

REBECCA
TIESSEN

'Walking Wombs': Making Sense of the Muskoka Initiative and the Emphasis on Motherhood in Canadian Foreign Policy¹

Abstract: The Muskoka Initiative – or the Maternal, Newborn and Child Health (MNCH) Initiative – has been a flagship foreign policy strategy of the Harper Conservatives since it was introduced in 2010. However, the maternal health initiative has been met with a number of key criticisms in relation to its failure to address the sexual and reproductive health needs of women in the Global South². In this article, I examine these criticisms and expose the prevalent and problematic discourse employed in Canadian policy papers and official government speeches pertaining to the MNCH Initiative. I examine the embodiment of the MNCH and how these references to women's bodies as "walking wombs" facilitate: the objectification and 'othering' of women as mothers and childbearers; a discourse of 'saving mothers' in a paternalistic and essentialist language; and the purposeful omission of gender equality. Feminist International Relations (IR) and post-colonial literature, as well as critical/feminist Canadian foreign policy scholarship are employed in this paper to frame these critiques.

Keywords: Canadian foreign policy, gender essentialism, gender inequality, maternal health, mothers

Introduction

In 2010 during the G8 Summit in Canada, Prime Minister (PM) Stephen Harper introduced the Muskoka Initiative as a hallmark of Canada's commitment to development in the Global South. Building on one of the Millennium Development Goals (MDG 5) of improving maternal health, the Muskoka Initiative (or the Maternal, Newborn and Child Health – MNCH – initiative was designed to foster increased international recognition of maternal health problems and to encourage greater support and funding to address this MDG. As an international commitment, the focus on maternal health held great promise. Addressing maternal health needs is central to improving the lives of women and communities and has the potential to address gender inequality in societies that limit women's sexual and reproductive health options. Several

¹ I wish to thank Julia Keast for her outstanding work as a Research Assistant.

² I use the term Global South to describe the regions of the world that are marked by immense poverty and inequality. There are pockets of the Global South within highly developed countries; however, the majority of the world's population living in poverty can be found in countries in the Africa, parts of Asia and parts of Latin America. As such, there is a racial analysis to be incorporated in this analysis of Canadian foreign policy directed to communities comprising the Global South.

important critiques immediately emerged, namely those that identified the weakness of the Muskoka Initiative in terms of its failure to address sexual and reproductive needs, specifically abortion. Soon after, PM Harper's maternal health initiative was criticized by the American and the British delegates for failing to address abortion needs. Over time, additional critiques began to emerge noting the failures of the maternal health initiative to address gender inequality and the reasons why women do not or cannot access maternal health services. In this paper, I examine these criticisms and add another layer to the analysis to expose the prevalent and problematic discourse employed in Canadian policy papers and official government speeches pertaining to the MNCH Initiative. In particular, I examine the embodiment of the MNCH initiative and how references to women's bodies as "walking wombs" facilitate a language focusing on mothers rather than women; a discourse of saving mothers in paternalistic and essentialist language; and a purposeful omission of gender equality. Feminist International Relations (IR) and post-colonial literature, as well as critical/feminist Canadian foreign policy scholarship are employed in this paper to frame these critiques. I conclude that the instrumentalization of mothers in the maternal health initiative may be strategically advantageous for the Harper Conservatives' foreign policy approach, but it is highly problematic from a gender and development perspective. Several important theoretical contributions help to make sense of these critiques. A feminist, post-colonial analysis of development discourses, particularly of mothers as victims/in need of saving, facilitates a more nuanced analysis of the implications of the discourse employed under the Harper Conservatives MNCH initiative.

Several important critiques have emerged in the past four years to highlight the weaknesses and challenges posed by the Harper Conservatives maternal health strategy, ranging from the exclusion of gender from the Initiative³ to the failure to include abortion⁴, to the argument that the choice to pursue maternal and child health was meant to appeal to domestic constituents⁵. Several scholars

3 Berthiaume, Lee. 2010. Harper's Maternal, Child Health Speech "Political Opportunism": Stephen Lewis". Embassy, February 3; Black, D. (2011). Canada, the G8, and Africa: The rise and decline of a hegemonic project. Retrieved from: <http://www.nai.uu.se/ecas-4/panels/21-40/panel-22/David-Black-Full-paper.pdf>; Caplan, Gerald. 2010. The sad truth about Harper and maternal health. *Globe and Mail*, March 26, 2010. <http://www.theglobeandmail.com/news/politics/second-reading/the-sad-truth-about-harper-and-maternal-health/article1314279/> (accessed November 5th, 2013); Percival, V. (2010). Women's health initiative fails to inspire. *The Ottawa Citizen*. Published June 28, 2010, retrieved October 16, 2013.

