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To cite this article: Kristina R. Proulx, Arne Ruckert & Ronald Labonté (2017) Canada’s flagship development priority: maternal, newborn and child health (MNCH) and the Sustainable Development Goals (SDGs), Canadian Journal of Development Studies / Revue canadienne d’études du développement, 38:1, 39-53, DOI: 10.1080/02255189.2016.1202103

To link to this article: https://doi.org/10.1080/02255189.2016.1202103

Published online: 10 Aug 2016.

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Canada’s flagship development priority: maternal, newborn and child health (MNCH) and the Sustainable Development Goals (SDGs)

Kristina R. Proulx\(^b\), Arne Ruckert\(^a\) and Ronald Labonté\(^c\)

\(^a\)Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada; \(^b\)Graduate School of Public and International Affairs, University of Ottawa, Ottawa, Ontario, Canada; \(^c\)School of Epidemiology, Public Health and Preventive Medicine, University of Ottawa, Ottawa, Ontario, Canada

**ABSTRACT**

This article explores the process through which Canada has positioned maternal, newborn and child health (MNCH) as its flagship development priority, first at the 2010 Muskoka Initiative and more recently in negotiations surrounding the United Nations’ Sustainable Development Goals (SDGs). This emphasis conflicts with the government’s recent alignment of development assistance with security and trade-related interests. We argue that a combination of policy path dependency with a constructivist focus on international identity and reputation building best explain the centrality of MNCH in Canada’s promotion of MNCH in the SDG process.

**RÉSUMÉ**

Cet article explore le processus à travers lequel le Canada a positionné le Réseau canadien sur la santé des mères, des nouveau-nés et des enfants (CAN-SMNE) comme sa priorité de développement phare: tout d’abord à l’Initiative de Muskoka de 2010, et plus récemment, lors des négociations entourant les Objectifs de développement durable (ODD) des Nations Unies. Cette emphase entre en conflit avec le récent alignement adopté par le gouvernement de l’aide au développement sur les intérêts en matière de sécurité et de commerce. Nous soutenons qu’une combinaison d’une dépendance au sentier avec une orientation constructiviste de l’identité internationale et de la réputation explique le mieux le rôle central du CAN-SMNE mis de l’avant par le Canada dans le processus des ODD.

**Introduction**

There has been considerable discussion recently on what motivates states’ inclusion of select global health concerns into both domestic and foreign policy. As Hoffman (2010, 18) suggests, “health diplomacy is said to be good politics, great economics, and essential for security”, which has been apparent through various states’ involvement in global health initiatives, funds and consultations. Explanations drawing on realist international...
relations (IR) theories and focusing on the link between health and security have been dominant in the effort to explain this integration of health into foreign policy (Fidler 2011). Such explanations, however, cannot account for the Canadian government’s strong emphasis since 2010 on maternal, newborn and child health (MNCH) in its foreign aid funding, and the elevated status of MNCH in the processes leading to the United Nations’ Sustainable Development Goals (SDGs). Building on earlier attempts to provide a comprehensive explanation for the motivations behind Canada’s official development assistance and foreign policy priorities, which suggested a mix of self-interest, ethical motivations, prestige and bureaucratic incentives as driving forces (Nossal 1988), this article revisits some of the dominant theoretical explanations for foreign aid to explain Canada’s recent and unprecedented focus on MNCH.

We argue that a combination of policy path dependency, with its focus on bureaucratic interests in maintaining the MNCH agenda (Brown and Olender 2013; Fidler 2011; Hoffman 2010), and constructivism (Kirton and Guebert 2009; Nielsen 2010), emphasizing the role of ideas, and especially international reputation, can best account for the emergence of MNCH as a central Canadian foreign aid priority and its continuation and prominent positioning in the SDG process. Using a systematic search strategy, we analysed documents on the post-2015 development agenda following the 2012 Rio+ Conference, as well as documents which referenced Canada’s MNCH efforts between 2002 and 2015; we identified 229 Canadian government and non-governmental organisation (NGO) documents related to MNCH or the SDGs.1 These documents were imported into the qualitative analytical software NVivo 10 and coded to identify the driving forces of Canadian government policy content and formulation in the SDG process. We first trace the process and events through which MNCH was initially proposed by Canada and vaunted on the world stage, beginning with the 2010 Muskoka Initiative, named after the venue of the G8 summit hosted by Canada. We then analyse the role of Canada as the main advocate for the inclusion of MNCH in the SDGs, not only as a singular goal or target but as central to the post-2015 development agenda. We conclude by discussing the explanatory power of different theoretical perspectives for why MNCH became Canada’s “flagship development priority” over all other global health concerns.

