



Canada's global leadership on health 2

Canada's global health role: supporting equity and global citizenship as a middle power

Stephanie A Nixon, Kelley Lee, Zulfiqar A Bhutta, James Blanchard, Slim Haddad, Steven J Hoffman, Peter Tugwell

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This is the second in a [Series](#) of two papers about Canada's health system and global health leadership

Department of Physical Therapy (S A Nixon PhD), International Centre for Disability and Rehabilitation, and Rehabilitation Sciences Institute (S A Nixon), Department of Nutrition (Prof Z A Bhutta PhD), Dalla Lana School of Public Health, University of Toronto, Toronto,

Canada's history of nation building, combined with its status as a so-called middle power in international affairs, has been translated into an approach to global health that is focused on equity and global citizenship. Canada has often aspired to be a socially progressive force abroad, using alliance building and collective action to exert influence beyond that expected from a country with moderate financial and military resources. Conversely, when Canada has primarily used economic self-interest to define its global role, the country's perceived leadership in global health has diminished. Current Prime Minister Justin Trudeau's Liberal federal government has signalled a return to progressive values, driven by appreciation for diversity, equality, and Canada's responsibility to be a good global citizen. However, poor coordination of efforts, limited funding, and the unaddressed legacy of Canada's colonisation of Indigenous peoples weaken the potential for Canadians to make meaningful contributions to improvement of global health equity. Amid increased nationalism and uncertainty towards multilateral commitments by some major powers in the world, the Canadian federal government has a clear opportunity to convert its commitments to equity and global citizenship into stronger leadership on the global stage. Such leadership will require the translation of aspirational messages about health equity and inclusion into concrete action at home and internationally.

Introduction

When asked at his swearing-in as Prime Minister of Canada why he appointed an equal number of women and men to his cabinet, Justin Trudeau replied: "Because it's 2015."¹ Diversity was further reflected by the appointment of Indigenous people and people of colour

to a quarter of his cabinet positions.¹ This moment exemplified the importance of equity and inclusion throughout Canada's nation-building history—as an aspiration, if not a reality. These values have also underpinned the country's foreign policy, in view of its geopolitical position as a so-called middle power.² These aspirations remain relevant today, as Canada marks 150 years since Confederation while grappling with its troubling treatment of Indigenous peoples, who inhabited the land for thousands of years before colonisation.

In this second paper of a two-part Series on Canada's health system and global health leadership,³ we analyse how this ideal of Canada as a work in progress, combined with its international position as a middle power, has shaped its role in global health policy and action. The country has mostly sought to be a socially progressive force, punching above its weight and exerting influence disproportionate to its financial and military resources. Leaders in Canada have been prominent and respected contributors to global health research, practice, and diplomacy for decades (panel 1). At times, however, the tendency to give primacy to consensus building, inclusion, and equity has led to a lack of decisiveness and timely strategic action. Conversely, when Canada has strayed from progressive social values, and economic self-interest has been prioritised in foreign policy, the country's perceived leadership in the global health community has diminished. On the basis of this analysis, we identify lessons for the Canadian federal government, acting strategically with limited political and economic resources, to translate values of equity and inclusion into strong, bold, and much-needed leadership in global health.

Key messages

- Canada boasts long-standing and active engagement in global health, shaped by the country's history of nation building and middle-power status. Ongoing nation building emphasises consensus building and equity in foreign policy, and relies on strong commitment to multilateralism.
- Canada's unique strengths in global health leadership draw from the country's legacy and contemporary challenges of building a multicultural society, maintaining a bilingual heritage, and reconciling the injustices inflicted on Indigenous peoples. Health equity has been a key focus.
- The quality of Canadian contributions to global health has been high, but impact has been diluted by a tendency to spread limited resources thinly, and by fragmentation among global health institutions, priorities, and policies in Canada.
- The previous Conservative federal government, led by Stephen Harper, adopted an approach to foreign policy that favoured technocratic solutions and tied global health initiatives to trade and investment opportunities benefiting Canada. It championed maternal and child health in the Millennium Development Goal era, but critics say this period was a sharp departure from traditional Canadian values of equity, human rights, and global citizenship.
- High expectations exist for the current Liberal government led by Justin Trudeau, which has signalled a return to these traditional Canadian values. Canada now has an important opportunity to assert much-needed global leadership, including in global health. Real policy change and concrete action on issues such as foreign aid assistance and Indigenous health inequities are urgently needed to demonstrate the credibility of the government's commitment to these values.

Canada's history and emergence as a middle power

The role of Canada in global health is inextricably linked to the country's history of colonisation and nation building. Canada could have looked very different. The discovery of gold on the west coast in the 1850s put these colonised territories at risk of absorption by the larger USA to the south. A geopolitical race ensued to unite the British and French colonies from east to west as a single country, and fend off American land-grabbing ambitions. The enactment of the British North America Act (now known as the Constitution Act) in 1867, to form the Dominion of Canada, marked the beginning of a decades-long effort to integrate and unify the diverse elements that would form this new country. The Canadian Pacific Railway, completed in 1885 as a condition for British Columbia to join Confederation, formed the critical infrastructural backbone of this vast territory.⁴ As part of the colonisation process, the British Crown pressed Indigenous peoples to agree to 56 land treaties between 1760 and 1923, many of which are challenged today for their legality or questionable due process.⁵ Other traditional territories were simply occupied and remain unceded today. Domestic politics focused on balancing the interests of the English and the French—while diminishing the power and rights of Indigenous peoples—and integrating a steady inflow of immigrants who together formed the tapestry of the Canadian population.

