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Health in Canadian foreign policy: the role of norms and security interests

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ABSTRACT
Despite health’s prominent place in Canadian foreign policy, as evidenced in the on-going support for maternal newborn and child health (MNCH) initiatives, little is known about the driving forces behind the integration of health into foreign policy. Based on document analysis and expert interviews, we provide an empirically grounded but theoretically informed perspective on health’s role in Canadian foreign policy. We argue that the integration of health into Canadian foreign policy cannot be understood by drawing on a single theoretical perspective. Instead we suggest that the integration of health into foreign policy follows competing logics, depending on whether or not health concerns intersect with high politics (such as national security and economic interests). In cases where health is directly or indirectly related to major security threats, realist theory (and the securitization logic) can best explain health’s positioning in foreign policy by highlighting the role that state interests play in maximizing security. In instances where health is not related to high politics concerns, liberal internationalism with its focus on the cultural and normative driving forces provides a more useful theoretical understanding of how or why health enters foreign policy prominence.

KEYWORDS
Foreign policy; global health; sustainable development goals; antimicrobial resistance

Introduction
Despite the rise of fiscal austerity and populist politics in much of the world, with some global health scholars fearing a decline in the relevance of health in this environment (Youde 2018), health issues remain a priority in international politics. The US Secretary of Health and Human Services Tom Price, told the World Health Assembly in May 2017 that the USA is committed to a “cooperative, transparent, and effective international response to outbreaks of infectious disease” through global cooperation (Konyndyk 2018). At the Global Health Security Agenda (GHSA) meeting in Uganda, the United States affirmed its intention to back the initiative for another five years, to 2024. Health also remained a central issue in the negotiations leading up to the Sustainable Development Goals (SDGs) (Buse and Hawkes 2015). In Canada, Prime Minister Justin Trudeau has
recently laid out Canada’s vision for global health in a special series of The Lancet journal (Evans 2018), and recommitted Canada to on-going engagement in global health through renewed financial commitments and foreign policy actions (Trudeau 2018). While Trudeau has been publicly criticized for failing to show leadership on the global health file after his election (Percival 2018), he has increased the share of official development assistance dedicated to health from US$ 580 million in 2014 to US$ 764 million by 2016 (Donor Tracker 2019). At the Fifth Replenishment Conference of the Global Fund to Fight AIDS, Malaria, and Tuberculosis held in Montreal in September of 2016, Canada pledged an additional CAN$804 million for 2017–2019 (some of it, however, previously budgeted), and shifted the policy discourse towards addressing gender inequalities in global health through foreign policy actions, leading to the launch of the Feminist International Assistance Policy in 2017 (Nixon et al. 2018, Trudeau 2018). This emphasis on health in foreign policy is not unique to the Canadian state, and reflects a global movement, as articulated in the Oslo Ministerial Declaration of 2006, towards ensuring greater consideration of health concerns in foreign policy (Amorim et al. 2007).

The World Health Organization (WHO) defines health, somewhat abstractly, as a state of complete physical, mental, and social well-being (World Health Organization 2006), with far-reaching implications for how its policy or programmatic outcomes might be identified or conveyed as a foreign policy concern. Irrespective of this conceptual ambiguity and contestation of where resources should be directed to address health issues, health remains a prominent issue in foreign policy and in international negotiations (Novotny et al. 2013). Despite the prominence of this topic, the driving forces behind the integration of health into foreign policy have rarely been examined empirically (Ruckert et al. 2016), especially so in the case of Canada. There are only four articles that have previously focused on health in Canadian foreign policy, describing the institutional architecture within which health enters foreign policy discussions (Hoffman 2010), thematically analyzing key foreign policy statements for their health content (Labonté et al. 2012), identifying barriers to the insertion of health into Canadian foreign policy (Runnels et al. 2014), and criticizing Canadian engagement in the area (Spiegel and Huish 2009). There has been no attempt to provide empirically grounded or theoretically informed explanations for health’s positioning within the Canadian foreign policy agenda, despite Canada’s long-standing and active engagement in global health (Nixon et al. 2018), and with the Muskoka Initiative on Maternal, Newborn, and Child Health (MNCH) widely seen as a legacy foreign policy initiative (Proulx et al. 2017).^1