The Muskoka Initiative, Canadian leadership and a global commitment to MNCH

Under Prime Minister Stephen Harper’s leadership at the June 2010 G8 summit, the Muskoka Initiative was launched as a strategy to accelerate the stalling progress in the Millennium Development Goals (MDGs) related to maternal, newborn and child health in developing countries. Of the eight goals, the two goals that focused specifically on improving the health of women and children, MDGs 4 and 5 (see Box 1), were the furthest away from being achieved by the MDG end date of 2015. The Muskoka Initiative was accompanied by a financial commitment of CAD1.1 billion from Canada, in addition to CAD1.7 billion in ongoing spending between 2010 and 2015. The Department of Foreign Affairs, Trade and Development Canada’s (2015a) website suggests that “Canada’s efforts were then amplified when United Nations (UN) Secretary-General Ban Ki-moon launched the Global Strategy for Women’s and Children’s Health” several months later, which led to an additional USD40 billion in pledges by partners
including political leaders, member states, the private sector and philanthropists), as well as numerous state and non-state actors. MNCH has subsequently become both Canada’s and the Prime Minister’s “flagship development priority” through which many subsequent development programmes and efforts have been framed (Canadian Council for International Co-operation 2014; Tiessen 2014).

Canada’s commitment to MNCH has demonstrated a certain approach to global health: without necessarily engaging in activities related to building the structures and infrastructure required to maintain health, the government has focused its funds and efforts on “improving nutrition, reducing the burden of disease, and strengthening health systems” (Government of Canada 2014). Projects have targeted improving pregnant women’s and children’s nutrition, enhancing the quality of MNCH health facilities and health care professionals, and preventing transmission between and providing proper care for HIV/AIDS-affected mothers and children (this list is not exhaustive). A substantial amount of efforts and funding have been associated with the Commission on Information and Accountability for Women’s and Children’s Health to improve monitoring and statistics (which is well in line with Canada’s intentions to strengthen civil registration and vital statistics systems, which it supported throughout the SDGs), as well as funding the Global Alliance For Vaccines and Immunisations (GAVI Alliance), to help immunise children in developing countries, specifically through the Strengthening Immunisation Supply Chains initiative. These efforts have been framed as necessary to address the health and wellbeing of the “poorest and most vulnerable people” (Government of Canada 2016). Despite this support for women, children and the world’s poorest, Labonté, Runnels, and Gagnon (2012, 12) note that “less than half of the committed amount [in the Muskoka Initiative] was new funding, the remainder being a re-packaging of existing allocations, and in the same year Canada announced a freeze on any increase in its development assistance budget over the same period”.

The Prime Minister subsequently hosted the Saving Every Woman, Every Child summit on 28–30 May 2014, committing an additional CAD3.5 billion to the Initiative for the period of 2015–2020 and identifying three initial platforms for the promotion of MNCH in Canada: Saving Lives at Birth, Saving Brains and MNCH Stars in Global Health (Paradis 2015). In her study of the MNCH movement and the overwhelming momentum behind it, Myers (2014) found that, following the launch, 400 commitments were made by over 300 partners, and an estimated CAD24 billion had been disbursed. She suggests that “the cross-cutting nature of women’s and children’s health makes it a

**Box 1. Millennium Development Goals (MDGs) 4 and 5.**


**Goal 4: Reduce Child Mortality**
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate (the probability per 1,000 that a newborn baby will die before reaching age five).

