadians, and promoting the prosperity of Canadians and global prosperity. Kyle Grayson makes the argument that the discourse of human security has provided Canada with 'brand recognition'; that the issues that Canadians have focused on – antipersonnel landmines, child soldiers, small arms transfers – are not divisive, require no sacrifice, and are shared by people across the political spectrum (p.49). "…while the Canadian human security agenda has been able to brand itself as transformative, the ways in which it has conceptualized contemporary security issues has done far too little to address the underlying global, political, social and economic inequalities that make these possible." [13]

But as Canada's foreign policy has distanced itself from 'freedom from want', little has changed in the discourse of enlightened internationalism. Canada's most recent International Policy Statement, under the title "A Role of Pride and Influence in the World," released in April 2005 as the government's first integrated international policy framework, lays out the 'vision' and 'action plan' in four areas: diplomacy, development, defence, and commerce to guide the activities of DFAIT, CIDA and National Defence. In the Introduction to the overview, the former Prime Minister, Paul Martin states:

> "Why is the time right for a foreign policy review? Because we want to make a real difference in halting and improving human welfare around the world. This may sound naively altruistic, but it's not. Rather, it's a doctrine of activism that over decades had forged our nation's international character – and will serve us even better in today's changing world. The people of our country have long understood that, as a proud citizen of the world, Canada has global responsibilities. We can't solve every problem, but we will do what we can to protect others to raise them up, to make them safe.

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[11] Cranford Pratt, 2001. "Moral Vision and Foreign Policy: The Case of Canadian Development Assistance" in *Ethics and Security in Canadian Foreign Policy.* Ed. Rosalind Irwin. Vancouver: UBC Press p.73

[12] David R. Black, 2006. " Mapping the Interplay of Human Security Practice and Debates: The Canadian Experience" in *A Decade of Human Security.* Sandra J. MacLean, Timothy M. Shaw and David Black Eds. Hampshire: Ashgate p. 55

[13] Kyle Grayson, 2004. 'Branding Transformation in Canadian Foreign Policy: Human Security' in *Canadian Foreign Policy* vol.11 no.2 Winter 2004. p.54

...real progress means not only keeping the pace but doing the hard work of building the systems of health, education and justice that will enable people to grow, to succeed, to thrive."[14]

Canadian civil society groups have responded to the contradictions contained in the documents. Far from an 'integrated' approach, it is only within the development document that human security is mentioned at all: "The obligation to address poverty is seen as subsidiary and instrumental to the pursuit of Canada's particular interests in promoting its own prosperity, reducing threats to global terrorism, and responding to regional insecurity" states the Canadian council on International Cooperation (CCIC). With the election of the Conservatives and Stephen Harper as Prime Minister in January of 2006, the IPS guides only the parts of CFP consistent with a stronger relationship and harmonization of foreign policy with that of the United States. Under Harper, any pretence of embedding human security in CFP has been further eroded by an agenda that shifts the focus to anti-terrorism and support for Canadian business interests overseas. Agencies involved in border control, anti-terror and security have received budget increases while Canada's military role in Afghanistan has become the government's flagship foreign policy issue, eating up a significant proportion of Canada's ODA. Between 2001 and 2004, about 28% of total new aid resources were targeted at Iraq and Afghanistan, with Afghanistan now the single largest recipient of bilateral aid. (put in website) Canada's role in Afghanistan signals the convergence of military intervention and humanitarianism for the creation of a 'liberal peace.' Human security has become the justification for military intervention; Canada's Prime Minister can claim that Canada is in Afghanistan to liberate women and girls, and to help secure the conditions for sustainable development. The harmonization of CFP with American 'interests' is further reflected in the government's increase in military spending, abrogation of the Kyoto protocol and consistency with the US position on Israel's use of pre-emptive strikes, and its participation in the relatively new 'Security and Prosperity Partnership' (SPP) with Mexico and the US.