In the literature on health in foreign policy, realist explanations that focus on the securitization of health are dominant in explaining health’s policy relevance (Fidler 2009). Realism,^2 broady conceived, is characterized by its core belief that states are inherently self-interested and constitute the main actors in an anarchically organized international system (Snyder 2004). Realists argue that health is only integrated into foreign policy negotiations instrumentally to achieve important foreign policy functions (Fidler 2009), such as protecting national security interests in the quest for state survival (McInnes and Lee 2012). Bergh and Gill (2013), as well as Rushton (2011), suggest that the multiplying number of actors involved in foreign policy and agenda-setting, and the emergent number of non-traditional security challenges, have elevated numerous global health concerns to the status of national (or international) security threats through securitization processes (an issue we will return to later).
The two main competitors to this security driven understanding of health’s role in foreign policy are liberalism and idealism. For liberalism, foreign policy positions are largely a function of competing interest groups that influence the policy process and state behavior by shaping state preferences (Moravcsik 1997). Liberalism is based on the assumption that the rule of (international) law and transparency of democratic processes will facilitate international cooperation, especially when such practices are enshrined in multilateral institutions (Snyder 2004). In line with liberalist theory, some scholars note that non-state actors play a particularly important role in global health diplomacy, utilizing expert and advocacy networks based on shared values, norms, and understandings to influence the agenda-setting process (Collin et al. 2002, Betsill and Corell 2008). Institutional characteristics and design are other central dimensions of many liberal IR theories, with the notion of path dependency of particular importance to this article. Path dependence describes how certain past policy decisions, in our case support for MNCH, can be culturally and operationally inscribed into institutions, leading towards a certain conservative bias in foreign policy towards staying on the same policy path.

Idealism (and its more modern reincarnation of constructivism) focuses on how international politics is shaped by collective and individual norms, ideas, and discourses which states seek to align with. This theoretical perspective predominantly frames the justification for the inclusion of health into foreign policy as driven by normative concerns, such as development, human rights, and equity. In this ideas-based approach (Harmer 2011), the discourse surrounding global health diplomacy and the integration of health into foreign policy are not necessarily generated by the most powerful state and non-state actors, but by close networks of actors through the sharing of ideas and values (Shiffman et al. 2016). The increasingly apparent, and in some cases growing, health disparities continue to invoke global responses, which have been attributed to the notion of a single global community (Lencucha 2013) which operates based on “progressively shared perceptions of health risks and builds coordinated response to global health issues” (Figuié 2013, pp. 230–231).

While realism (Stairs 2003, Lagassé and Robinson 2008) and liberal internationalism (arguably a combination of elements of liberalism and idealism/constructivism) (Munton and Keating 2001, Plazek 2017) have traditionally provided the dominant explanations for foreign policy behavior in Canada, the following article will probe the limitations of each of these perspectives as complete explanatory theories of health in foreign policy. We probe these limitations through an analysis of two policy issues: Canada’s vocal support for maternal, newborn and child health in the negotiations leading up to the Sustainable Development Goals (SDGs), and the rise of antimicrobial resistance (AMR) on Canada’s foreign policy agenda. We argue that the rise of MNCH and AMR onto Canada’s foreign policy agenda represent competing logics which cannot be explained in reference to a single IR theory.

**Methods**

The findings presented in this article are part of a comparative Canadian Institute of Health Research (CIHR)-funded research project on “Global health diplomacy: an explanatory multi-country study to explain the integration of health into foreign policy”, undertaken in four countries (Canada, Mexico, Brazil, and Chile). In this article we report only on
findings from the Canadian research site. Our analysis combines thematic document analysis \((n = 233)\) with key informant interviews \((n = 34)\) from a variety of sectors, including government representatives across various departments (Global Affairs Canada, Health Canada, and Public Health Agency of Canada), to generate evidence about the driving forces of health in Canadian foreign policy. The goal of document analysis was to identify how various stakeholders position health in foreign policy, and the extent to which these positions are taken up by the government, whereas the interviews reconstructed the process of how, in the opinion of bureaucrats, non-state policy advocates, and private sector lobbyists, health enters the foreign policy process and why it was established as a foreign policy concern. Elements of the document analysis have been published elsewhere (Proulx et al. 2017), and we mostly focus on presenting empirical findings from the interview stage in this article, with occasional reference to the document analysis for triangulation purposes.

We incorporated all data into NVivo 10 and conducted a thematic analysis using constant comparative methodology (Corbin and Strauss 2015). The coding tree was developed deductively based on previous experiences with researching health in foreign policy but enriched inductively as new thematic categories emerged in the coding process (see Appendix 1. Coding Template). We report our findings, starting with the general rise of health onto Canada’s foreign policy agenda, before providing a more in-depth discussion of two issues where health has recently been central in foreign policy activities: the role of maternal, newborn, and child health (MNCH) in the negotiation of the Sustainable Development Goals, and the rise of antimicrobial resistance on the Canadian foreign policy agenda. We will then reflect on what these findings mean to make theoretical sense of health’s recent positioning in Canadian foreign policy Table 1.