**Goal 5: Improve Maternal Health**
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio (the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births).
Target 5.B: Achieve, by 2015, universal access to reproductive health.
particularly attractive and worthwhile investment for long-term global development by public and private actors alike” (Myers 2014, 95), which could explain the various initiatives that evolved under the movement’s umbrella, including the Commission on Life-Saving Commodities and Family Planning 2020. Such initiatives helped contribute to the sustained global interest in, and support for, MNCH. Canada’s initiative and leadership in MNCH has been perceived fairly well internationally, with celebrities such as Bill Gates and Bono praising Canada for its leadership and contributions to the cause.

However, criticisms have arisen in response to the Muskoka Initiative. Tiessen (2014, 195) argues that the introduction of the Muskoka Initiative signalled a “targeting of mothers as ‘victims and beneficiaries of development services’ rather than active agents in the design and implementation of development programs”. Tiessen (2015) has further criticised the almost exclusive emphasis of MNCH on “mothers and motherhood”, often with the effect of treating women as objects of development assistance in need of saving (reiterating the Canadian government’s MNCH discourse on the need to help the “poorest and most vulnerable”) rather than as agents capable of engaging in changes in the social, political and economic contexts that create maternal risks in the first instance. Huish and Spiegel (2012) highlight the lack of attention given to sustainable capacity building in the countries of focus in MNCH, as well as the missing elements in ongoing initiatives that could contribute greatly to progress, including education, work opportunities and family planning. Canada’s approach to MNCH has faced additional criticisms concerning the notion that a rights-based and gender-responsive approach to the issue would include sexual and reproductive health services (UNFPA 2013), which the Canadian government, in keeping with the social conservatism of the ruling party, has notably excluded from its efforts. Instead, the government has chosen to focus its resources on less contentious programme elements, such as nutrition through the Micronutrient Initiative and immunisation through the Inactivated Polio Vaccine Initiative. This exclusion was highly criticised by Hélène Laverdière, the opposition party’s shadow development minister (Laverdière 2015), who argued that sexual and reproductive rights should be a key focus of Canada’s work in MNCH.

**MNCH: a central component of the SDGs**

In early consultations on the post-2015 development agenda, Canada maintained the need to focus on the unfinished business of the MDGs, mainly Goals 4 and 5 (women’s and children’s health), while also emphasising the need to focus efforts towards the most vulnerable, including women, girls, children and people with disabilities (International Institute for Sustainable Development 2013). This discourse was reiterated by Canadian representatives throughout consultations on the SDGs over a three-year period. In an announcement on 25 September 2014 at the 69th United Nations General Assembly, the Prime Minister took the opportunity to solidify Canada’s development focus, stating that country efforts to prevent the deaths of mothers, children and newborns would be sustained in the new development agenda and that MNCH would have to remain a priority for all member states in the SDGs (Star Staff 2014). In a later interview with Bill and Melinda Gates on 30 May 2014, the Prime Minister maintained this position, suggesting that in the upcoming post-2015 development agenda “we will essentially be going farther with a little bit more resources in the same direction” (Globe and Mail 2014).
Canada’s decision to make MNCH its key priority in the SDGs is both interesting and potentially problematic, considering the universality aspect of the new development agenda, which is set to come into force following the MDGs’ end date in January 2016. Contrary to the former development goals, in which focus was directed specifically towards development efforts in low-income countries, the universality aspect of the SDGs represents:

- a paradigm shift from previous global development frameworks that typically identified goals to be achieved in developing countries [...]. While developed countries are expected to continue playing a supportive role with the post–2015 agenda, they will also be required to take actions to address their own sustainable development challenges. (Kindornay et al. 2015, 14)

Critics of the universality principle have suggested that this condition could provide states with the legitimate means to focus development resources inwards, rather than towards efforts to tackle global challenges (Kindornay 2015). MNCH as a self-identified priority by Canada seems to contradict this notion.