The goal of unifying this diverse range of people, across a vast territory of 10 million km² that spans more than 5500 km from east to west, has made cooperation, compromise, and consensus building essential to Canadian politics and society. These values are reflected in the Canadian Constitution, which upholds “peace, order, and good government” by contrast with “life, liberty and the pursuit of happiness” in the US Constitution.⁴ The building of this societal mosaic (unlike the American melting pot) is an ongoing enterprise—in 2016, Canada welcomed more than 296 000 permanent immigrants (including 62 000 refugees) from more than 190 countries (led, in order, by the Philippines, India, Syria, China, Pakistan, the USA, Iran, France, the UK, and Eritrea), a 9% increase from the previous year.⁶ Restoration of the place of Indigenous peoples within this political landscape, following the findings of the Truth and Reconciliation Commission of Canada regarding the devastating effects of the Indian Residential School system, has yet to be realised.⁷

This history of diversity and nation building has, in turn, defined Canadian foreign policy. At the end of World War 2, Canada emerged as a middle power—ie, countries that are defined by their moderate military and economic resources (compared with major powers, such as the permanent members of the UN Security Council), but with the potential to wield considerable political influence. Middle powers achieve such impact by forming alliances, promoting shared norms, working cooperatively

Panel 1: Canadian contributions to global health

- The discovery of insulin in 1921 by Canadian physician Frederick Banting and medical student Charles Best
- The development of Rh immunoglobulin by Alvin Zipursky, Jack Bowman, and Bruce Chown in the 1960s, contributing to the elimination of rhesus haemolytic disease
- Leadership on the World Federation of Public Health Associations since 1985 by Margaret Hilson
- The discovery of natural immunity to HIV by Francis Plummer in 1988, based on a cohort of sex workers in Kenya, which signalled the potential for a future vaccine
- The birth of evidence-based medicine in the 1990s—the assessment, production, dissemination, and uptake of evidence in the context of clinical decision making—led by John R Evans, Gordon Guyatt, Brian Haynes, and David Sackett
- The development of microencapsulated Sprinkles by Stanley Zlotkin in the 1990s as a novel means of providing micronutrient supplements to children
- The near elimination of chancroid (*Haemophilus ducreyi*) in sub-Saharan Africa through systematic control of sexually transmitted infections, led by Allan Ronald and colleagues since 2000
- The International Network of Indigenous Health Knowledge and Development, advancing health of Indigenous peoples in Canada, Australia, New Zealand, and the USA since 2003, co-led by Judith Bartlett (Métis), Barry Lavallee (Métis and Sauteaux Nation), Jeffrey Reading (Mohawk), and Deborah Schwartz (Métis)
- Leadership on the development, evaluation, and implementation of new diagnostic technologies for low-income countries by Rosanna Peeling as Head of Diagnostics Research at the UNICEF-UNDP-World Bank-WHO Special Programme for research and training in Tropical Diseases (2003–08)
- The Teasdale-Corti Global Health Research Partnership Program (named for Canadian surgeon, Lucille Teasdale, and her husband, Piero Corti), which supported north–south projects in Asia, Africa, the Middle East, Latin America, and the Caribbean (2005–13)
- The advancement of male circumcision for HIV prevention by Stephen Moses in 2007
- The creation of the Canada Gairdner Global Health Award in 2009 to honour a biomedical researchers affecting the health outcomes of populations in low-income and middle-income countries
- The lead role in the discovery of the VSV-EBOV vaccine to prevent Ebola virus disease by Heinz Feldmann and colleagues in 2015 at the Public Health Agency of Canada

through multilateral channels, and engaging in diplomatic solutions. Although conducting foreign policy in this way can be more restrictive than unilateral action, in return, middle powers can exert greater influence on health and other global concerns than their material resources would normally allow. Other recognised leading middle powers include Australia, Norway, and Sweden.⁸

Despite occupying the world's second largest national territory, Canada's economic and military resources are overshadowed by its southern neighbour, which gives multilateralism greater strategic importance for Canada. Canada was active in the creation of the UN system and has been a non-permanent member of the UN Security Council a dozen times (fourth most frequent). Although the government's support for human rights initially required external pressure, individual Canadians had prominent roles in drafting the UN Charter, and in founding and leading the UN Division of Human Rights (including drafting and adoption of the Universal Declaration of Human Rights).² At the height of the Cold

ON, Canada; Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, Canada (Prof K Lee DPhil); Centre for Global Child Health, The Hospital for Sick Children, Toronto, ON, Canada (Prof Z A Bhutta); Centre for Global Public Health, Department of Community Health Sciences, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, MB, Canada (Prof J Blanchard PhD); Centre de Recherche du Centre Hospitalier Universitaire de Québec-Université Laval, Québec City, QC, Canada (Prof S Haddad PhD); Département de Médecine Sociale et Préventive, Université Laval, Québec City, QC, Canada (Prof S Haddad); Global Strategy Lab, Dahdaleh Institute for Global Health

Research, School of Health Policy and Management, and Osgoode Hall Law School, York University, Toronto, ON, Canada (Prof S J Hoffman PhD); Ottawa Hospital Research Institute, Ottawa, ON, Canada (Prof P Tugwell MD); and Department of Medicine and School of Epidemiology and Public Health, University of Ottawa, Ottawa, ON, Canada (Prof P Tugwell)

Correspondence to: Dr Stephanie A Nixon, Department of Physical Therapy, Dalla Lana School of Public Health, University of Toronto, Toronto, ON M5G 1V7, Canada stephanie.nixon@utoronto.ca

Panel 2: Canada's role as a middle power in global health

Alliance building to assert greater influence on foreign policy

- Canada joins Australia, Italy, Norway, Sweden, and the UK to support a donor-led study of WHO reform of country offices (1996–97).¹⁰
- Canada initiates the Global Health Security Initiative with WHO and seven like-minded countries, as an informal partnership to strengthen public health preparedness and response to threats of biological, chemical, and radionuclear terrorism, and pandemic influenza (2001).¹¹
- Canada, Norway, the USA, the World Bank, and UN co-launch the Global Financing Facility (GFF) in support of the Every Woman Every Child initiative. Canada contributes US\$40 million to jumpstart a GFF-IBRD (International Bank for Reconstruction and Development) partnership for community health workers and malaria control, which leverages funding from private capital markets (2015).¹²
- Canada contributes CAN\$20 million at an international conference hosted by Belgium to replace the US\$600 million cut to aid for abortion-related services by the Trump Administration (2017).