The geopolitical and domestic context of CFP began to shift long before the Harper government took power, however. On the domestic front, change began around in the early 1990s with successive provincial and federal governments overhauling welfare states and promoting economic and political restructuring along neo-liberal lines, following the post- Cold War 'Washington consensus' and the global consolidation of the neo-liberal project. While acknowledging its achievements, Canada's human security agenda has directed little attention to the political and economic forces that undermine human security; it has essentially been 'system maintaining' in Black's words, viewed in isolation from national security agendas, and the changing global distribution of wealth, resources, and life chances. It is in this context that health has recently become securitized, defined as a threat to global order. Global health has been mentioned explicitly as an issue in Canadian foreign policy in the 2002 Romanow Commission Report on the Future of Health Care in Canada. The Report states that health promotion in other countries has been an afterthought in Canadian foreign policy, but that now 'we have an opportunity to ensure that access to health care is not only part of our own domestic policy but also a prime objective of our foreign policy as well' and that Canada should use its leadership role in the world to help improve health and health care around the world. Tony Clement, Canada's Federal Minister of Health had these words for the meeting of the World Health Assembly on May 14th of 2007: "When it comes to global health, more and more we talk in terms of health security. And in Canada's view, our strongest asset is shared knowledge, cooperation our smartest strategy...Whether it comes to continuing our work internationally to safeguard our societies from a pandemic; contribute to the drive for developing desperately needed vaccines; or

[14] *Canada's International Policy Strategy: A Role of Pride and Influence in the World* http://geo.international.gc.ca/cip-pic/ips/ips-overview2-en.aspx accessed Aug 30th, 2007.

sharing our success in developing new policy to protect our people and environment, Canada will always stand as a ready, willing and compassionate partner, as we work together, toward a healthier and more secure world for all." [15]

Global Health and Canada's ODA

Many Canadians remain committed to a strong national public health care system, and to the legacy of Canada in the world (whether perceived or real) as an enlightened middle power committed to social justice. ODA is the normative arm of foreign policy, a mechanism for revealing 'Canadian' values and the underlying humanitarianism of CFP, yet the Canadian government is explicit in its articulation of the links between Canada's ODA and 'security' and prosperity at home. The stated mandate of the Canadian International Development Agency is "To support sustainable development in developing countries in order to reduce poverty and contribute to a more secure, equitable, and prosperous world; to support democratic development and economic liberalization in the countries of Central and Eastern Europe and central Asia; and to support international efforts to reduce threats to international and Canadian security."[16]And the benefits to Canadians? "The aid program plays an important role in Canada's global reach and influence; provides a concrete expression of values Canadians cherish, such as humanitarianism, democracy and human rights; provides security, control of population movements and immigration, as well as protection from global diseases; builds long-term relationships with some of the fastest-growing economies in the world; and helps make the world more secure for Canadians."[17]

David Morrison's comprehensive review of Canadian development assistance captures the contradictory mix of humanitarian, commercial and political goals that have been pursued by foreign aid. Canada extended international cooperation to all parts of the developing world under the leadership of Maurice Strong 1966-1970 and since that time, aid has ebbed and flowed, with the 1980s budget crisis marking the beginning of cutbacks and downsizing to CIDA. Geopolitical and economic context has always shaped the aid regime in Canada and elsewhere, but in contradictory ways. State preferences and policy orientations are have not been fixed. The turn toward neo-liberalism translated into a greater emphasis on private sector development and a drop in Canada's aid budget; at the same time donor programs and projects have responded to the various crises induced by austerity measures, adding a 'human face' to adjustment in the 1980s, and today, ensuring that even the most marginalized can share in the 'benefits of globalization.' Morrison rejects the deterministic flavour of accounts of development assistance that view it as always deferring to corporate hegemony, demonstrating instead that officials within CIDA and Canada's strong voluntary and NGO sectors have pushed hard to promote poverty alleviation and sustainable development. Beginning in the 1980s the discourses of poverty reduction, women and development, environment and human rights became prominent in CIDA and they have continued to shape interventions, to greater or lesser extents. Bill C-293 which was passed in the House of Commons in 2007 established that Canada's ODA must contribute to poverty reduction, take into account the perspectives of the poor, and be consistent with international human rights standards. It is too soon to tell what kinds of changes might emerge from the bill, but the January 2007 Senate Report on CIDA

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[15] Canada's Statement to the World Health Assembly, May 14, Geneva Switzerland, http://www.dfait-maeci.gc.ca/Canada_un/Geneva clf1/2007-05-14-en.asp , retrieved August 20 2007.

[16] CIDA, Departmental Performance Report for the period ending Mar 31 2006: 4

[17] Ibid.

fixes Canada's aid reform securely within the parameters of market liberalism. (This needs elaboration.)