Despite the unsatisfactory state of maternal, newborn and child health in aboriginal communities within Canada (infant mortality rates are reportedly 1.5–4 times greater among aboriginal Canadians compared to the overall population; for example Mikkonen and Raphael (2010)), in 2014 the federal government faced criticism for eliminating the Strengthening Families – Maternal Health (SF–MCH) programme, a family-focused maternal health programme for First Nations communities in Manitoba (NDP 2014). While no stand-alone goal on indigenous peoples has been included in the SDGs, Post-2015 Data Test (2014), an initiative which examines SDG priorities across a variety of countries including Canada, notes that the Canadian government has been ambivalent with respect to the universality principle. The release of an apparent briefing memo for Minister Paradis on 15 June 2015 suggests that, although the current government had until then supported the principle, this had changed and “Canada has no plans to apply the Post–2015 Agenda domestically, or to take on new reporting obligations beyond what we are currently producing” (Berthiaume 2015). Whereas the support for the inclusion of MNCH in the SDGs could have given Canada further justification for focusing more resources towards improving maternal, newborn and child health in aboriginal communities, Canada, at least in the period prior to the recent Liberal election, appears to have no intention of doing so. This raises questions concerning why a state would utilise an international forum to encourage an initiative on which it will be held accountable by the UN General Assembly, despite having no intention of applying it domestically, even in the face of documented domestic need (Berthiaume 2015).

**Potential motivations for MNCH and competing theoretical explanations**

The identification of MNCH as Canada’s “flagship development priority” is significant, as it arguably acts counter to the government’s recent alignment of development assistance with security and trade-related foreign policy issues, notably Afghanistan (which was the top recipient of Canadian aid in 2006–2007). The new alignment was further solidified with the merger of the Canadian International Development Agency (CIDA) with the Department of Foreign Affairs and International Trade (DFAIT), and was again demonstrated through Canada’s 3D approach of defence-diplomacy-development, with the place
of ‘development’ as the third D being highly criticised (Huish and Spiegel 2012). While Brown (2015) suggests that Canada’s current foreign policy concerns in development assistance are well-aligned with commercial self-interests, identified through a new geographical focus on areas of specific interest, including various Latin American countries with mining opportunities, the overwhelming focus on MNCH arguably requires a different explanation.

Before we explore the motivating factors behind Canada’s support for MNCH, it is worth noting how the traditional motivation for an increase in political relevancy and funding for a health concern, namely for security interests, arguably does not apply to the case study of MNCH. Fidler (2011, 12), drawing on realist theories of foreign policy, suggests that traditionally there has been a lack of focus on including global health concerns in foreign policy, as well as a general lack of attention for global health concerns, due to the notion that health problems rarely infringe upon a state’s key tasks of ensuring national security, economic power and wellbeing. While MNCH may contribute to what Fidler (2011) designates as “policy functions”, including fostering the development of strategically important regions through foreign aid and supporting human dignity by aligning these disbursements with human rights strategies, much of the global focus on health has been as a result of a concern for security and is best explained by drawing on realist theories. With increased mobility, rapid travel and population movements, “health security” has become a potent concept to capture the risk that new or virulent pathogens now pose to all states, regardless of their originating location or initial proximity, as seen in the focus of the 2007 World Health Report “A Safer Future: Global Public Health Security in the 21st Century” (World Health Organisation 2007). MNCH, however, does not contribute to any potential perceived health threat requiring immediate action, or to state security; indeed, MNCH has rarely been discussed as a potential threat even to local security due to its probable destabilisation effects for communities (Baringer and Heitkamp 2011). Although MNCH has certainly been politicised (with Canada’s exclusion of certain aspects, including access to contraception and safe abortion), MNCH has not yet undergone the steps for a “successful securitisation”, having not been identified as an existential threat requiring emergency actions beyond the realm of normal politics (Buzan, Waever, and de Wilde 1997). This implies that realist theories focusing on the securitisation of health concerns in foreign policy are not well-positioned to explain the persistence of MNCH as a Canadian foreign aid priority in the SDG process.