Collective action through multilateral institutions to address shared problems

- Health Canada in partnership with WHO creates the Global Public Health Intelligence Network (GPHIN), an automated, multilingual, internet-based tool to rapidly detect, identify, assess, prevent, and mitigate threats to human health. GPHIN is headquartered in the Public Health Agency of Canada, and is a key data source for WHO Alert and Response Operations (2000).
- Canada actively participates in the revision of International Health Regulations after the outbreak of severe acute respiratory syndrome (SARS) and establishes the Public Health Agency of Canada as a national focal point for compliance (2004).
- Canada hosts the Fifth Replenishment Conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and increases its pledge by 20% to CAN\$804 million for 2017–19, as an example of “when we work together, we can truly transform the world” (2016).¹³

Compromise positions to resolve international disputes

- The Canadian International Development Agency (CIDA) collaborates with the UK and co-hosts a meeting of diverse stakeholders to discuss models, including an Ottawa Fund,

for a global mechanism to fund health issues. This process leads to the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (2001).

Assert leadership on non-security issue areas

- The Canadian Public Health Association, Health and Welfare Canada, and WHO co-sponsor the first International Conference on Health Promotion, which adopts the Ottawa Charter, calling for a comprehensive, multistrategy approach to health and wellbeing (1986).
- Canada introduces the idea of an international treaty on tobacco control at the World Health Assembly (WHA), arguing that a comprehensive, coordinated, and multifaceted approach is necessary. Finland and Ireland were persuaded to sponsor a WHA resolution to initiate the Framework Convention on Tobacco Control, since Canada was not on the WHO Executive Board at the time (1998).¹⁴
- The Minister of Health and the Minister of Environment and Climate Change commit to addressing risks from chemicals to health and the environment by 2020, guided by a Chemicals Management Plan. The plan made Canada a world leader on safe chemicals management, including the adoption of a WHA resolution (2006).¹⁵
- Canada co-leads (with Tanzania) the Commission on Information and Accountability for Women's and Children's Health in support of Millennium Development Goals 4 and 5 (2010).

Actively promote human rights and rule of law as core norms in foreign policy

- Canada hosts a conference at which Foreign Affairs Minister Lloyd Axworthy challenges world leaders to adopt the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction, known as the Ottawa Treaty (1996).
- Canada becomes the first country to create detailed legislation, known as the Canadian Access to Medicines Regime, to enact the 2003 World Trade Organization decision allowing countries to use compulsory licences on pharmaceutical products to export affordable medicines to countries with an insufficient capacity to manufacture them (2005).
- Canada co-sponsors the UN Security Council resolution on protecting medical missions in compliance with international humanitarian law (2016).

War, Minister of External Affairs (later Prime Minister from 1963 to 1968) Lester Pearson set the tone for Canada's role as an “honest broker” and “helpful fixer”.⁹ His use of quiet diplomacy to diffuse the Suez Canal crisis, and leadership in creating UN peacekeepers, earned him the Nobel Peace Prize in 1957.

Canadian approaches to health policy, at home and abroad, reflect this particular history centred on the values

of equity and universality. Canada's publicly funded, but largely privately delivered, health-care system straddles social and private medicine.³ Abroad, Canada's approach has mainly been to promote global health through multi-lateral cooperation, alliance building, and collective action (panel 2). The link between Canada's domestic interests and global citizenship is also well recognised; Canada is ranked the tenth most globalised country in the world,

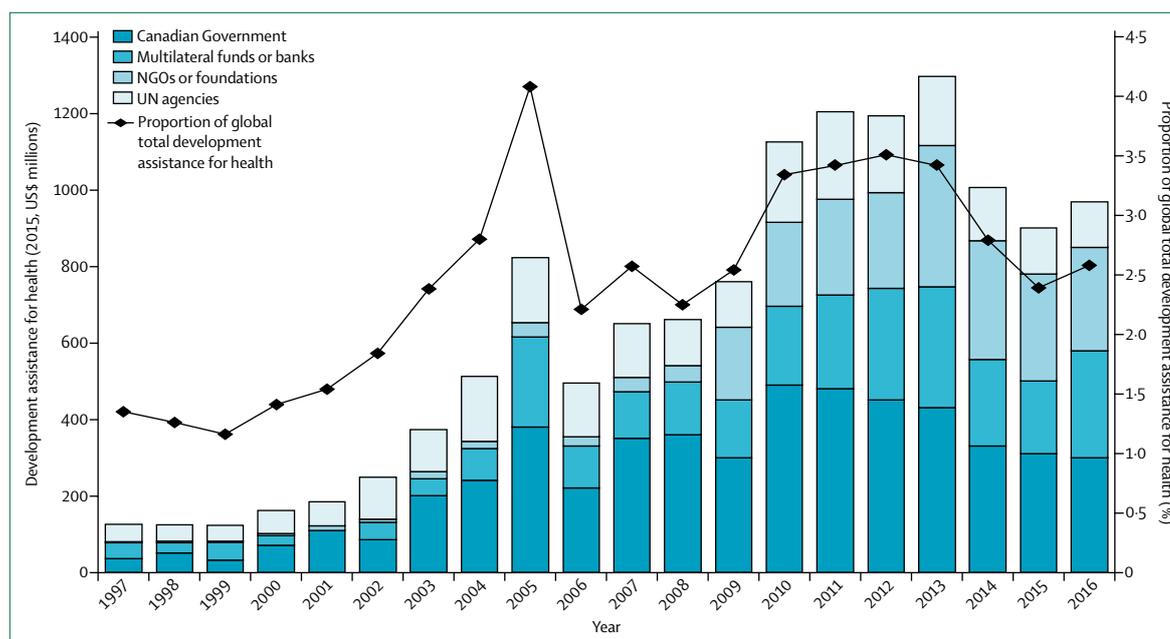


Figure 1: Canada's development assistance for health from 1997 to 2016

Canada's annual development assistance for health has been adjusted to constant US\$ (2015) by funding channel. Data from reference 19. NGOs=non-governmental organisations.

based on trade relations, population mobility, and openness.¹⁶ In advancing global health and equity, Canada's strategies have been fuelled by its long-standing commitments to multilateralism and global citizenship.