Anne-Emannuelle Birn and Klaudia Dmitrienkos'(2006) account of the recent history of Canadian development assistance in the health sector in Latin America reflects some of the contradictions and inconsistencies between the 'national interest' and 'human security.' They argue that the role of Canadian aid has been multi-fold; to forge an independent foreign policy without challenging traditional US hegemony, to develop cordial relations, and support the general goals and values of the Canadian government. Canada initially distanced itself from Latin America, not wanting to challenge US intervention and hegemony in the region. Involvement in Latin American health was 'more symbolic then substantive'; health aid consisting mostly of the provision of medical equipment and public health training which grew steadily from the mid-1950s and through the 1960s. It wasn't until 1971 that Canada became a member of the Pan American Health Organization (PAHO) only after attacks on Canada's reputation as a generous nation, and its late decision to join was ultimately based upon whether Canada would benefit the $500,000 a year membership. Pierre Trudeau's 1968 foreign policy review called for the strengthening of ties to Latin America leading to an increase in technical assistance in a variety of sectors: rural water and sanitation, nursing and dental health education, health worker training, development of food and drug standards, and emergency preparedness.[18] For Birn and Dmitrienko, given Canada's limited economic and military clout, health aid has been a diplomatic tool in the context of bilateral relations, giving the country a voice in the region. "Providing health and development assistance [was] a means of engendering international prestige and goodwill as well as securing national interests."[19]

Canada was also able to distance itself from American foreign policy in the region by providing aid to Cuba and to Nicaragua. But in 1980, Canada declined to support Nicaragua for a seat on the PAHO executive, citing that a possible 'shift to the left' in PAHO could have negative effects on policies in the region.[20] Though Canada's approach to Cuba was radically different than the United States, John Kirk and Peter McKenna (1997) argue that this was because both Canada and Cuba "were disconcertingly vulnerable to the twitches of the U.S.,"[21] and had a common vested interest in devising strategies to strengthen the sovereignty of each country vis-à-vis Washington. Trade dominated bilateral ties and the main reason to pursue bilateral relations was, and has been to respond to Canadian business interests.[22] During the Trudeau years Canadian aid was granted, but all CIDA programs were halted in May 1977 with the exception of a few essential medical and scientific programs administered by the International Development Research Centre, a Canadian crown corporation at arm's length from the government.[23] The official face-saving rationale was that "CIDA was putting greater emphasis on poorer countries" when in fact the cuts were in opposition to Cuba's military support to Angola and to guerrilla training for the war against Rhodesia's white minority; relations also cooled as a result of Cuba's support for the Sandinista government and for the FMLN in el Salvador. In 1993, when 'the storm of the century' compounded by the abrupt end of the Cuba-soviet relationship and sharp downturn in the economy, resulting in a massive humanitarian crisis, a $250,000 proposal by CIDA for medicines and hospital

[18] Klaudia Dmitrienko and Anne-Emanuelle Birn, "Juggling Demands: Canadian Health Aid to Latin America since WWII, in *Canadian Journal of Public Health*, Nov/Dec 2006, vol.97:6. pp.12-18.
[19] Ibid p.12
[20] Ibid p.16
[21] John Kirk and Peter McKenna (1997) *Canada-Cuba Relations: The Other Good Neighbour Policy*. Gainesville: University of Florida Press. p.4
[22] Ibid p.159
[23] Ibid p.112

supplies was rejected by the Secretary of State for External Affairs. The decision to provide (the rather paltry) basket of assistance was eventually made after persistent lobbying from Canadian NGOs and church groups and led, in 1994, to an opening of a variety of CIDA avenues in NGO division, industrial cooperation division, and bilateral support.

Today, health tops the list of Canada's most recent stated priorities for ODA, the focus on prevention and control of high-burden, communicable, poverty-linked diseases, especially HIV/AIDS, improving infant, child and maternal health, improving water and sanitation, and strengthening health systems.[24] The four other priorities are basic education, governance, private sector development, and tsunami relief and construction, while gender and the environment are considered 'cross-cutting' issues. The most recent budget breakdown puts multilateral disbursements at the top with $450.3 million and health spending constituting 43.6%; of Partnership branch's $41.2 million budget 16% is spent on health, funding 750 Canadian civil society and private sector organizations implementing projects overseas; and bilateral aid stands at $218.1 million, with almost half of that, $98.3 million targeted to African countries, and 20.1% going to health.[25]