4 Auld, Alison, and Michael MacDonald. 2010. 'Canada wants flexible approach to G8 Plan on maternal and child health'. *Canadian Press*, April 28; Campbell, 2010; Webster, Paul C. (2010). Canada's G8 health plan receives praise and criticism. *The Lancet*. Volume 375, pp. 1595-1596

5 Brown, Stephen and Michael Olander. (2013). "Canada's Fraying Commitment to Multilateral Development Cooperation". In H. Besada & S. Kidornay (Eds.), *Multilateral Development Cooperation in a Changing Global Order*. New York: Palgrave Macmillan, pp. 159-88; Smith, H. (2003). Disrupting internationalism and finding the others." In C. T. Sjolander, H. Smith, & D. Stienstra (Eds.), *Feminist Perspectives on Canadian Foreign Policy* (pp. 24-39). Toronto: Oxford University Press; Wells, Paul. Abortion: Harper's vigilant global audience. *Macleans*. September 22, 2011. <http://www2.macleans.ca/2011/09/22/abortion-harpers-vigilant-global-audience/>

have criticized the Muskoka Initiative for its failure to adequately address gender. The January 2010 announcement that the Canadian government would focus on an initiative to address maternal and child health was met with some skepticism. Stephen Lewis was critical of the Initiative for multiple reasons, one of which was the exclusion of gender. For him, “the stated focus [of the Initiative] avoids many of the root causes of maternal and child deaths, particularly gender equality – which is actually another MDG”⁶. Mr. Lewis went on to say that it would be difficult to overcome maternal mortality unless gender equality is addressed, and he also pointed out that women do not live their lives simply to bear children.⁷ Valerie Percival voiced a similar critique of the Muskoka Initiative: “Improving maternal health depends on the protection, promotion and advancement of the rights and freedoms of women and girls. Canada needs to push countries to fully respect these rights and support programs at home and abroad that allow women and girls to realize them”⁸. Huish and Spiegel are critical of the Muskoka Initiative for its failure to adequately address the social determinants of health (including gender equality, education, work opportunities and family planning) that lead to maternal and child mortality.⁹ Carrier and Tiessen have also argued that the maternal health initiative is a form of ‘hypocritical internationalism’ which suggests that ‘women and children’ come first in Canadian foreign policy, but in reality, women and children are the objects of foreign policy and end up coming in last when it comes to government priorities.¹⁰

Furthermore, David Black has argued that by not addressing the underlying causes of maternal and child mortality, the Muskoka Initiative is accepting the conditions that contribute to maternal and child mortality, including poverty, and that this jeopardizes the sustainability of the Initiative. He claims that this is evident in this statement made by Stephen Harper in which the Prime Minister says: “Let us close with something where progress is possible, if we are willing. It concerns the link between poverty and the appalling mortality among mothers and small children in the Third World. Did you know that every year over half

6 Berthiaume, Lee. 2010. Harper’s Maternal, Child Health Speech “Political Opportunism”: Stephen Lewis”. Embassy, February 3; Black, D. (2011). Canada, the G8, and Africa: The rise and decline of a hegemonic project. Retrieved from: <http://www.nai.uu.se/ecas-4/panels/21-40/panel-22/David-Black-Full-paper.pdf>

7 Berthiaume, Lee. 2010. Harper’s Maternal, Child Health Speech “Political Opportunism”: Stephen Lewis”. Embassy, February 3; Black, D. (2011). Canada, the G8, and Africa: The rise and decline of a hegemonic project. Retrieved from: <http://www.nai.uu.se/ecas-4/panels/21-40/panel-22/David-Black-Full-paper.pdf>

8 Percival, V. (2010). Women’s health initiative fails to inspire. *The Ottawa Citizen*. Published June 28, 2010, retrieved October 16, 2013.

9 Huish, R., & Spiegel, J. (2012). First as tragedy and then on to farce: Canadian foreign aid for global health. *Canadian foreign policy journal*, 18(2), 244-246.

10 Carrier, Krystel and Rebecca Tiessen. (2013). ‘Women and Children First: Maternal Health and the Silencing of Gender in Canadian Foreign Policy’, in Heather Smith and Claire Turenne Sjolander: *Canada in the World: Internationalism in Canadian Foreign Policy*, Don Mills: Oxford University Press.

a million women die in pregnancy and nearly nine million children die before their fifth birthday?"¹¹. Black goes on to argue that Stephen Harper's comments demonstrate the choice that was made to address the effects of poverty rather than the underlying conditions of poverty that result in maternal and child death.¹² These critiques have introduced the broader challenges surrounding the Muskoka Initiative; however, they have not involved a thorough discourse analysis of the language used to address maternal health. In this article, I pick up on some of the very important critiques available to date, and document how these larger critiques are manifested in the discourse on maternal health. Several key themes and critiques guide the analysis and can be summarized in relation to a specific discourse employed to define the embodied experience of motherhood; the strategic use of terminology surrounding mothers and motherhood; the essentializing and paternalistic manner in which mothers and children are positioned as objects of development assistance in need of 'saving'; and the notable omission of gender equality goals.