In support of multilateralism: Canada's contributions to development assistance for health

In 1948, Canadian doctor Brock Chisholm was elected the first Director-General of the newly established WHO, an appointment that marked the start of long-standing leadership by Canada in global health diplomacy and development assistance for health (DAH; development assistance that specifically targets health). Many Canadians occupied prominent roles in health development over ensuing decades. In 1969, Pearson led the eight-member World Bank Commission on International Development, which produced the landmark report,¹⁷ *Partners in Development*, that, in citing moral imperative and enlightened national self-interest, urged high-income countries to increase overall official development aid (ODA; all forms of development assistance) to 0.7% of their gross national product by 1975. Achieving recognition of this target epitomised the capacity of Canadians to use a middle-power voice to foster new norms. The Canadian Government's track record in adherence to such norms, however, has been chequered. Despite Canadian championing of the benchmark, Canada's own ODA commitments have lagged behind those of other countries that are members of the Organisation for Economic Co-operation and Development (OECD), including middle

powers such as Sweden. In 2016, Canada's net ODA (CAN\$3.96 billion) constituted 0.26% of its gross national income, placing it 15th among 29 OECD countries, and well below the OECD average of 0.40%.¹⁸

Canadian DAH contributions in particular, however, have risen substantially in recent decades, both in absolute and relative terms. According to the Institute for Health Metrics and Evaluation (IHME), Canada's overall DAH (adjusted to 2015 US\$) increased by more than seven times, from \$168 million in 1997 to \$1.25 billion in 2016 (figure 1).¹⁹ Canada's overall share of global DAH increased from approximately 1.35% during this period. By 2015, Canada placed third among Group of Seven (G7) countries, in terms of DAH as a percentage of gross national income (0.058%), behind the UK (0.170%) and the USA (0.073%), and ahead of France (0.036%), Germany (0.032%), Japan (0.014%), and Italy (0.012%).²⁰ This growth of DAH from Canada began around 2000 and mirrored overall growth in global health funding. Canada's allocation of DAH is consistent with its historical emphasis on multilateralism: in 2016, more than 41.0% of Canada's DAH flowed through multilateral channels (ie, development banks, Gavi, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and UN bodies), whereas 34.7% of all global health financing overall was channelled through multilateral mechanisms.¹⁹

Although Canada's emphasis on multilateral funding mechanisms has been maintained over the past two decades, notable changes over time are evident in how Canada has channelled its global health funding¹⁹

(figure 1). During the early phase of expanded funding (1997–2008), the most prominent funding channels were Canadian bilateral assistance mechanisms (47·7%), followed by UN bodies (27·1%). Less than 5% of funding was channelled through non-governmental organisations and private foundations. From 2009 to 2016, substantially more funding went through international and Canadian non-governmental organisations and foundations (25·3%), with a concomitant decrease in funding through Canada's bilateral assistance mechanisms (36·6%) and UN bodies (15·6%). One driver of this shift was Canada's large investment in the G8 Muskoka Initiative for Maternal, Newborn and Child Health, which was initiated in 2010. An analysis of financing patterns of the Muskoka Initiative for 2010–11 and 2012–13 estimated that the largest share of funding (47%) was channelled through foreign non-profit organisations, including multi-lateral partners, UN agencies, and international non-governmental organisations,²¹ whereas approximately 16% of the CAN\$2·85 billion commitment was channelled through Canadian non-governmental organisations.²¹ How Canada channels its global health funding has important implications for the future. The shift in funding from bilateral mechanisms to large, global, issue-oriented priorities, such as the Muskoka Initiative, can sharpen the focus of Canada's role in global health, but this narrowed scope might constrain responsiveness to local priorities.

Canada's leadership on equity as central to global health

Historic contributions

A long-standing theme in Canadian approaches to global health has been promotion of health equity. This theme has been pursued through the middle-power behaviours of collective action, leadership on non-security issues, and promotion of human rights norms. Health equity is concerned with disparities in health that are systematic, avoidable, and unfair; that is, where differences in health have social, economic, or political causes as opposed to biological causes.^{22,23} Concern for health equity goes beyond the health system to include structural causes of health disparities, often framed as the social determinants of health. In Canada, the domestic experience of creating a system of universal health coverage based on the principle of equity has been central to nation building.³ A key moment in this process occurred in 1974 when the landmark Lalonde Report²⁴ (named for then-Minister of National Health and Welfare, Marc Lalonde) emphasised the role of both biological and social factors as health determinants. The Lalonde Report is credited with advancing health promotion and public health domestically, and for setting the global stage for adoption of the WHO Alma-Ata Declaration on primary health care in 1978.²⁵

The theme of equity was also seminal to the Ottawa Charter for Health Promotion adopted in 1986 at

the inaugural International Conference on Health Promotion, led by WHO and hosted by the Canadian Government. The framing of health promotion, as “the process of enabling people to increase control over, and to improve, their health”,²⁶ substantially influenced public health practice worldwide.^{27,28} Reflecting on the influence of the Lalonde Report and the Ottawa Charter, Pan American Health Organization Director, George Alleyne, stated in 2001 that “it is perhaps not accidental that the impetus for the focus on health promotion for the many should have arisen in Canada, which is often credited with maintaining a more egalitarian approach in all health matters”.²⁵

This core idea that “[s]ocial injustice is killing people on a grand scale” was revisited in the 2008 report of the WHO Commission on the Social Determinants of Health.²² Supported by former Canadian Health Minister Monique Bégin (who was responsible for adoption of the Canada Health Act in 1984) as a Commissioner, and by numerous Canadians coordinating the Commission's Knowledge Networks, the Commission made three recommendations for improvement of global health equity: improve the conditions of daily life; tackle the inequitable distribution of power, income, and resources; and measure and understand the problem and interventions to address it.