**Path dependency and institutionalism: MNCH and forum shifting**

Considering the sustained focus on MNCH, the notion that it was already well integrated into the bureaucracy and institutional framework, both domestically and globally, suggests a potential motivation for Canada’s support for emphasising its inclusion in the SDGs. The traditionally economic explanation of how path dependency occurs is potentially applicable to this situation, through the steps of lock in, positive feedback, increasing returns and self-reinforcement (Greener 2005). The institutional framework was already available to allow for the expansion of policies and initiatives related to MNCH; the Canadian government had already gathered support from a wide array of state and non-state actors globally; and it could be assumed that support would be sustained if the government chose to continue to prioritise MNCH in the post-2015 development agenda.
Domestically, examples of the existing institutions and bureaucracies included first CIDA, then DFATD, both of which have invested time and resources towards projects related to MNCH since 2010, beginning with the support for UNICEF’s Vaccinating Children Against Measles project, as well as the International Development Research Centre (IDRC), which has invested extensively in research initiatives to address MNCH (Foreign Affairs, Trade and Development Canada 2015a, 2015b).

Fidler (2011) suggests that the relationship between health and foreign policy has been emphasised by the phenomenon of forum shifting, defined as the act of state and non-state actors moving (or attempting to move) an issue from one political or diplomatic forum to another more favourable to their interests. Brown and Olender (2013) explore this notion in the Canadian context, suggesting that while CIDA’s previous focus on MNCH appeared selfless, through the Muskoka Initiative “Canada relaunched a UN initiative and instrumentalized a forum to implement its policy preferences for reasons of self-interest” (a point we return to later), although with limited results (Brown and Olender 2013, 167). They suggest that the adoption of MNCH and the way it was applied in the G8 Summit could have been Canada’s attempt to impose its preferences internationally; advocating for its importance in the post-2015 development agenda certainly appears to be a continuation of this. Similarly, Hoffman (2010, 19) suggests that Canada’s high-profile and relatively successful G8 presidency in 2010 provided a “point of departure for future efforts and global leadership”, and the timing of SDG consultations, which closely followed the announcement of the Muskoka Initiative, provided an ideal opportunity for Canada to continue to showcase its support for MNCH and effectively shift the G8 countries’ focus to the post-2015 development agenda.

**MNCH and the liberal underpinning of humanitarianism**

Some have suggested that Canada’s ongoing focus on MNCH reflects the liberal notion of humanitarianism, and the growing global consciousness and sense of responsibility that has emerged with contemporary globalisation. Curtis (2001) emphasises the changing relationship between humanitarian aid and politics, with humanitarian efforts (in this case, a focus on addressing the stagnating progress on goals related to maternal, newborn and child health in the MDGs) being increasingly tied to underlying political objectives and self-interested motivations. However, he also suggests that there has been a redefinition of national self-interest “no longer narrowly defined in terms of immediate commercial interests and security threats, but in terms of good international citizenship” (Curtis 2001, 6). This redefinition has been accompanied by a new distinction between humanitarianism based on charity and humanitarianism based on human rights, in which development efforts are predicated on being egalitarian and dignifying individuals rather than patronising them, and in which the beneficiaries of development “become claimants of rights, rather than objects of charity” (Curtis 2001, 15).

Health in the SDGs is often framed as an issue of human rights by various actors, including CARE (2012), Medicus Mundi International Network (2012), UNAIDS (2012) and UNFPA (2013), and Canada at times has echoed this. At the UN General Assembly (UNGA) High-level Event on Contributions of Human Rights and the Rule of Law to the Post-2015 Development Agenda on 9 June 2014, Ambassador Michael Grant (2014) suggested that respect for human rights would be a core, integrated value
in the SDGs, justifying Canada’s focus on MNCH with the explanation that the SDGs will “only be achieved if women are able to fully participate as equal partners in the social, economic and political realms of their societies”. A human rights focus is especially effective in discussions on health, as health is increasingly being treated as a human rights issue itself, both in the MDGs and the SDGs, and as a key component to all development initiatives, such as Universal Health Coverage (UHC) (Delobelle, Fisher, and Corbin 2013; Sustainable Development Solutions Network 2014).