The research for this discourse analysis included a search of documents that contain information about government policy and initiatives: (1) APLIC, (2) the Canadian Government Information Search Engine, and (3) the Library of Parliament Research Publications using key word searches for "Muskoka Initiative". The databases provided access to press releases, and reports from the now-defunct CIDA¹³ – including CIDA's reports on plans and priorities, and Reports to Parliament on the Government of Canada's official development assistance, and Ministerial Roundtables about the Muskoka Initiative. Following the database searches, information was collected from the Prime Minister of Canada's website including press releases and backgrounders related to the Muskoka Initiative. The documents were searched using key words "Muskoka Initiative", "maternal and child health", "women" and "gender" in order to find documents that related to the Initiative. Data were also retrieved from the former CIDA's website¹⁴, including background information, information about the Muskoka Initiative Partnership Program, and the Fact Sheets on Canada's action on maternal, newborn and child health (broken down by country). Finally, data was collected by searching for official speech transcripts on this subject beginning with those available on Prime Minister Stephen Harper's

11 Black, D. (2011). Canada, the G8, and Africa: The rise and decline of a hegemonic project. Retrieved from: <http://www.nai.uu.se/ecas-4/panels/21-40/panel-22/David-Black-Full-paper.pdf>, p. 261

12 Black, D. (2011). Canada, the G8, and Africa: The rise and decline of a hegemonic project. Retrieved from: <http://www.nai.uu.se/ecas-4/panels/21-40/panel-22/David-Black-Full-paper.pdf>, 2011

13 The Canadian International Development Agency (CIDA) was merged with the Department of Foreign Affairs in 2013 to form the Department of Foreign Affairs, Trade and Development (DFATD).

14 Information that originally appeared in the CIDA website can now be found in documents re-titled as the Department of Foreign Affairs, Trade and Development. The material researched on the CIDA websites for this paper can be found here: <http://www.acdi-cida.gc.ca/acdi-cida/acdi-cida.nsf/En/FRA-119133138-PQT>

website as well as “Speeches and Statements” by International Development and Cooperation Ministers using keywords “Muskoka Initiative”, “women’s health”, and “maternal and child health”. A content analysis of official documents and speech transcripts included attention to recurring language of mothers, vulnerable, saving lives and other themes emerging from the document analysis.

About the Muskoka Initiative

The Muskoka Initiative is implemented through three different channels: bilateral aid focused on 10 priority countries, through multilateral and global institutions, as well as through partnerships with Canadian civil society organizations as part of the Muskoka Initiative Partnership Program. A brief summary of the types of efforts that are supported through each of these channels, emphasizing gender and the representation of women are outlined here.

The Government of Canada delivers bilateral programs under the Muskoka Initiative in 10 partner countries with high maternal and child mortality: Afghanistan, Bangladesh, Ethiopia, Haiti, Malawi, Mali, Mozambique, Nigeria, Southern Sudan and Tanzania. These projects focus on strengthening health systems in order to improve service delivery, reducing the burden of diseases that kill mothers and children, and improving nutrition by improving access to nutritious food and nutrient supplements¹⁵. Of the documents reviewed surrounding bilateral aid in support of maternal and child health¹⁶ aid was focused specifically around the three priority areas of nutrition, health systems, and strengthening and reducing the burden of disease for mothers and children. There was only one project in Nigeria that addressed gender in any way: “Canada will help increase women’s ability to ask for quality gender-sensitive primary health care services”.¹⁷

A common theme throughout all of the documents reviewed is that women are primarily referred to as mothers. In the case of documents discussing bilateral assistance, this was no exception. However, there are more references to “women” as opposed to solely “mothers” on CIDA’s website.¹⁸ However, often women are referred to as “disadvantaged”, “poor”, “pregnant women”, or “lactating women”. In the context of nutrition, improving women’s nutrition is emphasized when they are pregnant, breastfeeding and when they have children under the age of 5. So, while women’s nutrition is discussed for the

15 Implementing Canada’s Commitments under the Muskoka Initiative, Sept 20, 2011

16 Implementing Canada’s commitments, 2011; PM announces new MNCH initiative, 2011; New MNCH initiatives, 2011

17 Implementing Canada’s commitments, 2011

18 DFATD (n.d.a).Project profile: Global Fund to Fight AIDS, Tuberculosis and Malaria, retrieved from:<http://www.acdicida.gc.ca/cidaweb/cpo.nsf/vWebProjSearchEn/CB86056D6FC4BE>

benefit of women themselves, improving women's nutrition is emphasized more in relation to improving child nutrition and survival.