### Findings

#### General reflections on health and the Canadian foreign policy agenda

The interviews confirmed our suspicion that it is a range of competing and, at times, conflicting interests and values that explain how health is positioned on the Canadian foreign policy agenda. Many respondents highlighted the cultural importance of health in Canada’s national image. Health is a unique topic of interest to Canadians as it has long played a central role in Canada’s nation-state building process by providing the normative glue for an imagined community (Anderson 2006), and as a demarcation from US society with its commodified health system:

Historically, health has played an important role in Canadian nation-building and has always been a part of the Canadian state, and has for the longest time been a central part of the development agenda for Canada … so there is a historic kind of trend that is continuing and we’re glad for that. (Global Affairs Canada Representative)
The prominence of health in the Canadian foreign policy agenda was seen by many respondents as something that has been gradual in nature, initially starting in the 1990s with the emergence of a Liberal government’s promotion of a human security agenda. Under the Conservative Harper government, health continued its ascendancy to new foreign policy heights, which some attributed to how Canadians connect with the topic:

I mean the Harper government focused on women and children and health issues since this is an easy political sell. Why? Because we can talk all we want about the challenges around, you know, building capacity within public service [in developing countries but] that’s far from the average Canadian’s experience. But talk to them about health and education issues, they get it. (Finance Canada Representative)

However, while cultural explanations for understanding the place of health in Canadian foreign policy were wide-spread amongst some respondents, others also acknowledged that security interests linger in the background as motivating factors. As some of our respondents noted, health risk factors do not necessarily stop at the border and many of the most challenging global health problems cannot be solved without global cooperation:

I would also say that security’s still a big component of what is driving health in foreign policy, but not from a protecting Canada perspective as much as [a] perimeter approach. So let’s make sure that we’re all equally able to prevent, detect and respond to infectious diseases because we know ultimately it does help us in Canada. (PHAC Representative)

Besides such explicable self-interests, reflected in Canada’s participation in the Global Health Security Initiative, participants noted that normative considerations also served as drivers for health’s prominence in the foreign policy agenda. Global health diplomacy (GHD), for example, was seen as a potential international reputation builder for “Brand Canada”, with branding representing a rapidly growing area of interest in foreign policy analysis (Marland 2018, Nimijean 2018). The importance of branding was explicitly acknowledged in the context of Harper’s signature Muskoka Initiative on Maternal, Newborn and Child Health:

So I would say that global health has probably become a big factor in Canadian foreign policy, but I would say more so development policy because the international community has created the conditions for Canada to, you know, benefit from that for its branding. And it doesn’t hurt that it’s a branding that politically is very easy to get behind. (Academic)

While it is clear that there are a variety of driving forces behind specific global health positions, it is unclear to what extent health is trumping, or converging with other competing interests in global health negotiations (such as security or trade and economic interests). On the one hand, multiple respondents referenced how health diplomacy can function as an entry point to pursue other unrelated interests, such as trade interests, with health considered “a good soft diplomacy entrance. So it’s easier to have a strong bilateral relationship with a country on health issues than it necessarily is on some of the other issues […] and it’s a nice spot for countries to start to pursue other interests” (PHAC Representative). Another respondent noted the centrality of Memorandum of Understandings (MOUs) in health diplomacy, especially in bilateral relationships. MOUs represent a structured way of fostering relationships with other countries by formally defining the terms of health cooperation and by laying out policy expectations. Health as a cross-cutting theme in
MOUs can facilitate engagement across a wide array of sectors to pursue related interests (security) or completely unrelated interests (access to natural resources or military bases) (Global Affairs Canada Representative).

When we inquired about the role of non-state actors in the formulation of health-oriented foreign policy, little emphasis was placed by respondents on the role or influence of business, and the corporate sector in general. One PHAC representative noted that while PHAC occasionally reaches out to the private sector to seek views or feedback on global health issues, this does not impact policy: “If we do have engagement with them [private sector] it is primarily to provide us with views and we will take them, you know, in, but they have very little influence on our side on policy” (PHAC Representative).

The role of NGOs in global health diplomacy came up in a number of our conversations, and respondents generally highlighted how they are always open to receiving feedback from NGOs. At the same time there is no structured or regular engagement with NGOs in the area of health in foreign policy, except for the annual PHAC teleconference to consult with NGO stakeholders before the World Health Organization (WHO) Executive Board meeting. Some respondents noted that the ability of NGOs to engage in GHD discussions and influence specific foreign policy topics is dependent on the nature of the issue. For example, Canadian NGOs actively worked with the Canadian government during the negotiation of the Framework Convention on Tobacco Control (Lencucha et al. 2010).