Promotion of health equity through research

In line with this third recommendation, Canada has used research as a strategy for the promotion of equity. This priority is exemplified by Canada's health research funding structures, including the International Development Research Centre (IDRC). Established by Prime Minister Pierre Elliott Trudeau's Liberal government in 1970, IDRC is respected worldwide for its approach to funding low-income and middle-income country (LMIC) researchers in 150 countries, with sustained emphasis on capacity building.^{29,30} Despite recent funding cuts, IDRC remains the world's only government-mandated organisation devoted to research for development.

IDRC co-founded the independent Commission on Health Research in Development, chaired by Canadian John R Evans. In 1990, the Commission's ground-breaking report³¹ spurred debate about health equity by demonstrating that only 5% of funds (US\$30 billion in 1986) were spent on research addressing problems of poor countries whose citizens bore 93% of the global burden of preventable disease. Building on the Commission's finding of inequitable funding and the fragmentation of international efforts, WHO passed a resolution at the 43rd World Health Assembly recommending greater funding and better coordination to support LMIC researchers to enable them to do essential national health research. Despite leadership by Canadians on the Commission, the Canadian Government was slow to respond to these recommendations.³² However, since 2000, funding by the Canadian Institutes of Health

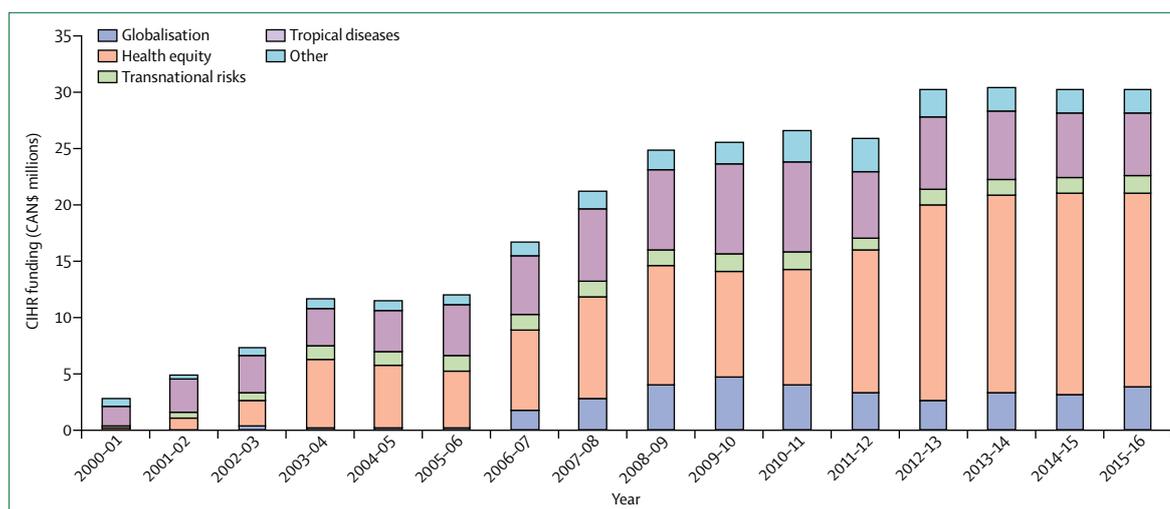


Figure 2: Canadian Institutes of Health Research (CIHR) funding of global health research by primary focus, 2000–15
Data provided by the CIHR on June 6, 2017.

Research (CIHR)—the main federal funder of health research in Canada, akin to the US National Institutes of Health—for global health has increased from less than CAN\$3 million to more than \$30 million. Furthermore, over the past decade, annual global health research funding has targeted health equity more than any other primary focus (figure 2). CIHR is unique among national health research funders for viewing global health research as directly serving its mandate to improve the health of Canadians, based on the premise that “we can’t be healthy in an unhealthy world”.³³

IDRC and CIHR form part of a broader global health research funding landscape in Canada that is fragmented.³⁴ To improve coordination, in 2001 the federal government created the Global Health Research Initiative (GHRI), a funding partnership of CIHR, IDRC, Health Canada, and the Canadian International Development Agency,³⁵ aiming to develop joint funding programmes, influence policy, and improve information sharing. More than CAN\$60 million was invested via the GHRI in health system strengthening and increasing research capacity, including the Teasdale-Corti Research Program and the Africa Health Systems Initiative-African Research Partnership Program.³⁶

This collaborative approach to global health research facilitated collective action on shared problems. To advance this same approach among researchers, in 2003 GHRI helped to create the Canadian Coalition for Global Health Research, which has advocated for research grounded in equity-based South-Canada partnerships^{34,37,38} and in 2015 released the Principles for Global Health Research, emphasising equity.^{39–41} The Canadian approach has focused on building capacity among researchers and research users to promote equity, including the creation of tools such as reporting guidelines for assessment of health equity evidence in systematic reviews,^{42,43} training

on equity-oriented research for LMIC researchers,⁴⁴ and mobilisation of evidence to help policy makers make decisions based on equity.^{45,46}

Despite the promising model and initial successes of GHRI, it has now all but disappeared. A decade after its creation, GHRI faced substantial cutbacks as the government shifted its funding strategy.³⁰ In 2008, Prime Minister Stephen Harper’s Conservative federal government made a 5-year investment of CAN\$225 million to establish a new research funder, Grand Challenges Canada, which was launched in 2010.⁴⁷ Using an integrated-innovation approach, Grand Challenges Canada has been lauded for its focus on impact (eg, supporting 800 innovations in 80 countries), direct funding to LMIC researchers, and investment in mental health.^{30,48} However, some people criticise it for pursuing an overly technocratic approach and for neglecting the social determinants of health.^{30,49} Moreover, the creation of a separate funding arm that is independent of the GHRI’s four partners has not contributed to coherence.