There were very few references targeting women outside of mothers, pregnant and/or lactating women, breastfeeding women, or poor and disadvantaged women. Unlike a few projects from the Muskoka Initiative Partnership Program (MIPP), none of the bilateral commitments refer explicitly to targeting women of reproductive age. Once again, confirming that the focus is mostly on women who are either pregnant or have young children, but not necessarily targeting all women of reproductive age. This begs the question: are only pregnant women and mothers worthy of sexual and reproductive health services?

Through multilateral channels, Canada supports the Micronutrient Initiative (\$75 million over 5 years), the GAVI Alliance (\$50 million over 5 years), Health 4 (H4) (\$50 million), and the Global Fund to fight AIDS, Tuberculosis and Malaria (\$540 million over 3 years). The Micronutrient initiative focuses on delivering essential vitamins and mineral supplements to women and children. The GAVI Alliance focuses primarily on distributing vaccines against pneumonia and diarrheal disease. Another organization is Renewed Efforts Against Child Hunger (REACH) which aims to reduce child hunger and under nutrition. Canada will contribute \$15 million between 2011 and 2014.¹⁹ H4 includes the World Health Organization, the United Nations Population Fund, UNICEF and the World Bank, all of which have come together in a concerted, focused effort to reduce maternal and child mortality. CIDA, prior to 2013, promised to provide \$50 million to H4 to help strengthen: country health plans in line with the United MDGs; budget plans for resources to support maternal and newborn health; health care training to health workers; increased access to trained health workers including reproductive health care and services; and country plans to tackle root causes of maternal mortality and morbidity (inequality between women and men; low access to education, especially for girls; child marriage; and adolescent pregnancy); and finally monitoring and evaluating successes and weaknesses in these initiatives.²⁰

It is unclear how much of the money going to the Global Fund addresses maternal and child health directly. According to one press release, funding was expected to increase from \$450 million to \$540 million, with \$90 million in new funding to achieve the goals of the Muskoka Initiative.²¹ The Global Fund project improves health through STD control including HIV/AIDs, malaria control and

19 DFATD (2010). Minister Oda Announces Global Health, Nutrition and Disease Prevention Initiatives. Retrieved from: <http://www.acdi-cida.gc.ca/acdi-cida/acdi-cida.nsf/eng/FRA->

20 DFATD (2010). Minister Oda Announces Global Health, Nutrition and Disease Prevention Initiatives. Retrieved from: <http://www.acdi-cida.gc.ca/acdi-cida/acdi-cida.nsf/eng/FRA->

21 Implementing Canada's Commitments, Sept. 20, 2011

tuberculosis control. Canada's contribution to the Global Fund is its largest contribution to a single global health initiative.²² Part of the programming done by through the Global Fund addresses some of the root causes of maternal mortality and morbidity including inequality between women and men, low access to education, child marriage and adolescent pregnancy. Of the multilateral partnerships, this appears to be the only one that deals with issues related to gender equality. The others focus explicitly on improving nutrition, reducing the burden of disease and illness among pregnant women and children, and strengthening health systems.

The Muskoka Initiative Partnership Program (MIPP) supports 28 Canadian organizations to reduce maternal, newborn and child mortality. Part of the criteria for selection was that each of the projects focuses on at least one of the three priority areas. Partner organizations will receive a combined total of \$82 million between 2010 and 2015.²³ In the descriptions of the projects that the Canadian government has made public, only one of the projects has a stated focus on gender: the project being implemented by Health Bridge is working towards making more effective and gender-sensitive interventions and services related to maternal, newborn and child health available to both women and their husbands.²⁴ Of the projects under the MIPP, only three of them refer specifically to targeting not only mothers or pregnant women, but also women of reproductive age: the Christian Children's Fund of Canada, Health Bridge and Save the Children.

Emphasizing Motherhood Rather than Women or Gender Equality

A near-exclusive emphasis on mothers and motherhood in the MNCH signals an important critique of the embodied nature of Canadian foreign policy on maternal health. When maternal health is reduced exclusively to a focus on women's bodies, the nature of the policies and debates surrounding maternal also shift to a highly essentializing approach to treating women as objects of development assistance. The embodied approach to foreign policy making is a theme that runs through the critiques provided in this article including a focus on mothers and children as objects of development assistance and an instrumentalist approach to foreign policy that situates mothers and children as the highly essentialized and exclusively vulnerable bodies in need of 'saving'. As such, the critiques of the MNCH initiative discussed here are overlapping and interconnected. At the heart of the critiques presented in this article is a

22 DFATD (n.d.a). Project profile: Global Fund to Fight AIDS, Tuberculosis and Malaria, retrieved from: <http://www.acdicida.gc.ca/cidaweb/cpo.nsf/vWebProjSearchEn/CB86056D6FC4BE>

23 DFATD (n.d.b). Muskoka Initiative Partnership Program. Retrieved from: <http://www.acdi-cida.gc.ca/acdi-cida/acdi-cida.nsf/eng/NAT-9221046-JHN>

24 Projects under the MIPP, Sept. 20, 2011

focus on the embodiment of maternal health through Canadian foreign policy and its implications for women and gender equality.