Finally, respondents distinguished between the role that different levels of analysis (global, domestic, regional, local) play in understanding the driving forces behind the integration of health into foreign policy, suggesting that consideration of health issues can either arise domestically through interest group pressure (corporate lobbying), NGO activism (as in the case of health in the SDGs), or be driven by outside pressures and global policy developments to which Canada is responding (the case of antimicrobial resistance). To further illustrate these dynamics, we now turn to these two concrete instances of health’s positioning on the Canadian foreign policy agenda.

**Health in the sustainable development goal (SDG) negotiations**

"Improving maternal health is part of the unfinished agenda for the post-2015 period" (United Nations 2015)

Our first example describes how MNCH became the central Canadian concern in negotiations to develop the post-2015 Sustainable Development Goals (SDGs). MNCH first rose to prominence in the global policy arena due to its inclusion in the Millennium Development Goal agenda (MDG goals 4 and 5) and the use of evidence-based MNCH advocacy by various policy networks, funded by high-income countries, important philanthropic organizations, and international health organizations (McDougall 2016). This process led to the WHO’s Delhi Declaration on Maternal, Newborn, and Child Health in 2005 which announced the formation of a new platform for action on partnerships for MNCH and raised expectations from the international community for meaningful engagement with MNCH (World Health Organization 2005). Building on the unfinished MDG agenda, the SDGs represent a universal call to action to address global poverty, protect the planet from environmental destruction, and ensure peace and prosperity for all people, and were negotiated through the Open Working Group (OWG) at the United Nations. When
we asked informants about the main Canadian goals in the SDG negotiations, MNCH promotion was usually the first response:

What were the main Canadian priorities in negotiating the SDGs? Well certainly MNCH, giving it as high a profile as possible within the SDGs was … one of the top priorities, if not the top. I think initially the intent was to advocate for a standalone goal on MNCH. (Global Affairs Canada Representative)

While a standalone goal did not materialize, a number of Global Affairs Canada respondents felt that Canada was successful in maintaining the visibility of MNCH on the SDG agenda. This was perceived as important due to the overall lack of progress on achieving the MNCH targets in the Millennium Development Goals (MDG) era, and the large investments in MNCH previously made by Canada through the Muskoka Initiative. Other areas of Canadian policy priorities during SDG negotiations included inclusive and sustainable economic growth, and better access to nutrition and education, all issues with important health implications that have long been central to Canadian development cooperation (Global Affairs Canada Representative).

Both our interview and the document analysis made it clear that the predominance of health in Canada’s SDG negotiation strategy cannot be understood without exploring the historical importance of health in the MDGs, and particularly Canada’s earlier support for MNCH, foreshadowing the importance of path dependency in understanding the role of health in Canadian foreign policy today (Proulx et al. 2017). As one respondent highlighted, MNCH started to emerge on the radar of policymakers in the early 2000s, with Canada’s support for MNCH peaking during its G8 leadership (2010) when it announced the Muskoka Initiative (Global Affairs Canada Representative). Another respondent considered the Muskoka Initiative a water-shed moment in Canadian foreign policy:

I think it all started with the importance that’s attributed to the G7 as a negotiating body and as a world, quote unquote, “force”. And I think that Canada took its position within the G7 very seriously. So the amount of energy Canada put into the Muskoka initiative, the signature initiative during its presidency, I think it really wanted to demonstrate that it was going to carry through on those commitments, and it was a huge signature initiative. (NGO Representative)

The role of NGOs in contributing to the emergence of, and support for, the Muskoka Initiative was a common theme in the interviews, with one respondent noting that five important development NGOs in particular pitched the idea of making Canada a champion of MNCH in the lead up to the G8 Summit, acting as policy entrepreneurs for MNCH programs and policies, and “being successful beyond our wildest dreams” (NGO Representative). This was also confirmed by our document analysis which found that these five NGOs had made submissions during the SDG consultation process, emphasizing the need to focus on the unfinished MNCH agenda as part of SDG implementation (Proulx et al. 2017). There were specific policy areas where NGO representatives felt that their lobbying efforts made a difference in the SDG process, such as in Canada’s focus on forced child marriage (NGO Representative). In addition to the clear role of NGOs in promoting the MNCH agenda as part of the Muskoka Initiative, there were also voices within the non-partisan Ottawa bureaucracy which ensured that such ideas would be well-received inside the bureaucracy:
The second component was that the government, the bureaucracy, also landed on this area, maternal newborn child health. So when I asked him [Chief of Staff to Stephen Harper] the question, why did you make the decision in 2010 [to include MNCH on the Muskoka agenda], he flagged that there were people in the Privy Council Office who brought this to his attention. So there were individuals in the Privy Council Office who had worked in development, and were kind of lobbying for this internally. Similarly there was some strong leadership in CIDA [the Canadian International Development Agency, now part of Global Affairs Canada] at the time who were connected to the Privy Council. (NGO Representative)