Compared to Latin America, Canada's role in global health in Africa has garnered a higher public profile, in large part owing to the severity of the HIV/AIDS pandemic in SSA. HIV/AIDS has dominated donor assistance in Africa over the last decade.[26] In 1987 CIDA began funding HIV/AIDS programs, disbursing over $135 million to HIV prevention, education and care between 1987 and 1999, aid largely concentrated in Sub-Saharan Africa with some activities in the Caribbean, and through multilateral channels such as the World Health Organization Global Programme on AIDS (WHO/GPA) and UNAIDS. The initial Canadian response was heavily tilted toward support for biomedical and behavioural programs, consistent with the global response to AIDS emerging from WHO and then UNAIDS. But soon enough it embraced all the hallmarks of the global multisectoral approach of the 1990s: of gender sensitive training, 'local ownership,' 'mitigating local impacts' and a variety of other AIDS initiatives tied to a 'community base.' The Southern African AIDS Training Program, implemented by the Canadian Public Health Association was first funded for $13 million by CIDA in 1990, with subsequent disbursements of 24.3 million and then in 2002 31.5 million for 5 years, the program viewed as successful and a model to emulate. HIV/AIDS moved deeper into the Canadian spotlight with the appointment of Stephen Lewis in 2001 as the UN Envoy for AIDS in Africa, and with civil society pressure to ramp up aid, especially to SSA. Canada's aid was a drop in the bucket given the severity of the pandemic. (elaborate – G8/OECD comparisons).

Health aid from Canada to countries in Africa deviates little from the list of global priorities set out at G8 meetings and multilateral forums. The Millennium Development goals (MDGs) were adopted in 2000 at the UN Millennium Summit, and have become the central benchmarks around which the global donor agenda is to revolve until 2015. As host of the G8 Summit in Kananaskis, the Canadian government gave itself credit for getting the G8 to embrace NEPAD and the G8 Action Plan in 2002, a policy framework to place Africa on a path of sustainable development emerging from 15 African heads of state and supported by G8 leaders. Aspects of NEPAD have been praised, particularly those relating to conflict resolution and the alleviation of poverty. But it has come under criticism from African civil society organizations for a lack of democratic consultation in its formulation, as well as for fixing its vision uncritically on increased global

[24] Canadian International Development Agency: CIDA Departmental Performance Report, March 31 2006.
[25] Ibid
[26] Ibid

integration and unregulated markets.[27] The MDGs have faced similar criticism. Of the eight goals, three are related directly to health: to reduce infant mortality by two-thirds, maternal mortality by three fourths; and to stop the spread of pandemic disease (AIDS, malaria and tuberculosis); while four other goals address health's social determinants: to reduce extreme poverty by half, achieve universal primary education, promote gender equality and empower women, and promote environmental sustainability. The 8th goal is to 'develop a global partnership for development, the first principle of which declares the development of "an open trading and financial system that is rule-based, predictable and non-discriminatory, includes a commitment to good governance, development and poverty reduction – nationally and internationally."[28] The MDGs do represent a break from the Washington consensus, an acknowledgement that human needs cannot be guaranteed through growth alone; that 'public goods', 'social empowerment' are critical to development and poverty alleviation. But the partnership becomes synonymous with liberal economics and the externally imposed 'good governance' agenda consistent with the range of development declarations of the new millennium, (such as the Monterey Consensus for the financing of Development, and the Paris Declaration), all which reaffirm commitments to trade liberalization, and are unquestioning of the macroeconomic policies that have generated human insecurity and have been unresponsive to human needs.