The embodiment of maternal health takes places through a number of activities including the medicalization of maternal health approach. Furthermore, one way in which the state and medical system are able to construct women's bodies as controllable is through the use of 'western' biomedicine that relies on objective, or technologically mediated diagnostics. According to Harcourt, "[m]odern diagnostics construe the body as distinct, divisible parts, organs and functions that can be isolated and treated separately from a person as a whole"²⁵. An important point here is that the focus is typically on women's bodies in discussions about reproductive bodies. There is often little acknowledgement of the male's role in reproduction since male bodies are not usually seen in relation to their reproductive roles (Harcourt, 2009). Women's bodies are often constructed by the state and medical system in terms of fertility to be controlled.²⁶ Harcourt posits that a standard stereotype that 'woman equals reproduction' is often left unexamined in literature surrounding international development and health programming.

Harcourt also makes the argument that the use of technocratic language in speaking about maternal mortality, and in framing MDG 5 has been used because speaking about maternal death in technical, medical, terms makes it more easily measured. It is also more straightforward and simple, as opposed to addressing it within the context of sexual and reproductive health and rights.²⁷ By presenting maternal mortality in this way, the focus gravitates towards the pregnant body. In this sense, the pregnant body is in need of outside interventions from professional health experts who are able to solve the problem. Harcourt goes on to argue that this is an example of a biopolitical strategy focused on the management and measurement of the reproductive female body, and that this fits well within the neo-liberal agenda of reducing all things to economic outputs and measurable data.²⁸ Moreover, replacing an agenda of reproductive rights with a specific focus on maternal health narrows women's reproductive experience to her biological ability to give birth rather than her rights or options around sexual and reproductive health. Throughout this process, women's voices and lived experiences are largely removed from the policy making process. The focus is then shifted away from viewing women as subjects who are entitled to rights and who possess agency to demand those

25 Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books, p. 367

26 Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books.

27 Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books.

28 Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books.

rights²⁹ to a focus on women as objects of policy focus. It is clear from a review of key policy documents and official government statements that the Harper Conservatives have indeed adopted this embodied approach to policy making by referring to women nearly exclusively as mothers.

In all of the documents analysed, there is an over use of the word “mother” used to describe women in all of the texts examined. This is seen frequently in press releases and background documents. Several examples of references to “saving the lives of mothers and children” (Sept. 20, 2011), and “Targeting the leading causes of mortality in mothers and children...” (May 27, 2011), can be found. Instead of highlighting the need to address gender issues that contribute to women’s needs, the language most prevalent is around the “health needs of mothers, newborns and children in developing countries ...” (Sept. 20, 2011).

Canada resolves to address these issues through: “comprehensive and integrated approaches to provide the necessary health services for mothers and children” (June 25, 2010). These are only a few examples from the many texts where women are mentioned. This language is not limited to press releases and background documents. In speeches on the topic of maternal and child health, Stephen Harper often refers to women exclusively as mothers. For instance: “...one of the world’s great tragedies [...] is the shocking mortality of mothers and their young children in developing countries” (Sept. 25, 2013), and later in the same speech “We have to remember that to the world’s mothers and children, what we are working for here is... these goals are literally vital” (Sept. 25, 2013). In another speech on September 2010, “[i]t is a sad reality that each year hundreds of thousands of mothers die in pregnancy...” (Sept. 20, 2010).

This language is not limited to the Prime Minister, in a speech delivered by Kellie Lietch (Minister of Labour and Minister of Status of Women as of July 2013), she also refers to the government’s efforts in “reducing the burden of diseases that are killing mothers and children...” (Oct. 28, 2013), and “Under the Muskoka Partnership Program alone, 28 projects have received funding to help mothers and children” (Oct. 28, 2013). And then-Minister, Bev Oda stated in reference to increasing access to medicines, “we have also made needed medicines, vitamins and food supplements available to millions of mothers and babies” (Nov. 13, 2011). There is no real change in the language used to discuss women targeted by the Muskoka Initiative over time. Women are consistently referred to as “mothers”, or alternatively, as women defined entirely by motherhood including references to “pregnant and/or lactating women”, or “breastfeeding women”. For example, in projects under the MIPP,

29 Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books.

pregnant women are a category that are targeted with efforts to reach specific targets including: more than 4,500 pregnant and lactating mothers and more than 9,000 children under the age of five will benefit from better nutrition...; approximately 35,000 beneficiaries, including mothers, pregnant women and children..."; and ... "more than 56,000 pregnant and lactating mothers and their husbands" will be reached through these programs. It is also found in the former CIDA's departmental performance reports where it is reported that: "The Muskoka Initiative announced commitments totaling \$7.3 billion in new funding to save the lives of mothers and children..."³⁰