The role of the business sector in negotiating the SDGs was perceived by respondents as less important than in other areas of foreign policy, for example, in trade and invest treaty negotiations where corporate lobbying clearly informs and influences trade negotiation outcomes (Kukucha 2003). As one respondent noted, the business sector was completely absent at the Addis Ababa Financing for SDG Conference, despite the widely embraced notion that business actors need to contribute to such financing and through Public Private Partnerships (PPPs). Although business representatives did convene side meetings during the SDG negotiation process in New York, it is unclear from the interviews the extent to which Canadian business interests may have influenced SDG agenda-setting through such informal channels. This limited business engagement and private sector lobbying in the SDG process is also reflected in the small amount of private sector submissions in the SDG consultation process we encountered during the document analysis stage.

Finally, we must also consider the sustained focus on MNCH by the international community and policy advocacy networks as contextual driving forces in the SDG process, as well as the fact that MNCH was already well integrated into the daily operating routine of the bureaucracy and institutional frameworks at Global Affairs Canada. Institutionalist theory refers to this as path dependency, in this instance capturing how, because the Canadian government had already received support for its MNCH promotion from a wide array of state and non-state actors globally, it expected that this support would be sustained if it continued to prioritize MNCH in the post-2015 development agenda (Proulx et al. 2017).

The rise of antimicrobial resistance and Canada’s foreign policy response

“Arguably the greatest risk … to human health comes in the form of antibiotic-resistant bacteria” (World Economic Forum 2013, p. 12).

Modern antibiotics are the backbone of health care systems, and without antibiotics many of the basic interventions that modern medicine has to offer would become unfeasible. While the development of antimicrobial resistance (AMR) is essentially a natural phenomenon, it has been accelerated by human actions and now requires global collaboration to propose and implement solutions (Paphitou 2013). Antibiotics are some of the most overused and misused medications due to their affordability, widespread availability related to poor regulation, high levels of effectiveness, and underappreciated side effects. Overuse of antimicrobial products is also observed in agriculture (especially animal husbandry) and aquaculture, and resistant pathogens have been shown to spread through water systems and elsewhere in the environment (World Health Organization 2017).
The scale of the AMR problem is now well understood. It is estimated that if resistance continues to increase at current rates, there will be up to 10 million annual global deaths from AMR by 2050 (Organization for Economic Development and Cooperation 2015), more than presently die from cancer (Yuk-ping and Thomas 2018). The economic cost of AMR (if unaddressed) is also staggering, with the OECD predicting that up to USD23 trillion of Gross Domestic Product could be lost across OECD countries due to AMR by 2050, even at current resistance rates (Organization for Economic Development and Cooperation 2015). These alarming forecasts have led the World Health Organization, the World Economic Forum, and numerous countries to consider antimicrobial resistance an increasingly serious threat to both global public health and global political stability. The globalized nature of the AMR challenge, with resistant pathogens easily crossing borders traveling in human hosts and via food commodities, means that countries cannot successfully address AMR individually, but need to coordinate their responses through foreign policy actions (Yuk-ping and Thomas 2018).

AMR has been on the domestic policy agenda in Canada since the early 2000s, but did not enter the foreign policy sphere until the mid-2010s. This was only after AMR was placed on the World Health Assembly (WHA) agenda and became a topic of serious global concern (Health Canada Representative). Our respondents noted that even though AMR has long been identified as a policy issue, “it has not yet become a political priority, although there is a tremendous amount of work being done both at the government level and by stakeholders, lobbyists, etc. to make it a political issue in Canada as well” (PHAC Representative). The organization of a high-level meeting surrounding AMR at the UN (in September 2016) was seen by some respondents as a strategy to garner more political support amongst the highest bureaucratic level through venue shifting, from the WHA to the UN where heads of States are more likely to partake in high-level meetings.

The reasons for the slow ascendancy of AMR onto the Canadian foreign policy agenda are multifold. Some respondents noted the sluggish pace at which the AMR threat is unfolding, compared to infectious disease outbreaks such as Ebola or SARS which, after an acute episode, can present a serious health security threat to countries around the world within a matter of days. Another characteristic of AMR that might explain its slow rise in foreign policy is the absence of advocates that are impacted by the issue, since AMR does not leave an easily identifiable trail of victims (NGO Representative). Related to this, one respondent emphasized the absence of NGO activism in the area of AMR:

You know, one thing that I didn’t also mention that has also hampered efforts [to address AMR] in Canada, probably elsewhere as well, but more so in Canada, is civil society has not taken up the cause whatsoever. (Academic Representative)