A number of high profile funding mechanisms have emerged to support NEPAD and the MDGs. At the national level, Canada established the $500 million Canada Fund for Africa to support NEPAD; 22 percent of which is allocated to health; another 28% for agriculture, environment and water, 15% for peace and security, ICTs 7%. [29]Health initiatives supported by the Canada fund include $50 million for AIDS vaccine Research and Development, $50 million for polio eradication through immunization, $12 million for HIV prevention and care targeted at youth, and 1.5 million for childhood development through sport in refugee camps. Since 2000, Canada has committed more than $800 million to global HIV/AIDS, but most of this is through high profile Global Public Private Partnerships, consisting of multilaterals such as UNICEF, IFIs, foundations such as Bill and Melinda Gates, the pharmaceutical industry, and public health institutions. Canada has disbursed $550 million to the Global Fund to Fight AIDS Tuberculosis and Malaria, (60% of which goes to HIV/AIDS); $100 million to the WHO '3 by 5 initiative' (a program to provide 3 million HIV positive people with ARVs by 2005, which ultimately missed its target) of which Canada was the first and largest donor; and 67.4 million to the UNPF, including over $58 million to sexual and reproductive health and HIV/AIDS among women and girls. $100 million was earmarked for 'gender based responses to HIV/AIDS and $15 million for the International Partnership for Microbicides. Canada also supports the Global Polio Eradication Initiative, (GPEI) and has been among the top five donors since its formation in 1988, providing a total of $152 million. The Global Alliance for Vaccines and Immunization (GAVI), has received $200 million between 2001and 2005 from the Canadian government.

In many countries the government is not capable of managing the scale up of AIDS treatment due to lack of health care infrastructure, limited financial resources and human capacity, and evidence suggests that high levels of aid have compromised the quality of local governance (put in refs.). The Global Fund, created to finance "a drastic turn around in the fight against AIDS, tuberculosis and malaria", has disbursed $8.4 billion in 136 countries since its inception. It is a financing instrument that works through 'country coordinating mechanisms' to ensure 'local ownership' and 'participatory decision-making'. Public and private sector organizations can serve as

[27] John Saul (2004) 'Africa: The Next Liberation Struggle?' Theme Paper prepared for the workshop *Socialism, Democracy, Activism*. Department of Political Science, York University, Toronto. p.4
[28] http://www.un.org/millenniumgoals/
[29] (CIDA, Canada Fund for Africa, Delivering Results retrieved Aug 14 2007 http://www.acdi-cida.gc.ca/cidaweb/acdicida.nsf/En/ANN-76105016-KEG)

principal recipients of grants.[30] Like other PPPs, it has been criticized for its narrow focus on treatment and specific technical interventions, and in some instances for undermining the conditions needed for a sound public health system, and for deflecting attention away from the social determinants of health. Often it is the case that grants from large global funds exceed national health budgets, and the uncoordinated nature of the aid regime creates problems of competition between health personnel working in the beleaguered public system and the aid regime. The externally imposed governance agenda consists of the management of the complex web of largely uncoordinated development projects, sometimes competing, at other times complementary. The recent scandal over the misuse of Global Fund grants in Uganda is a case in point. In August 2006, grants were suspended after 'serious mismanagement' in funds was discovered through an outside audit. A former health minister was charged with embezzlement, while other health deputies were accused of abuse of office, causing financial loss and theft. But the graft was more widespread, with hundreds of millions of shillings being spent on generous hardship allowances for everyone from secretaries up, as well as "sensitization workshops."

The laws governing the global trade in pharmaceuticals are central to the governance of global health, with the pharmaceutical companies having a vested interest in the current regime of patent protection. Despite the increasing use of generic first-line drugs through a number of funding mechanisms that have involved preferential pricing, donor purchase of patented drugs for developing country use, and provisions in the TRIPS agreement, newer, less toxic 1st and 2nd line drugs now recommended by WHO remain financially out of reach. (http://www.accessmed-msf.org/) To much public fanfare in 2004, changes were introduced to the *Patent Act* and the *Food and Drugs Act* making Canada the first country to take concrete measures to implement the World Trade Organization's (WTO) Declaration on the Trade-Related Aspects of Intellectual Property Rights Agreement and Public Health (Doha Declaration) under which member countries may allow patented products to be manufactured under licence by someone other than the patent holder for a limited period of time and in response to a public demand by a country with insufficient pharmaceutical manufacturing capacity. The change would allow developing countries to obtain more affordable drugs from Canadian generic manufacturers. Bill Graham, Minister of Foreign Affairs at the time, stated that this was "one of the most important steps Canada can take to advance global health and human rights, and we hope to see other G-8 countries following suit." Three years into the legislation, not a single generic drug has left Canada. Global Treatment Access Group blames disincentives and red tape that are built into the legislation that have encouraged both Canadian generic manufacturers and countries in Africa from using the law, while Amir Attaran argues that changes to the law are fruitless; the high price of Canadian generic drugs renders them unaffordable.