The explicit word choice here serves to emphasize women's reproductive roles, particularly motherhood. A focus on mothers is not, at first glance, particularly surprising since the initiative is on maternal health. However, the programs in the maternal health initiative assume that all women in need of maternal health are mothers – or identify as such. Some women may be pregnant but choose not to keep their babies; others may have babies die during childbirth and may never become mothers. The creation of this category – "mother" – allows them to be grouped together as a homogenous entity, portraying women as both fixed and conventional instead of recognizing their varied realities and experiences, not to mention their preferred identities. Thus the exclusive focus on mothers obscures other aspects of women's identities and essentializes all women in relation to their biology. The focus on maternal mortality has helped to fuel an essentialized view of motherhood, while also erasing the role of male bodies in the construction of policy addressing maternal mortality. The biological ability of women to give birth and to be a mother is one of the most 'natural' concepts associated with the female body. Awareness of embodiment can work to disrupt this naturalized assumption about reproduction in policy addressing gender and development.³¹ As such, there is a disconnect between the lived experiences of people targeted by developing interventions, and the places in which policy discussions about these interventions occur. Harcourt encourages us to contemplate "how ... embodied practices are perceived, negotiated, reinforced and/or challenged in particular historical, geographical and institutional settings"; "whose bodies are seen as worth of policy attention"; and "which bodies are producing knowledge on, and speak for, which bodies" as well as the implications of this are for international development in practice.³²

³⁰ Report to Parliament on the Government of Canada's ODA 2010-2011, p. 1

³¹ Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books, p. 38

³² Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books, p. 38

Pregnancy is an embodied experience in many senses of the word. The act of carrying a child is indeed one of embodied occupation of another living being(s). However, feminists have used the notion of embodiment more broadly to reflect “the lived experienced of human beings, an experience which always bridges “the natural” and “the cultural”.³³ Critical theorists of embodiment include Elizabeth Grosz, Sara Ahmed, Judith Butler, Margrit Shildrick, Raia Prokhvnik, Moira Gatens and Rosi Braidotti. While the approaches used by diverse feminists on this subject vary, they are unified by the view that there are no natural bodies, but rather bodies are continually produced and differentiated through historical, political and social relations of power.³⁴ In other words, motherhood is not a single, unifying experience for all women.

Using a feminist lens we can add that the body is seen as the primary site of location. According to Braidotti, “[t]he subject is not an abstract entity, but rather a material embodied one. The body is not a natural thing; on the contrary, it is a culturally coded socialized entity. Far from being an essentialist notion, it is the site of intersection between the biological, the social, and the linguistic, that is, of language as the fundamental symbolic system of a culture”³⁵. Theories of embodiment challenge the notion that the body is an empty vessel, waiting to be formed by power operations. Instead, the body is actively involved in social relations³⁶ and is therefore subject to cultural practices that promote gender equality or inequality.

Embodiment therefore encompasses the “complex processes of social, cultural and psychic differentiation proceeding through bodily channels and how power shapes bodies in particularly enduring ways”³⁷. According to Grosz, “far from being an inert, passive, non-cultural and ahistorical term, the body may be seen as a crucial term, the site of contestation in a series of economic, political, sexual and intellectual struggles”³⁸. This is important because these struggles can impact directly on the actual bodies of women (Pettman, 1997).

In a related analysis, Judith Butler posits gender as performance. This means that gender is constructed through repetitive performance of gender. Like Foucault, Butler views discourses as productive of the identities they appear

33 Harcourt, W. (2009). *Body politics in development: Critical debates in gender and development*. London: Zed Books.

34 Pedwell, C. (2010). *Feminism, culture and embodied practice: The rhetorics of comparison*. New York: Routledge. p. 20

35 Braidotti, R. (1994). *Nomadic subjects: Embodiment and sexual difference in contemporary feminist theory*. New York: Columbia University Press. p. 238

36 Beasley, C & Bacchi, C (2000). Citizen bodies: Embodying citizens ‘a feminist analysis’. *International Feminist Journal of Politics*, (2) 3.

37 Pedwell, C. (2010). *Feminism, culture and embodied practice: The rhetorics of comparison*. New York: Routledge. p. 48

38 Grosz, E. (1994). *Volatile bodies: Toward a corporeal feminism*. Indiana: Indiana University Press, p. 19

to be describing. The subjection of bodies to normalizing practices is a way in which male and female bodies seek to emulate an ideal. Through this process of performing gender, it also produces and reproduces gendered subjects. As stated by Butler, gender is “a stylized repetition of acts... which are internally discontinuous ... [so that] the appearance of substance is precisely that, a constructed identity, a performative accomplishment which the mundane social audience, including the actors themselves, come to believe and to perform in the mode of belief”.³⁹

The implication of gender performativity is that gender is only real to the extent that it is performed. From this perspective, it could be deduced that women become women through their reproductive roles. The conceptualization of what it means to be a woman is based on a woman's ability to become a mother. This conforms to heterosexual normativity, and means that the type of woman addressed by the Muskoka Initiative must be a heterosexual woman who conforms to the gendered expectation of motherhood. Where does this leave women who may not conform to this gender expectation, such as women who do not have children, lesbian, intersex or transsexual women? The focus on the embodied experience of motherhood is significant in this analysis and provides insights into how these embodied experiences translate into other policy approaches and discourse geared to 'solving' issues pertaining to mothers.