When Canada finally started engaging internationally with AMR, the drivers for this were largely seen as external to the Canadian polity. On the one hand, AMR was perceived as a growing (human) security threat that, while gradually materializing, could undermine Canadian efforts to protect the health of its citizens in the near future, and as such [something that] required foreign policy engagement (Health Canada Representative). Linking AMR to security concerns was highlighted as an effective strategy for wider policy buy-in, especially since AMR is also a growing threat to the treatment of infectious diseases worldwide; in the wake of SARS and Ebola, pandemic threat has become an important consideration in international relations.
On the other hand, a number of respondents highlighted that AMR policy development and implementation represents a case where the integration of health into foreign policy is mostly driven by actors outside of Canada, through policy advocacy by international organizations such as WHO, and by influential policy developments in the United States. As one respondent highlighted:

I would say one of the biggest sparks was something happening in the U.S., in 2012, when they released their Policy Guidance 209 on AMR initiatives. Because our industry is so integrated, you know, the agri-food industry, with the U.S., and the U.S. is actually 25 percent of the global market. We are only 2.5 percent. And so because things were happening there, it really helped us to move this issue onto the foreign policy agenda. (Health Canada Representative)

In particular, Canada’s failure in international fora to promote the regulation of medically important antibiotics (used extensively in food production for growth promotion and prophylactic treatment) reflects the US policy position in this area. This contrasts with the position of the European Union which recently banned prophylactic and metaphylactic use of medically important antibiotics in food production (Vet Record 2016). The importance of the EU’s move to address antimicrobial resistance with such a ban cannot be overstated given that the vast majority of medically important antibiotics are used in animal husbandry, and that the overuse of antibiotics in agriculture is widely believed to be a driving force behind increased bacterial resistance (Economou and Gousia 2015). Many OECD countries are now also strongly advocating for regulatory changes to limit use of last line of defense antibiotics in agriculture. Canada’s policy alignment with the more laissez-faire position of the USA was seen by one respondent as an outcome of the integrated agricultural market in the Northern American hemisphere (Heath Canada Representative). The document analysis further reinforced this point as it showed close alignment in the regulatory changes proposed in both jurisdictions (Dadjo 2019). Several respondents also identified other external driving forces behind Canada’s foreign policy forays into AMR, in particular WHO’s effort to make AMR a global policy priority, with Canada being rebuked by its own Auditor General for not responding to WHO’s push for development of national and international AMR action plans (PHAC Representative).

After some initial hesitations, Canada started to engage heavily on the AMR file in 2014. Key planks of Canada’s international engagement include crucial financial support for WHO (CAD$ 9 million, announced in 2016) to facilitate implementation of the global action plan on AMR (WHO 2015); chairing the AMR action package at the Global Health Security Agenda (GHSA) to logistically support the action plan in low-income settings; engaging the CODEX Intergovernmental Taskforce on AMR to develop prudent antimicrobial use in animals guidelines; and contributing to the Transatlantic Taskforce on AMR (Public Health Agency of Canada 2018).

Discussion – theoretical Reflections on empirical findings

Liberal internationalism has been the dominant paradigm used to explain foreign policy behavior in Canada (Munton and Keating 2001), and remains firmly embedded despite the Harper government’s turn towards a more openly interest driven and mildly isolationist foreign policy (Paris 2014). For liberal internationalists, Canada’s external state behavior is a reflection of the democratic and egalitarian values and cultural norms that
predominate in Canadian society, and global health interventions are seen as a logical extension of humanitarian concerns in a world where wealth and social inequalities continue to co-exist. Our findings affirm the importance of cultural and normative factors in propelling health concerns onto the foreign policy agenda; and that even before entering foreign policy discussions regularly in the early 2000s health had been an important facet of Canada’s international development cooperation. The continuation of strong Canadian advocacy for MNCH throughout the MDG era and into the SDG negotiations suggests a certain element of policy path dependency, a concept used widely in institutional theory, to protect Canadian legacy investments made on behalf of “Brand Canada”, with foreign policy branding becoming ever more prominent (Nimijean 2018).