> None of this is to say that overriding patents is never justified. The appalling failure of manufacturers of brand name drugs to pool efforts and patents — for manufacturing co-packaged or co-formulated antiretroviral treatments that are convenient for first-line AIDS treatment in poor countries — was remedied only once manufacturers of generic drugs in India ignored patents and acted (although the fact that these same manufacturers in India patented their new co-formulations in Africa is a helpful reminder that even they are not impelled by altruism). Some allowance in law must exist to prevent patents standing in the way of desperately needed inventions such as this. [31]

[30] www.theglobalfund.org/en retrieved Aug. 14 2007

[31] Amir Attaran. 'A Tragically Naïve Law for tragically neglected global health" CMAJ June 5 2007 176 (12) April 20 2007, retrieved at: http://www.cmaj.ca/cgi/content/full/176/12/1726 Aug. 12 2007

While the Canadian government has supported multilateral initiatives to scale up treatment in Africa, another arm of its foreign policy has involved the recruitment of health personnel from countries in the global South. Even the WB admits to the desperate shortage of doctors, health care workers and researchers, and the chronic lack of basic health services. The entry of private sector recruitment agencies and the growth of targeted bilateral recruitment schemes have accelerated the pace of specialized labour migration, many from countries at the bottom of the UN scale who show the lowest ratios of per capita health workers and have the most critical health worker shortages. According to the WHO 2006 World Health Report, 36 countries have critical shortages of doctors, nurses and midwives; an estimated shortage of over 817,992 workers, requiring a 139% increase. There are more Ghanaian doctors working outside of Ghana than in the country, and in the past decade it has lost 50% of its professional nurses to Canada, the United Kingdom and the USA.[32] Canada has been a destination country for health professionals who offset the domestic shortage of health workers in Canada. Historically Canada has recruited and received a large number of health workers from the global South, trained at the expense of their governments.[33]

Supportive donors and effective policies no doubt play a role improving public health, and this discussion is not meant to paint all Canadian aid with one brushstroke. There is an obvious need for the delivery of health services, including essential medicines. The point is that aid for global health has ambiguous and mixed results, and is palliative to the extent that it fails to address the structural drivers of poor health, and in some cases serves to undermine the governance structures that are needed to improve 'human security.' When we turn to Canada's role in pandemic preparedness, national security goals more explicit, the disjuncture between human security and national security goals more obvious.

Pandemic preparedness

Canada's recent experience of SARS removed any notion that Canadians were somehow immune to the effects of pandemic disease. When the virus landed in the city of Toronto in 2003, the cracks in Canada's public health system were exposed. The economic impact of SARS in Toronto was tiny compared to that in the Asia Pacific Region estimated at $40 billion. In Canada, 438 people became infected and 43 died, costing the local economy almost half a billion dollars, and the health care system about $793 million.[34] Given that the Ontario health care system had difficulty coping, it is hard to imagine anything less than a global disaster if a more virulent pathogen was not immediately stopped in its tracks. Global pandemic preparedness has been part and parcel of the merging of security agendas with global health; a potential global pandemic viewed by commentators on both sides of the political spectrum as a potential destabilizing force. Avian influenza has been under the spotlight as the next coming pandemic, and its potential mutation is being closely watched. As prominent global health commentator Laurie Garrett states:

> "In a world where most of the wealth is concentrated in less than a dozen nations representing a distinct minority of the total population, the capacity to respond to global threats is, to put it politely, severely imbalanced. The majority of the world's governments not only lack sufficient funds to respond to a super flu; they also have no

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[32] F. Nyonator, D. Dovlo and K. Sagoe, (2004), "The health of the nation and the brain drain in the health sector, UNDP Conference on migration and development in Ghana, September 14-26, Accra. retrieved at http://www.undp-gha.org/Document/MD%20CONF%20_%PAPER%20BY%NYONATOR%DOVLO%SAGOE.pfd

[33] Chantale Blouin (2007) "Canada and the Global Right to Health" in *The Global Right to Health: Canadian Development Report 2007* Ottawa: The North-South Institute.