In the case of Canada’s involvement in MNCH, the focus on improving the health of women, newborns and children at first blush does appear to exemplify this redefined human rights-infused humanitarianism. Huish and Spiegel (2012), however, draw attention to the potential strategic interests of the countries involved in this initiative, including Mozambique, Haiti, Mali, Nigeria, Sudan and Tanzania (considering that Canada has strong energy and mining interests in each of these). What is more, if humanitarian motivations were the key explanation for Canada’s development assistance and programmes of focus, this would require an increase in both the quality and quantity of Canada’s resources and commitment to development, and better overall alignment with the foreign aid needs of recipient countries. This has not been the case, considering that Canada’s Budget 2012 was accompanied by three years of major aid cuts and Budget 2015 includes no announcement to improve or increase Canada’s international development assistance. The Canadian Council for International Co-operation (2015) suggests that Canada will continue to linger at 16th place out of 28 donor countries in OECD–DAC (the Organisation for Co-operation and Development’s Development Assistance Committee), while Canadian official development assistance (ODA) as a percentage of Gross National Income (GNI) in 2014 was 0.24 per cent, the lowest contribution by Canada since 2001, when it was 0.22 per cent (OECD 2015). Thus humanitarian explanations alone cannot suffice as the motivating factor behind the integration of MNCH in the SDGs.

Constructivism, ideals and the role of reputation building

The constructivist understanding, which emphasises the role of ideas, desirability and reputation as motivating factors behind state action, may offer new insights into Canada’s prioritisation of MNCH. Nielsen’s (2010) constructivist explanation of foreign aid suggests that donor countries respond to the needs of poor countries through development goals (including the MDGs and SDGs) and various other initiatives as a result of their state identity. Canada’s identity as a global caring citizen, acquired over a long period of international engagement, partially explains why it provides resources and official development assistance to countries in need, and why international giving and redistribution are considered to be important foreign policy goals. Constructivist theories emphasise the role of ideas and norms in aid allocation and suggest that exposure to and interaction with the problems of developing countries through globalisation functions as a primary determinant of a needs-orientation amongst donor countries. Nossal (1988) characterises the use of development assistance and programmes as a means for a state (most commonly Western, industrialised and wealthy) to acquire a status of good standing in the international community. For example, beginning with a 2002 commitment to eradicate polio and enduring throughout ensuing G8 summits, Canada was identified as a
leader in its commitments to polio eradication and continued to remain one of the top donors for the cause. However, as Nossal presciently posited, “an interest in prestige can only account for the continued existence of a commitment to ODA, not for the nature, type or range of the programmes themselves” (Nossal 1988, 51).

Canada has been repeatedly criticised by development NGOs for failing to reach the ODA target of 0.7 per cent of GNI goal, which was ironically recommended by former Canadian Prime Minister Lester B. Pearson in 1969 and adopted by the UNGA in 1970. In 2011–2012, Canada’s aid to GNI ratio tumbled from 0.32 per cent to 0.27 per cent, with Canada falling to the bottom half of the ranking of the OECD–DAC donor countries (Reilly-King 2014). In light of such criticism, the ongoing and very public commitment to MNCH could be seen as drawing attention away from Canada’s poor and declining aid ranking, and instead encouraging global admiration for the government’s sustained focus on an issue of consensual global importance. Similarly, Canada has emphasised the role of financing solutions such as the Global Financing Facility, as seen in a recent address by Minister Paradis (2015) in which he suggested Canada “sees [the Facility] as playing a key role in financing for development”, and which deviates from traditional financing mechanisms which heavily involved state actors and on which Canada is performing poorly (Government of Canada and Foreign Affairs, Trade and Development Canada 2015). This new partnership, launched as the key financing platform in support of the Global Strategy for Women’s, Children’s and Adolescents’ Health, “expects to mobilise between US$3 to US$5 dollars from the private capital markets for every US$1 dollar invested into the GFF” (World Bank 2015). Notably, in 2014 Canada committed CAD200 million to the Global Financing Facility, and later committed an additional CAD40 million “to strengthen critical front-line health systems” (UNICEF Canada 2015). Similarly, Brown (2015) suggests that Canada’s continuing emphasis on increasing effectiveness, as it does with its funding for MNCH, can be seen favourably as a need to focus resources towards the most vulnerable through development initiatives, and more critically as an attempt to increase (or at least maintain) Canada’s reputation and prestige despite its much criticised decreasing aid flows.