It is important to note that liberal internationalism regards non-state actors as having a significant role to play in foreign policy processes. NGOs are seen as increasingly important drivers of Canadian foreign policy (Macdonald 2018), whose participation in policy decision-making has long been perceived as a form of democratization (Cameron 1998). The global literature on health diplomacy similarly identifies the influence of policy advocacy networks and non-state actors in positioning health concerns within foreign policy debates (Ruckert et al. 2016). In the UK, The Nuffield Trust (an independent policy think-tank) played a central role in bringing the issue of the health effects of globalization to UK policymakers’ attention in the lead up to the articulation of its 2008 Health is Global strategy (Gagnon and Labonte 2013). Canadian NGOs were instrumental in generating support amongst governments in the negotiation of the Framework Convention on Tobacco Control, by contributing to the establishment of a global epistemic community where members assisted each other in their interactions with the foreign policy apparatus (Lencucha et al. 2011). Another prominent example is the case of Brazil where NGOs have played a central role in promoting Brazil’s foreign policy stance focused on global access to AIDS medications. As Gomez (2012) argues, the impetus behind Brazil’s drug diplomacy derives from actions by social health movements which believe “that it is the state’s responsibility to provide free universal healthcare, as a human right, which entails purchasing and distributing medications for various diseases, including HIV/AIDS” (p. 6).

In a similar vein, the impetus behind Canada’s push for MNCH came largely from development NGOs that had already been active in the area of global health, identified a policy opening to push for uptake of MNCH, and connected with policy advocates receptive to MNCH inside the bureaucracy, especially the Prime Minister’s Office. Such NGO lobbying was cognizant of the importance of framing to ensure policy uptake, with MNCH interventions presented as cost-effective, calculable and measurable, and easily implementable, while facilitating nation-state branding of initiatives (by for example engraving Canadian flags on micronutrient pills administered to mothers during pregnancy). The importance of framing has long been emphasized in global health scholarship (Labonte and Gagnon 2010), especially so when it comes to propelling health issues onto the foreign policy agenda (Youde 2018).

While the role of NGOs and the normative considerations at the heart of the promotion of MNCH seem to confirm the explanatory power of liberal internationalism in the case of MNCH, the rise of AMR onto Canada’s foreign policy agenda does not fit well with this theoretical perspective. There are very few NGOs operating in the space of AMR, despite its growing presence in the media, and AMR is not a topic of concern for most Canadians. Instead, as indicated by our interview findings, health diplomacy at times
functions as an entry point to pursue more traditional foreign policy interests, such as external security threats or external trade interests, the "bread and butter" of realist theory. AMR seems to be a policy area where the coupling of health and security interests is wide-spread, a process often referred to as securitization. The concept of securitization, initially developed by the Copenhagen School of international relations (Buzan et al. 1997, Buzan and Waever 2009), describes a process consisting of three main elements: the discursive articulation of an existential threat, in the AMR case the loss of antibiotics and a related (modeled) rapid increase in global mortality; audience acceptance of the claimed existential threat, as seen in wide-spread global agreement about the need to address this complex issue to avoid an apocalyptic scenario, with the UN General Assembly in 2016 declaring “that the future of humanity will depend on our ability to respond to the challenge antimicrobial resistance” (UN News 2016); and mobilization of resources, new policies, and practices as emergency measures (evidenced by the WHO Global Action Plan on AMR and development of national action plans, including the Pan-Canadian Action Plan on AMR to be released later this year).

Securitization has been widely applied in global health, especially in reference to infectious disease governance (Elbe 2010, McInnes and Rushton 2013), and has allowed a broadening of the security agenda to integrate non-traditional security threats (such as AMR) into foreign policy deliberation. The securitization of health concerns, including the strategic use of security language when discussing health issues, has also facilitated the flow of additional funds and resources to address health threats which may not have been possible otherwise (Youde 2018). Conversely, such securitization risks a focus on those health concerns that are specific to developed countries, privileging these over those constituting the greater disease burdens, as can be seen in the neglect of non-communicable diseases (NCDs) in foreign policy discussions (Novotny et al. 2013). As Rushton (Rushton 2011) points out, the security frame has largely been employed by Western states to protect their own interests. This was recently made apparent by Tejpar and Hoffman (2017), who illustrated how Canada violated its commitments under the International Health Regulations, an international legal norm governing transborder health risk, by imposing unsanctioned border controls during the 2014 Ebola outbreak. Others counter, however, that the securitization of global health concerns such as HIV/AIDS (Elbe 2006, Sjöstedt 2008, 2010, McInnes and Rushton 2010, 2013), SARS (Caballero-Anthony 2006, Wishnick 2010), and Ebola (Burci 2014), provoked a global response well beyond the traditional bounds of action and funds used to address global health concerns.

Although AMR was effectively securitized in Canadian policy practice, Canada was slow to respond to, and prioritize, actions on AMR in its foreign policy. This is arguably related to the role of trade and economic interests in Canada's foreign policy response to the global AMR challenge, factors which were completely absent in the rise of MNCHs. In particular, the close alignment between Canada and the USA in the international AMR policy response reflects their closely integrated agricultural markets, and the Canadian desire to have a common regulatory response so as to maintain a harmonized regulatory landscape for agricultural producers. The USA is by far the largest export market for Canadian agricultural commodities, and imposing regulatory guidelines for antimicrobial use in animal husbandry that are not in sync with US guidelines would likely undermine Canadian competitiveness. In addition, as our document analysis revealed, many agricultural and livestock producers have opposed, and continue to oppose, antimicrobial use
regulations, instead preferring self-regulation of antimicrobial use (Chicken Farmers of Canada 2015, Dadjo 2019), and actively discourage the Canadian government to take an international leadership role in addressing antimicrobial resistance, for example through negotiating binding regulations or a global treaty on AMR.