Threats to health equity gains

Despite Canada’s aspiration to address the structural drivers of inequities, other actions or lack of action have undermined this aim. A pernicious example is Canada’s sustained position as one of the leading countries (with the USA, the UK, and Australia) that drain health human resources from LMICs, leading to a perverse subsidy from poorer to richer nations.⁵⁰ The continued supply of foreign-trained clinicians is an assumed factor in Canadian health-care planning initiatives, exacerbating rather than challenging inequities,⁵¹ and there is little evidence of Canada’s uptake of the WHO Global Code of Practice on the International Recruitment of Health Personnel that is meant to mitigate harms produced by this long-standing practice of brain drain.^{52,53}

Another example is Canada's global position as a mining giant, with Canadian companies operating in more than 100 countries, and Canadian mining assets abroad totalling CAN\$170.8 billion in 2015.⁵⁴ This industry has been widely criticised for its detrimental effects on health—both through direct harm to people living in mineral-rich settings and by the displacement of populations, environmental degradation, and resource theft that can occur.^{55,56} The Canadian Government has come under fire for poorly handling allegations of human rights violations and environmental harm associated with Canadian mining companies abroad.^{57,58}

Furthermore, Canada was one of the four countries worldwide to vote against the UN Declaration on the Rights of Indigenous Peoples in 2007. Canada finally adopted this declaration in May, 2016, following years of pressure from Indigenous peoples and the international community, but a gap still remains between Canada's constitutional practices and recognised international norms.

Canada's role among others in transnational activities can powerfully influence health equity. These global political determinants of health occur across a range of policy areas, including economic austerity, intellectual property, foreign investment treaties, food security, and violent conflict.⁵⁹ Canada's complicity with some of these inequitable systems risks undermining hard-won gains in global health equity. Canada must implement a health equity lens with its activities across all spheres of government and not only health.⁶⁰

The Harper decade: equity and global citizenship under fire

The election of a minority Conservative federal government in 2006, under Prime Minister Stephen Harper, brought a decidedly new direction for Canada's role in global health. As Harper described in his speech to the 2011 Conservative Party convention, Canadian foreign policy was "no longer just to go along and get along with everyone else's agenda".⁶¹ Instead, the federal government adopted an agenda explicitly oriented towards prioritisation of Canada's competitive position, promoted through an agenda of economic nationalism and hard-nosed diplomatic style. In foreign policy, this shift was evident in a further decrease in Canadian contributions to multilateral action, such as UN peacekeeping, as part of putting "Canada first" under a new defence strategy.⁶²

After the Conservatives were returned to power with a majority government in 2011, this trend accelerated. Development assistance was reduced by 14%, from a high of CAN\$5.7 billion in 2008 to \$4.9 billion in 2010.⁶³ In 2012, a 3-year plan to further cut the aid budget was announced. This plan included an 11% cut in 2012 to IDRC, which led to the closure of two of its six regional offices. The government also allowed ten of IDRC's 14 board member positions to remain vacant. Moreover, more than a third of IDRC's budget remained unspent or lapsed in 2012–13, described as "cuts by stealth."⁶⁴

Canadian development assistance took on a utilitarian slant when it was bundled with economic policy and trade priorities, rather than human rights, social justice, and equity. In 2013, the Canadian International Development Agency was amalgamated with the Department of Foreign Affairs and International Trade (renamed the Department of Foreign Affairs, Trade and Development) to more closely align aid policy with Canadian trade and investment interests. These interests included the promotion of Canadian business, both domestically and abroad, in extractive industries such as oil, gas, and mining. This change was accompanied by what critics called a war on science to prevent opposition to Conservative policies, including cuts to research funding and controlling science communication, notably for environmental research.^{65,66}

This approach led the Conservative government to selectively engage with multilateralism to fit with the vision of Canada as an aspiring major power. Funds channelled through the World Bank's International Development Agency increased. In 2013, the government announced a 30% increase in Canada's 3-year pledge to the Global Fund to Fight Tuberculosis, AIDS and Malaria. At the same time, the government scuppered a G20 initiative to create a financial transaction tax as an innovative funding mechanism for global development, which had been proposed by former UK Prime Minister Gordon Brown. Perhaps most visibly, Canada hosted the G8 Summit in 2010, where Harper announced the Muskoka Initiative on Maternal, Newborn and Child Health along with CAN\$2.85 billion of funding. This focus was complemented later in 2010 by Harper's role as co-chair (with Tanzanian President Jakaya Kikwete) of the UN Commission on Information and Accountability for Women's and Children's Health.⁶⁷ The Muskoka Initiative was extended for another 5 years (and a further \$3.5 billion was pledged) in 2014, earning high-profile praise for Canadian leadership from Melinda Gates and UN Secretary-General Ban Ki-moon.⁶⁸ The initiative was positively welcomed in some UN circles at a time of flagging funding for global health. Canada's leadership on accountability and establishment of an independent oversight mechanism for Millennium Development Goals 4 and 5 was also welcomed. Others argued that the initiative overemphasised the need for health-care services for women and children to survive, and gave insufficient attention to the root causes of maternal mortality, including reproductive rights of women and girls.^{30,69}

Overall, this shift in foreign policy during the Harper decade did not sit well with many Canadians working in global health at home and abroad. As a sharp break from Canada's traditional middle-power role,⁷⁰ critics were concerned about the reputational damage done by a Conservative government asserting "a muscular new identity for Canada: military aid over peacekeeping, unilateralism over teamwork, free trade over foreign

aid".⁷¹ This shift included a retreat from multilateral initiatives, including withdrawal from the Kyoto Protocol to the UN Framework Convention on Climate Change in 2012⁷² and UN Convention to Combat Desertification in 2013.⁷³ At this time, Harper considered withdrawing from the Organization for Security and Co-operation in Europe, a 57-country alliance that includes NATO, although he was later dissuaded by US President Barack Obama.⁷⁴ Canada's reputation abroad plummeted as a result. In 2010, the unprecedented rejection of Canada's bid to serve a seventh time as a non-permanent member of the UN Security Council was described as an embarrassment and was an indication of how far the country's standing had fallen in the eyes of the world.⁷⁵