MNCH is an ongoing, rather than crisis-driven, health concern (Fidler 2011), at least when contrasted with such pandemic risks as SARS, Ebola or HIV in its early decades of rapid spread. The focus on the lack of progress in achieving the MDGs related to maternal, newborn and child health nonetheless has allowed for a crisis-driven spin on the issue, one to which Canada has contributed; the Permanent Mission of Canada to the UN’s (2011) website, for example, emphasises the thousands of women who die during pregnancy or childbirth and the nearly nine million children who die before reaching the age of five, as well as the notion that these deaths are preventable. While Fidler (2011) suggests that health’s elasticity as a foreign policy issue creates vulnerability, as when a crisis passes so does the focus on that health concern, the inclusion of MNCH in the SDGs assures that it will be an issue of focus throughout the period of the SDGs, from 2015–2030.

These factors have aided in Canada’s successful position as a saviour for women, newborns and children in the developing world, with the World Bank Group’s President, Jim Yong Kim, at the Maternal, Newborn and Child Health Summit 30 May 2014, suggesting that the 2010 Muskoka G8 Declaration was a pivotal moment in addressing the needs of women, newborns and children worldwide. Kim went on to praise Canada’s “leadership
and commitment” as “crucial for all our current efforts” and, “once again, Canada is leading the charge to ensure that we meet our commitment to improve maternal health and reduce child mortality” (World Bank 2014). Similarly, UNICEF (2015) referred to Canada as “an established global leader on child and maternal health”. Conversely, Smith and Heap (2010, 10) suggest that, despite being an important initiative, the choice of MNCH as a priority “seems to have been essentially a political call related to improving the government’s standing with domestic constituencies”. Brown and Olender (2013, 169) suggest that, “with [Prime Minister] Harper leading a minority government and a federal election possible at any time – one was held later that year – the promotion of (literally) a motherhood issue within a high-profile international forum likely played into calculations to garner a warm response from voters”.

Relevant to the argument of national reputation as a motivating factor is that of compliance. In an article based on detailed assessments of country compliance scores at annual G8 summits, Kirton and Guebert (2009) measured compliance on a scale in which −1.00 indicates complete or near complete failure to implement a commitment, 0.00 indicates work in progress or partial compliance and +1.00 indicates full or near full compliance. The G8 has had a relatively good record of compliance with its annual health commitments, and health has fared much better than other sector areas that comprise the agendas of such summits. Evidence in the study suggests that Canada specifically has done very well in complying with health commitments (achieving an overall average score of +0.78 between 1975 and 2008); but it also shows that it is less successful in encouraging other member states to keep their promises to the same degree (Kirton and Guebert 2009, 91). In a detailed analysis of compliance following the 2010 Muskoka G8 Summit by the G8 Research Group (2011), on the topic of maternal, newborn and child health the G8 received a compliance score of +0.75. The study suggests that this score signifies that “the G8 commits to an action plan for maternal and child health that is in line with the objectives of the Canadian presidency but G8 members do not commit any new funding to adequately supplement Canada’s own pledge of CAD 1 billion”. The role of acquiring member state compliance as a component of increasing soft power and national reputation may help to explain Canada’s central focus on MNCH, both as an attempt to improve its own record of compliance and to increase G8 member states’ involvement and commitment to areas of interest that Canada chooses to highlight (albeit evidence finds that this strategy was only partially successful).