Mothers as “victims”, in need of “saving”: a post-colonial critique

A second major theme emerging from the discourse analysis of official government material on the Maternal Health Initiative is the essentializing language of the victimhood of mothers and children. Mothers are constructed in a passive role throughout the texts, and words such as “vulnerable” and “poor” are often used to describe the women. In some instances, women are not referred to explicitly as vulnerable, but it is implied within the text. For instance, in discussing Canada's contribution to the Muskoka Initiative, Stephen Harper states, “Our contribution will make significant, tangible differences in the lives of the world's most vulnerable people” (June 25, 2010). In another example, Stephen Harper says, “These new maternal, newborn and child health initiatives will help some of the most vulnerable people in Tanzania...”⁴⁰. In another announcement about new maternal, newborn and child health initiatives, Stephen Harper states, “The support being announced today will help Bangladesh, Ethiopia and Mozambique address the urgent and long-

39 Butler, J. (1997) *Performative acts and gender constitution: An essay in phenomenology and feminist theory*. In K. Conboy, N. Medina & S. Stanbury (Eds.) *Writing on the body: Female embodiment and feminist theory*, pp 401-417. New York: Columbia University Press. p. 402

40 PM announces support for MNCH Tanz., 20 Sept., 2011

term health needs of these vulnerable groups” (PM announces new MNCH, January 26, 2011). In these examples we can read vulnerable people as women and children. The notion of vulnerability is attached to the role of Canada and Canadians in addressing this vulnerability.

The discourse of maternal health documents highlights the role of Canada in saving the lives of mothers/women and children and facilitates the ‘othering’ of disadvantaged individuals requiring maternal health-related assistance. A variation of this phrase appears in practically every text that relates to the Muskoka Initiative. Some examples include: “The Muskoka Initiative will save millions of lives and make a significant, tangible difference to the world’s most vulnerable people”⁴¹. Other examples include: “Canada led the launch of the Muskoka Initiative to save and improve the lives of mothers, newborns, and young children”⁴² and “Saving the Most Vulnerable: Canada’s Initiative on Maternal, Newborn and Child Health”⁴³. Canada benefits from this image as “the catalyst in 2010 for the renewed global effort to save the lives of mothers, children and newborns in developing countries,” said Prime Minister Harper⁴⁴. In fact, the Government of Canada’s 2014 launched renewed commitments to the MNCH initiative during the May, 2014 summit in Toronto, aptly titled: “Saving Every Woman, Every Child within Arm’s Reach”.

The use of this language to describe women as vulnerable, combined with the ongoing use of the phrase “saving the lives of mothers/women and children”, serves to create a narrative that stresses Canada’s ability to literally save the lives of ‘others’, namely, mothers and children in developing countries. Saving the lives of mothers becomes the primary action that is linked to women in the texts, and the exclusion of any women’s voices in the texts portrays women as lacking voice or agency. Women’s voices are never heard in any of the texts surrounding maternal and child health and their roles are confined to childbearing and childrearing. When women are exclusively situated as the “others” in Canadian foreign policy,⁴⁵ internationalism is not neutral.⁴⁶

41 PM reaffirms Canada’s commitment... Sept. 21, 2010

42 Report to Parliament on the GoC’s ODA 2010-2011, page 6

43 Title of Press release, June 25, 2010

44 PM announces new MNCH initiatives, January 26, 2011

45 Sjolander, C.T. & K. Trevenen. (2010) Constructing Canadian foreign policy: Myths of good international citizens, protectors and the war in Afghanistan. In M. Beier & L. Wylie (Eds.), *Canadian Foreign Policy in Critical Perspective* (pp. 44-57). Toronto: Oxford University Press; Sjolander, 2013; C. T. (2013). Canada and the Afghan ‘other’: Identity, difference and foreign policy. In H. Smith & C.T. Sjolander (Eds.), *Canada in the world: Internationalism in Canadian foreign policy* (pp. 238-254). Toronto: Oxford University Press; Smith, H. (2003). Disrupting internationalism and finding the others.” In C. T. Sjolander, H. Smith, & D. Stienstra (Eds.), *Feminist Perspectives on Canadian Foreign Policy* (pp. 24-39). Toronto: Oxford University Press.

46 Smith, H. (2003). Disrupting internationalism and finding the others.” In C. T. Sjolander, H. Smith, & D. Stienstra (Eds.), *Feminist Perspectives on Canadian Foreign Policy* (pp. 24-39). Toronto: Oxford University Press.