[34] Michael Osterholm (2005) "Preparing for the Next Pandemic" in *Foreign Affairs* vol.84 (4) p.28

health infrastructure to handle the burdens of disease, social disruption, and panic. The international community would look to the United States, Canada, Japan, and Europe for answers, vaccines, cures, cash, and hope. How these wealthy governments responded, and how radically the death rates differed along worldwide fault lines of poverty, would resonate for years thereafter." [35]

Canada's experience of SARS, and its negative impact on the economy, led to the Canadian state's deeper mobilization around pandemic preparedness. On the international front, Canada has contributed $1 million to support the United Nations System Influenza Coordination, and over $15 million over 5 years to the WHO, FAO and OIE to support collaborative work on avian and human influenza pandemic preparedness; and over $18 million to projects in SE Asia and China to improve surveillance and outbreak investigation, strengthen laboratory systems, and develop capacity for risk communications and public education. It has also contributed through PAHO, resources to support the development of national influenza pandemic preparedness plans. Canada's overall contribution totalled $105.5 million as of July 2006. [36] Canada is also home to the Global Public Health Intelligence Network, an internet based early warning system that tracks significant public health outbreaks and disseminates information globally, in seven languages. The GPHIN is managed by the Public Health Agency of Canada's Centre for Emergency Preparedness and Response, which was created in 2002 as the country's central coordinating point for public health security. States the website: "It tracks topics such as disease outbreaks, infectious diseases, contaminated food and water, bio-terrorism and exposure to chemical and radio-nuclear agents, and natural disasters. It also monitors issues related to the safety of products, drugs and medical devices."[37]

Tracking is of critical importance. But who would be the beneficiaries? Neil Ferguson postulates that a virus similar to the one that caused the 1918 pandemic would likely cause a death toll of 62 million, but only 4 percent of those deaths would be in the industrialized world.[38] At this point, access to vaccines, anti-viral and other drugs for the most vulnerable groups do not exist, and biological and social co-factors: malaria, HIV infection, malnutrition and compromised immunity, would render certain people more susceptible to contracting the virus. Living conditions in the burgeoning slum areas: overcrowding, and lack of basic hygiene would also augment viral spread. Even if a global stockpile of anti-virals was created, it is not clear today how and under what conditions it would be deployed. [39] And though new global health regulations oblige countries to report suspicious clusters of novel diseases, a real disincentive to poor country reporting is the devastating socio-economic effects of quarantine that might follow. Little evidence exists to suggest that the first affected countries would be assisted by the international community. The Canadian government has placed far more emphasis on the North American pandemic plan, through the new 'Security and Prosperity Partnership' between Mexico, the US and Canada which is evolving in a less than transparent manner. The Web-site assures us that "The SPP provides the framework to ensure that North America is the safest and best place to live and do business. It includes ambitious security and prosperity programs to keep our borders closed to terrorism yet open to trade". The North American approach to pandemic preparedness is to prevent or slow a strain to North America, sustain infrastructure, and mitigate impact on the North American economy. North America will not be alone in developing a bunker

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[35] Laurie Garrett (2005) "The Next Pandemic?" in *Foreign Affairs* vol.84 (4) p.5

[36] (http://www. International.gc.ca/pdf/Infosheet-DFAIT-en.pdf) retrieved on June 13 2007

[37] (Public Health Agency of Canada: Global Public Health Intelligence Network http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004_gphin-rmispbk_e.html retrieved June 13)

[38] Neil Ferguson (2006) "Poverty, death and a future influenza pandemic" in *The Lancet* vol.368 (9554) pp.2187-2188

[39] WHO media centre June 13 "WHO and manufacturers move ahead for plans for H5N1 influenza global vaccine stockpile" retrieved at: http://www.who.int/mediacentre/news/statements/2007/s14/en/index.html August 12

mentality if and when a new pandemic emerges. The new discourses of interdependence and 'mutual vulnerability' that have accompanied threats of SARS and avian influenza have yet to lead to any significant shifts in global health policy. While it has become a more central feature of the foreign policy of nation-states, chronic, persistent poor health, malnutrition, access to health's social determinants, and the fragile state of public health systems, are not high up on the global public health agenda. And the health impacts of the current governance of the global political economy are not even on the radar screen.

Some Concluding Thoughts

Canadians may be committed to human security abroad, but are also interested in the maintenance of their own 'prosperity' and standard of living, and competitive position in the global economy. They are also, in the post 9/11 era concerned about their personal security and 'threats out there;' the preoccupation with the 'war on terror' nurturing a climate and economy of fear and deflecting attention from the forces that shape human insecurity at home and abroad. A question, then is whether Canada's 'good deeds' cancelled out by Canada's role in the governance of global trade, investment, environment, and military policy. It is not within the scope of this paper to answer this question, apart from raising a few issues that require further exploration. Foreign policy in the health arena does not operate separately from other domains of foreign policy, and this is where the analysis becomes more complex.