Thus, when Prime Minister Justin Trudeau declared that "Canada was back"⁷⁶ at the Paris Climate Change Conference in 2015, he was signalling an intent by the newly elected Liberal government to return to a more consultative, collaborative, and progressive approach to health and other global issues. In 2017, the government launched the Feminist International Assistance Policy, which pledges to reallocate CAN\$150 million of existing aid budgets over 5 years to help grass-roots women's organisations in LMICs. By 2021–22, at least 80% of Canadian aid will target the advancement of gender equality and the empowerment of women and girls.⁷⁷ The impact on public opinion of this shift in Canadian policy was confirmed in a June, 2017, Ipsos MORI poll in which the majority of respondents from across 25 countries ranked Canada as first among countries that "have positive influence on world affairs today".⁷⁸

However, although the messaging has been widely welcomed, both domestically and globally, concrete actions to reverse policies adopted under the Harper Government have yet to materialise. In its 2017 review of Canadian aid policy, the non-governmental organisation Global Canada found the country to be "worse than a laggard—it is last among its global peers".⁷⁹ Based on 2015 data, as well as budgets announced under the Liberal government, the report stated Canadian commitments to international aid to be close to an all-time low.⁷⁹ Canada's ranking also remains unchanged (55 of 58) on the Climate Change Network's list of countries scored as very poor on climate protection performance.⁸⁰ Most observers agree that it will take more than Trudeau's "sunny ways" to re-establish Canadian leadership on health as a middle power and global citizen.⁸¹

Looking forward

Lessons for advancement of global health equity

Collective global action to meet shared health needs is currently threatened by the rise in populist support in the USA and Europe for the unilateral pursuit of national interests. Given its experiences of ongoing nation building, alongside valuable experience of collaborative engagement in global affairs as a middle power, Canada is now ideally positioned to assert bold, strategic, and

much-needed leadership in global health. Rising to this opportunity, however, will require critical attention to a number of key lessons.

Diversity as a strength and opportunity

The Indigenous peoples in Canada, alongside the waves of settlers that form Canada's demographic mosaic, have made the country extraordinarily diverse. This diversity also arises from Canada's two official languages (English and French) as well as the one-fifth of Canadians born abroad. At the crossroads of unprecedented global population mobility, Canada has worked hard to prevent the levels of social tension found in other countries and to achieve a remarkable degree of social cohesion. Diversity is formally recognised and protected in Canada through relatively extensive settlement services, social rights, and protections against discrimination. At a time when many Europeans are declaring multiculturalism a failure, and the vision of an interconnected world is under political retreat, the Canadian experience offers important lessons.⁸² Canadians with lived experience of such diversity should be nurtured as valued assets for their leadership skills, cultural sensitivity, and openness of perspective that are ideal for advancing global health equity. Yet there is little room for complacency. Canada ranked third in the world on the Migrant Integration Policy Index until 2015, but then dropped to sixth after changes that restricted immigration and refugee policy by the former Conservative government.^{83,84} Under the current Liberal government, planned increases in immigration, including from countries listed on the US Trump Administration's travel ban, will require ongoing and concerted efforts at nation building. Canada has been far from immune from the social tensions felt in other countries. Although hate crimes in Canada declined between 2012 and 2015, police-reported hate crimes targeting Muslims more than tripled during this period.⁸⁵ Thus, how successfully Canadians address social cohesion at home will form the foundation for an expanded role internationally. Canada's capacity and credibility, as a global health leader, derive directly from how well diversity and inclusion are championed at home.

Truth and reconciliation as a domestic and global health challenge

As described by Prime Minister Trudeau at his September, 2017, speech to the UN General Assembly, Canada is a work in progress. At the top of the country's priorities is "true, meaningful, and lasting reconciliation between Canada and First Nations, Inuit, and Métis peoples".⁸⁶ This long-overdue task begins with taking responsibility for past and continued social exclusion of, discrimination against, and state-sanctioned policies inflicted on Indigenous peoples, as embodied in the Indian Act,⁸⁷ passed in 1867 and still law today, which is far-reaching legislation designed to restrict and control the rights, movement, and cultural practices of Indigenous

peoples in Canada. For example, the Indian Act created reserves, imposed a band council system of governance, forbade First Nations from speaking their languages, denied First Nations the right to vote, and forbade First Nations from forming political organisations. The Indian Act also introduced the infamous Indian Residential School system, in operation from the 1940s until 1996, which was a key tool in the cultural genocide of Indigenous peoples by forcibly removing Indigenous children from their families at a young age and relocating them to state-run and church-run institutions, where they were subjected to assimilation to European culture as well as profound levels of physical, sexual, and emotional abuse.⁷ Historically embedded and institutionalised forms of racism remain the root causes of stark, multigenerational inequities in Indigenous health status.⁸⁸ Although ostensibly a domestic issue, the extent to which Canadians genuinely understand and redress this colonial legacy will define the authenticity of Canada's voice on the global stage, including leadership and policy making that will influence other governments and international agencies' work to improve health equity for the 370 million Indigenous people living across more than 70 countries.⁸⁹ At home, this improvement begins with full implementation of the 94 recommendations of the Truth and Reconciliation Commission of Canada, including seven that are directly related to health, including funding for Indigenous health centres, and implementation of the health rights of Indigenous people in international law, constitutional law, and treaties previously negotiated with the Government of Canada.⁷ Canada should mirror these actions abroad by increasing global health funding to promote solidarity among Indigenous peoples in their pursuit of commitments under the UN Declaration on the Rights of Indigenous Peoples, notably Article 24 on the attainment of physical and mental health. The government should also renew the CIHR's recently expired Tripartite Cooperation Agreement to Improve Indigenous Peoples' Health, with the National Health and Medical Research Council in Australia and the Health Research Council of New Zealand.⁹⁰ Renewal should include a considerable scale-up of investment for research, mentorship, and knowledge synthesis driven by Indigenous leaders, and the inclusion of additional countries in the cooperation agreement.