Kirton and Guebert’s (2009) study suggests that when G8 leaders use a powerful international organisation – such as World Health Organisation (WHO) or the UN – in the issue area, compliance has a habit of increasing. MNCH and its accompanying elements have been endorsed by both the WHO and the UN, as well as the numerous organisations involved in SDG consultations. The study also suggests that when member states craft their commitments in ways that embed particular compliance catalysts (such as dealing with the issue the years before and after the summit, invoking international organisations and embedding their commitments in one-year deadlines for completion), compliance increases. By acting as a proponent for the inclusion of MNCH in the SDGs, Canada ensured that G8 member states would have to continue to engage with its initiative.
Conclusion

While we may never know with certainty the exact motivations behind Canada’s focus on MNCH, an analysis of the process through which MNCH has been integrated into Canada’s foreign policy agenda and the SDGs can indicate several possible explanations. In contradiction to traditional (realist) explanations that emphasise security and economic interests as reasons for integrating health into foreign policy, the case of Canada and MNCH instead suggests that a combination of policy path dependency with a constructivist focus on international identity and reputation building best capture the centrality of MNCH in Canada’s engagement in the SDG process. Path dependency refers to the advocacy role of existing organisations within the bureaucracy strongly invested in the MNCH approach, as well as civil society and industry support for a movement which made it relatively easy for Canada to continue its support for MNCH; while a constructivist understanding suggests that Canada utilised MNCH to not only increase its reputation as a selfless and giving country despite decreasing aid amounts but also increase its soft power by increasing compliance amongst fellow G8 members.

We conclude with a plausible but uncertain inference: Heads of state who have been long in office and who may have aspirations to a future global leadership role often groom an international legacy for themselves. Canada’s (now former) Prime Minister has done well in vaunting his particular vision of MNCH, creating a legacy that may endure past his own tenure as the country’s political leader. It is also one that avoids upsetting domestic social conservatives or those in other countries who do not full-heartedly embrace select components of MNCH. Finally, it is a policy vision that is being financed through deep cuts in almost all other facets of Canada’s development assistance, pleasing the domestic fiscal conservative base, albeit at the cost of short-thrifting sectors related to social and environmental protections that could indirectly promote (and sustain) maternal, neonatal and child health long past the immediately important health care interventions supported through the initiative.

Postscript: While it remains to be seen to what extent the new Liberal government will shift the framing and financing of the Muskoka Initiative, the Party did state before the election that it would fund abortion services. Fieldwork discussions on a study emanating from the initiative co-led by Ronald Labonté further suggests that sexual and reproductive health are already being re-integrated into MNCH programmes.

Notes

1. The types of documents which were reviewed included policy and ministerial statements, compliance studies, submissions from non-governmental and civil-society organisations on the post-2015 priorities, UN General Assembly Open Working Group documents, analysis by select think tanks, high-level forum documents, conference reports, interviews and Canadian political party platforms, as well as official development assistance statistics.

2. These main donors include, but are not limited to, the Bill and Melinda Gates Foundation, the Global Alliance For Vaccines and Immunizations (GAVI Alliance), Amnesty International, CARE, The Body Shop, GlaxoSmithKline, Merck, the Aga Khan University, United Nations Population Fund (UNFPA), United Nations Children’s Emergency Fund (UNICEF), BBC World and Grand Challenges Canada.
3. The Department of Foreign Affairs, Trade and Development, which bore this name in 2013–2015 before being given its current name, Global Affairs Canada.

Funding

This study was funded through an Operating Grant from the Canadian Institutes of Health Research (CIHR), Operating Grant No. 136927. Ronald Labonté received additional support through the Canada Research Chair Programme.

Notes on contributors

Kristina R. Proulx is a second-year Master of Arts Candidate at the University of Ottawa’s Graduate School of Public and International Affairs. She is currently working on her major research paper, which explores the influence of donor country interests on the provision of official development assistance towards maternal health and family planning programmes.

Arne Ruckert is a Senior Research Associate and part-time Professor in the Faculty of Medicine at the University of Ottawa. His principal areas of research include the international financial institutions (IFIs), the international aid architecture, the financial crisis and health equity, social determinants of health and global health diplomacy and governance.

Ronald Labonté holds a Canada Research Chair in Globalisation and Health Equity and is Professor in the Faculty of Medicine at the University of Ottawa. He has over 250 scientific publications and several hundred articles in popular media.

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