There are issues which raise questions about Canada's commitment to global health. The recruitment of health personnel from the global South has already been mentioned. Another obvious example is the Canadian government's continued opposition to adding asbestos to an international treaty, the Rotterdam Convention, which restricts trade in toxic substances. Canada continues to be one of the world's leading exporters of asbestos, a clear carcinogen that is banned in Canada, with more than 90 percent of these exports going to the global South, where standards are poorly enforced. The European Union and Australia support the addition of Asbestos to The Rotterdam Convention, while Canada "continues to lobby hard against such a move, anxious to protect a lucrative niche selling a highly toxic carcinogen to the world's poor."[40] One could also question whether Canada's roles in global environmental and corporate governance are health enhancing or health destroying. At first glance, the picture is bleak; the abandonment of the Kyoto protocol, support for the development of the Tar Sands provide 'oil security' principally to the North American markets, and its failure to regulate the activities of its corporate nationals seem clearly in the security interests of Canadian capital. Elizabeth Blackwood's research has focused on the Canadian government's actions on corporate social responsibility in response to the Harker (2000) 'Report on the Sudan', which scrutinized the former business relationship between the Canadian oil giant Talisman Energy and its indirect and direct complicity in the Sudanese war. The common justification for the support of dubious investment activities overseas and voluntary codes of corporate social responsibility is that trade constitutes 'constructive engagement that can lead to 'respect for human rights' and democracy, despite not a shred of evidence. Blackwood provides examples of Canadian companies including Petro-Canada International, Ivanhoe Mines, Cameco Corp of Canada, Placer Dome, Tiomin Resource, such as selling military equipment to dubious regimes, and destroying ecosystems upon which local communities depend for their health and livelihoods. "Canada has pursued a human security agenda that, despite its laudable achievements, takes a piecemeal or ad hoc approach to

[40] Linda McQuaig (2007) *Holding the Bully's coat: Canada and the U.S. Empire"* Doubleday Canada. p.233

humanitarian issues and directs little attention to the political economy of conflict."[41] She views Canada's commitment to human security as "a case of the government trying to have it both ways, supporting its humanitarian 'brand,' but not undermining the state's priority to protect Canadian investments.[42] Neither CIDA nor the Export Development Corporation have mandatory corporate social responsibility frameworks.

These policies sacrifice the health and human security of vulnerable people, and undermine their human rights. The current global governance of health fails to grapple with the constraints that current economic policies impose on the realization of the right to health – the entitlements to the material conditions required for basic survival and subsistence. The fact that millions of people lack protection for access to the absolute basics of what is needed for sound health fails to generate a response like the Canadian government's concern for the people of Afghanistan, whose suffering is the justification for military intervention to restore democracy. The super-imposition of the securitization framework reinforces the exclusionary tendencies of neoliberal policies, and amplifies contradictions. I will end with Mark Duffield's cautionary words:

> Politicians need to think carefully about the uncritical evocation of security at every opportunity. While mass society should defend its democratic heritage, rather than introducing measures that are ever more authoritarian to manage the ongoing crisis, more urgency should be given to tackling root inequalities, divergent opportunities and destabilizing futures that are driving it. Mass society is a fragile biopolitical equilibrium that enables a small part of the world's population to live through consuming beyond its means while a larger part is allowed to die chasing the mirage of self-reliance. Development does not seek to remove this life-chance lottery. At best it operates as a security mechanism that attempts, through poverty reduction measures, selective debt cancellation and selective funding, to insulate mass society from the permanent crisis on its borders by making the latter more predictable and manageable.[43]

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[41] Elizabeth Blackwood (2006) "Human Security and Corporate Governance: A Critical Assessment of Canada's Human Security Agenda" in *A Decade of Human Security.* Sandra J. MacLean, Timothy M. Shaw and David Black Eds. Hampshire: Ashgate p.87

[42] Elizabeth Blackwood, Ibid

[43] Mark Duffield (2005) "Getting savages to fight barbarians: development, security and the colonial present." in *Conflict, Security&Development,* Vol.5 Issue 2, August 2005. p.155