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COMMENTARY

First as tragedy and then on to farce: Canadian foreign aid for global health

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The Global Health Group in the Faculty of Health Sciences at Simon Fraser University have rightly called for deeper critical reflection on the current state of Canada's foreign aid for Global health. We are delighted that the group took note of our 2009 publication, "Canadian foreign aid for global health: Human security opportunity lost" (*Canadian Foreign Policy Journal*, Vol. 15, Issue 3, January 2009, pages 60–84), which pointed out that Canada marginalized its global health commitments in favor of its military and diplomacy commitments. In the paper we noted that in the 3-D (or whole of government) approach that conjoins defense, diplomacy, and development for certain foreign initiatives, it is by no accident that "development" factors last.

Three years since preparing this piece, we see that little has changed in Canadian foreign aid for global health. As such, we applaud the Global Health Group's call and sincerely hope that academics and policy-makers can find opportunities to explore ways in which to put Canada's global health commitments back on track. Some proponents of the current government may suggest that Canada should be praised for generously funding recent global health initiatives such as the Muskoka Initiative on Maternal Health, or for contributing hundreds of millions in disaster relief for Haiti, or through innovating strategic public–private partnerships for health aid. As we see it, however, in only a three-year span, the state of Canadian foreign aid for global health has gone from tragedy to dark comedy, and notably so with all three of these initiatives. The descent of Canadian foreign aid into security and corporate models are of notable concern, as these programs insolently further the interests of Canadian organizations without real transformative benefits to marginalized communities abroad. It flies in the face of Canada's moral commitments for improving the lives of the world's poor.

First, the nature of Canada's emergency response to natural disasters, notably the 2010 earthquake in Haiti, demonstrates Canada's brazen priority of "security" above that of "human security". Second, the Muskoka initiative has committed enormous funds to maternal health, but almost nothing to the creation of sustainable capacity building at the local level. The program does not focus on family planning methods either, which is an important human security

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factor for resource-poor countries. Third, The Canadian International Development Agency's (CIDA) new collaboration with mining companies shows a perverse global health geography that recognizes health needs only where Canadian business interests are to be found. Fourth, the political leadership at CIDA has descended to an unabashed state where there is little appetite for critical reflection, and almost no consequences for tasteless political decisions. Taken in sum, Canada's foreign aid for health is on life support. Where once there was potential to see long-term outreach and solidarity to the poorest regions of the planet, now we have overt neo-colonial programs of tied aid. This goes beyond tragedy of an opportunity lost, to outright absurdity in how a G8 nation should position its moral commitment to the health of the global poor.

When the devastating earthquake struck Haiti in January 2010, Canada was one of the first states to commit to the disaster relief, pledging over \$150 million in relief within the first three months. In addition, the Canadian government committed over \$400 million to relief efforts, with \$325 million earmarked in 2010–2011, and \$75 million thereafter. Impressive numbers, but little of this went to the health of Haitians. According to CIDA data collected by the Canadian Haiti Action Network, the two largest non-security spending items in the Canadian relief budget were \$19 million for the World Food Program, and \$10 million for the promised construction of a hospital in Gonaives in what is today still an empty field that still only has a sign that reads, "future hospital to be funded by the government of Canada". While Haitians still await the hospital, Canada committed over \$18.5 million for the construction of a police academy, \$16.5 to run the police training program in the academy, and \$10 million for prisons so that criminals have somewhere to go when the police catch them. The Government of Canada also committed \$34 million in debt relief through the World Bank. The numbers speak for themselves \$45 million to security, \$34 million to service foreign debt, and \$10 million for a future hospital. In looking at the long-term commitments to Haiti, the three Ds remain in order, with global health as development taking the back seat.

The Muskoka Initiative was announced at the 2010 G20 meeting. Canada took the lead in calling for an additional \$1.1 billion in new funding to address three strategic areas of maternal health in ten countries. CIDA claims to prioritize access to services, strengthen national health services, and fill in gaps for service provision. In Ethiopia, one of the ten priority countries, funds are going towards vaccinations, malaria bed nets and improving access to village health workers. While these are all notable contributions, and no doubt there will be life saving benefits from these projects, the focus remains distal from building the appropriate responses to the social determinants of health that lead to maternal and infant mortality. Education, work opportunities, and family planning are all missing elements from the Muskoka Initiative. Moreover, many of the priority countries happen to be strategic for Canadian business interests, notably energy and mining in Mozambique, Haiti, Mali, Nigeria, Sudan and Tanzania.

CIDA's recent announcement of funding aid programs within partnerships with Canadian mining companies has been widely criticized as a return to tied aid. The idea that Canadian development will only go where Canadian business interests can be found is a shameless move that minimizes Canada's place in a global health community to one of self interest. The nature of some of the partnerships with companies like Barrick Gold or IAMGOLD have been critiqued by international development scholars, while others have simply said, "this is the way of the future" in current economic conditions. The nature of these programs, such as the partnership between IAMGOLD and Plan Canada to provide skills training for youth aged 13–18 may be highly problematic as a gateway for child labor into Canadian mining operations. Even more problematic is that mining outfits have been extensively criticized for involvement in displacing locals, hiring private security to intimidate unions, and even having connections to the disappearance of anti-mining activists in Peru and Guatemala. If this is CIDA's new approach to aid, it is

one that smacks of public money going towards mending bruised images of Canadian mining firms. Again, the development “D” comes in last.

Finally, it is worth mentioning that the descent from tragedy to farce has come amidst an operating climate of top-down politics into policy making. Canada’s Minister of International Cooperation and Development, Bev Oda, has been very involved in shaping CIDA’s path, even to the point of manipulating documents to deny funding to organizations like Kairos, after CIDA officials finalized the arrangements. The scandal had many calling for the resignation of the Minister, but Prime Minister Stephen Harper defended her actions. More recently, Minister Oda has received sharp criticism for spending taxpayer money upgrading to top luxury hotels in London, billing taxpayers for \$16 glasses of orange juice and \$1000 a day limo services, while Ottawa undergoes deep budget cuts. It is a gross double standard for a minister to spend wildly when her ministry resorts to partnering with corporations because it cannot muster funds on its own. While we have not agreed with the direction of foreign aid for health under Prime Minister Harper and Minister Oda, the descent into top down political decisions being made without any genuine form of public debate or responsiveness to criticism is deeply troubling.

We commend the Global Health Group at SFU for recognizing the need for deeper critical engagement on the place of health in Canada’s foreign aid strategy. We cannot help but feel that with the examples listed in this reply that the de-prioritizing of health aid is having perverse consequences for the global poor. The Expert Panel on Canada’s Strategic Role in Global Health suggests that we are on the right track and all it takes is greater political will for larger ministerial budgets to meet global health needs. But as we see it, this isn’t the case and talk of bigger budgets is not necessarily the sort of critical discussion that is most needed. Rather, it comes down to reviewing the deep intentions of our international health priorities, from serving our own security, diplomatic and governance interests to actually finding the political and moral value in positioning Canadian foreign aid to make a positive difference for the health of others.