Conclusion

We end our paper with the conclusion that the driving forces behind health in foreign policy, in the case of MNCH and AMR, cannot be explained in reference to a single IR theory. The case of MNCH reveals the importance of NGO advocacy coalitions, both at national and international levels, and normative values and cultural considerations, both a central focus of constructivist theory. It also speaks to the importance of path dependency, referring to the way in which parts within the bureaucracy, especially at Global Affairs Canada, are strongly invested in maintaining visibility for the MNCH approach due to significant historical investments, both in terms of human and political capital. As such, the MNCH case supports a liberal internationalist understanding of the rise of MNCH on Canada’s foreign policy agenda which subsumes elements of constructivism and institutionalist IR theory in its emphasis on normative and institutional driving forces of Canadian foreign policy.

The case of AMR, however, does not align well with liberal internationalism, and the way in which AMR has become securitized suggests that security concerns related to the potential cross-border spread of antimicrobial-resistant pathogens are the leading driving forces behind AMR’s rise as a foreign policy issue. This understanding of health in foreign policy through a security lens is prominent in realist explanations of health in foreign policy. However, the slower uptake of the issue and the tepid support by the Canadian government for international AMR initiatives require drawing on additional explanatory factors, in particular the role of the agricultural and livestock sectors in wanting to limit any Canadian commitment to a binding global treaty on antimicrobial use.

Our findings, more generally, suggest to us that no single IR theory can convincingly account for the driving forces of health in foreign policy. While many of the health concerns rising onto the foreign policy agenda are arguably driven by how health is culturally embedded in Canadian society and promoted by policy NGO advocacy coalitions, representing Canadian foreign policy solely in liberal internationalist terms would be a misrepresentation, or at least simplification, of the complex reality of competing interests and logics inherent to Canadian foreign policy deliberation.

Notes

1. The Muskoka Initiative on Maternal, Newborn and Child Health was a funding initiative announced at the 36th G8 summit in 2008 which committed member nations to collectively spend US$5 billion between 2010 and 2015 to accelerate progress toward the achievement of Millennium Development Goals 4 and 5, the reduction of maternal, infant and child mortality in developing countries. A second summit on Maternal, Newborn and Child Health was held in Toronto from May 28-30, 2014 in follow-up to the original 36th G8 summit.
2. While there are many variants of realism, including classical realism, structural or (neo-)realism, neoclassical realism, offensive and defensive realism, for the purpose of this article we group them together.
3. Global health diplomacy (GHD) is a relative new concept intended to capture the multi-level and multi-actor negotiation processes that shape and manage the global policy environment for health (Kickbusch et al. 2007) and, more specifically, the “policymaking processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilize health concepts or mechanisms in policy-shaping and negotiation strategies […]” (Smith et al. 2010, p. 2).

4. Unlike national security, the concept of human security is people- rather than state-centred with particular emphasis placed on vulnerable populations. It implies a concern for global health that transcends narrow national interests and embraces cosmopolitan values.

5. In 2014 Russia was removed from G8 membership, reducing the club to G7.

6. The Policy Guidance for Industry (GFI) #209 is entitled The Judicious Use of Medically Important Antimicrobial Drugs in Food-Producing Animals and outlines how the Food and Drug Administration (FDA) plans to move forward with its effort to restrict the use of medically important feed-grade antimicrobials for production purposes (ie, growth promotion and feed efficiency) in livestock. GFI #209 is intended to guide veterinarians, farmers, and animal producers on the judicious use of medically important antibiotics in food-producing animals by targeting their use to address only diseases and health problems. Under this voluntary initiative, certain antibiotics are not supposed to be used for production purposes, such as to enhance growth or improve feed efficiency in an animal.

7. Although we use the terms, civil society and NGOs, interchangeably in this article, we recognize that there are important differences in how they are conceptualized. Civil society has a broad meaning in the sense of conveying all forms of social interactions that are not formally part of either government or market relations. Civil society includes NGOs, which often represent the more formally organized sectors of civil society and thus more likely to be engaged in policy advocacy. NGOs, however, can also become self-interested actors whose engagements in such advocacy reflects specific rather than broader public interests and whose governance may be less transparent or democratic as sometimes assumed.

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