The limitations of a Canada-first agenda

At a time when nationalism is being fuelled as a political and economic strategy to address the social harms caused by market-driven globalisation in countries around the world, Canadian leadership is urgently needed as a progressive voice. The country's own pursuit of a Canada-first agenda under the Harper Government demonstrated the false dichotomy between global citizenship and advancement of domestic interests. Indeed, evidence suggests that the prioritisation of aid, to maximise trade and investment returns, or to fund only research with

direct benefits to Canadians, has been counterproductive. As well as detrimental to poverty reduction abroad, instrumental approaches to foreign policy reflect a limited view of Canadian interests. Instead, the lesson for Canada is that domestic and global interests are deeply intertwined, and best served by equity-based approaches.⁹¹ Thus, Canada's health interests are better served through collective action to support health system strengthening, effective health policies, and health workforce capacity in all countries. This collective action includes Canada adhering to and advocating others to commit to the WHO Global Code of Practice on the International Recruitment of Health Personnel, the International Health Regulations,⁹² UN treaties,⁹³ human rights instruments,⁹⁴ development assistance commitments,⁷⁹ and other international obligations. Moreover, Canada should continue to champion the social determinants of health approach, which is focused on reduction of poverty and health inequalities as well as ensuring basic needs, as a strategy for countering the health inequalities created by economic globalisation—ie, market-based restructuring of the world economy since the 1990s. For example, the government should support improved accountability mechanisms (eg, ombudspersons, report cards, and complaint processes) to address the health harms arising from Canadian corporate interests in the extractive sector at home and abroad. To this end, Canada should benchmark the impacts of its foreign and development policies, as a whole, on global health equity against other progressive middle powers such as Norway.⁹⁵

Better coordination to increase Canadian impact

The importance given to inclusiveness and consensus building in Canada has led to resources being spread thinly, and an exceptional degree of fragmentation, across Canadian institutions concerned with global health. Weak coordination has led to a lack of clear strategic priorities and action plans, along with missed opportunities to act more decisively with available resources. This lack of coordination is apparent across government departments at the federal and provincial levels, and among the policy, practitioner, and research communities. Canada's main contributions to global health comprise health development activities led by Global Affairs Canada (formerly the Department of Foreign Affairs, Trade and Development); technical and policy responses overseen by Health Canada and the Public Health Agency of Canada; and global health research supported primarily by CIHR, IDRC, and Grand Challenges Canada. This fragmentation and the lack of coordinating mechanisms undermine Canada's overall impact. A Canadian global health strategy should be developed along similar lines to that of the UK,⁹⁶ Switzerland,⁹⁷ Japan,⁹⁸ and other countries⁹⁹ as a unifying vision of Canada's engagement in global health efforts.^{30,100,101} Mechanisms such as knowledge platforms, strategic partnerships, and inter-agency coordinating bodies should be created to amplify Canadian efforts.

Central to this approach should be a revived and improved version of the former GHRI, whereby substantial common resources are available to government entities to encourage alignment of their activities around shared global health priorities. The framework for improved coordination should include investment in the global health-related activities of Canadian universities and civil society organisations to facilitate high-impact partnerships. It should also include commitment to a career path within Canada by establishing training and support for an interprofessional cadre of global-minded health professionals to respond to the international regard for Canadian values and amplify the benefits arising from the country's diversity.^{87,88} Overall, this framework should emphasise resource allocation guided by the outcomes it produces for beneficiaries, and the principles of alignment, ownership, and harmonisation of the Paris Declaration on Aid Effectiveness and Accra Agenda for Action.¹⁰²

Walking the talk

The rise in divisive politics worldwide has led to perceptions of Canada as a “beacon of light”¹⁰³ and the observation by US President Barack Obama that “the world needs more Canada”.¹⁰⁴ The Liberal government has obliged, articulating foreign policy in familiar middle-power tones, focused on alliance building, collective action, and human rights. Prime Minister Trudeau's personable qualities and progressive statements about immigration, gender equality, and climate change have created expectations of elevated Canadian leadership on the world stage. The plans for Canada to seek a return to the UN Security Council in 2021, as a non-permanent member, reflect these ambitions. However, assuming this mantle will require more than persuasive words. Indeed, concerns are growing about the sincerity of the Liberal government's commitment to progressive ideas, given a perceived disconnect between the Prime Minister's words and government actions. For example, no new funding accompanied the ambitious Feminist International Assistance Policy, by contrast with the national defence strategy announced the same week.^{77,105} Furthermore, nearly 2 years into Trudeau's mandate, the government has yet to reverse historically low levels of Canadian development aid.⁷⁹ The government should use its presidency of the G7 in 2018 as a platform for backing its words with concrete actions—and should call on other G7 governments to follow suit—framed around achieving the Sustainable Development Goals.

Conclusion

Canada was formed 150 years ago, bringing together a vast land at risk of being subsumed by its larger neighbour to the south. The political forging of the country came at a considerable price, notably to Indigenous peoples, and the country has learned hard lessons about the importance of inclusion and equity. Moreover, Canada's

unique history continues to unfold. Authentically reconciling its relationship with Indigenous peoples, maintaining social cohesion amid diversity, and successfully meeting domestic needs while remaining open to globalisation will be integral to the country's next 150 years. Against this backdrop, Canada is uniquely positioned to become a more prominent global health leader by harnessing its distinct experiences, diverse assets, and core values. Like the country itself, Canada's role in global health remains a work in progress.

Contributors

All authors contributed to the conception of the article's content and structure. SAN, KL, and PT co-led the overall writing and revision of the article. SAN, KL, ZAB, JB, and PT drafted selected sections, with JB and SJH collecting and interpreting global health expenditure data. All authors reviewed, critically commented on, revised, and provided final approval of the published version of this article. SAN and KL are co-first authors.

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