Rather a set of assumptions (gendered, racialized and colonial) facilitate the construction of the “other” in Canadian foreign policy.⁴⁷

The combined focus of mothers and children is also of significance. In doing so, the lumping together of mothers and children is a paternalistic approach that treats these two groups as vulnerable and without agency or rights. Overall, the documents reviewed offered a fairly equal amount of attention women and children in the texts. In some of CIDA’s progress reports, when results were highlighted, the results related to children’s health including vaccinations and improved nutrition as opposed to progress on women’s health. An interesting addition to this analysis is that the Muskoka Initiative is considered to be a central part of programming under CIDA’s Children and Youth Strategy. In the run up to the consolidation of the Muskoka Initiative, Ms. Oda expressed that the government was interested in pursuing MDGs 4 and 5 for some time. At the Ministerial Consultation held in regards to establishing maternal and child health as a priority area in March 2010, Ms. Oda made it clear that the government was looking at effective ways for achieving results by using CIDA’s Strategy on Children and Youth as the base for the Initiative on Maternal, Newborn and Children Health (Ministerial Consultation, March 29, 2010). She made the argument that the initiative would fit nicely into this priority focus on children and youth, and that nutrition for infants and mothers would also be related to CIDA’s focus on food security.⁴⁸ The Children and Youth strategy focuses on three areas: “child survival, including maternal health; access to quality education; and safe and secure futures for children and youth”.⁴⁹ The strategy is intended to guide CIDA’s efforts to “meet the needs of the world’s most vulnerable and help them to become resourceful, engaged, and productive adults”.⁵⁰ In the same report, it is stated that Canada has made progress in addressing the health needs of children, mothers, pregnant women and infants.⁵¹

By using CIDA’s strategy on Children and Youth as the primary area through which the Muskoka Initiative is implemented, it is highlighting children’s health. When maternal health is linked with child survival in this way, it suggests that maternal health is being pursued in order to improve child survival as opposed to working towards improvements in maternal health as a goal in and of itself. This is reminiscent of the argument that was initially articulated by Allan Rosenfield and Deborah Maine in their seminal 1985 article “Maternal Mortality – A Neglected Tragedy. Where is the M in MCH?”.

47 Sjolander, 2013; C. T. (2013). Canada and the Afghan ‘other’: Identity, difference and foreign policy. In H. Smith & C.T. Sjolander (Eds.), *Canada in the world: Internationalism in Canadian foreign policy* (pp. 238-254). Toronto: Oxford University Press

48 Berthiaume, 2010

49 CIDA 2011-12 Departmental Performance Report, p. 7

50 GoC’s ODA 2010-2011, p. 6

51 GoC’s ODA 2010-2011, p. 6

The Purposeful Omission of Gender

Throughout all of the texts, the most glaring omission was the failure to identify and address gender issues and gender inequality. This absence is noticed particularly in the Muskoka Declaration, which lays out the purpose and scope of the Initiative. According to this document, the Initiative is meant to target MDGs 4 (reduce child mortality) and 5 (improve maternal health) directly, as well as elements of MDGs 1 (on nutrition) and 6 (on HIV/AIDs and malaria). Here it is also stated that the Initiative will focus on health systems strengthening in countries with a high burden of maternal and child mortality and with an ‘ummet need for family planning’. These documents also acknowledge the importance of a comprehensive approach, however there is no reference in the documents to underlying causes leading to maternal or child death including poverty and gender inequality. Despite making reference to MDGs 1 and 6 that are linked with maternal and child mortality, the critical connections to MDG 3 (promote gender equality and empower women) are excluded.

While there is a notable general absence of references to gender or gender equality in many of the texts, some guiding documents do make fleeting references to gender equality such as the “the G8 Muskoka Flagship Initiative: Maternal Newborn and Under-Five Child Health”. In this document, it is stated that without advancements in gender equality, as well as human rights of women and girls, progress in improving maternal and child health will not be sustainable: “Major improvements in the health and well-being of women and children will not be sustainable without parallel acceleration of donor and developing country commitments to gender equality, human rights of women and girls, women’s economic empowerment and political engagement, to education for all children, particularly for girls, and to protection of women and children in situations of conflict”.⁵²

Despite recognition of the importance of addressing gender equality and human rights of women and girls, the next sentence explains that the Muskoka Initiative will instead “focus on achieving significant progress on health systems strengthening and interventions directly related to maternal and under-five child health”.⁵³ This statement might help to explain why there is very little focus on gender equality in the documents that address the Muskoka Initiative. However, it is a weak justification for the exclusion of gender from the Initiative. A more complete explanation for the omission of references to gender inequality can be found in the Harper Conservative’s erasure of gender in their policies and programs.⁵⁴ As of 2009, references to gender equality have been removed from

52 G8, 2010b, p. 2

53 G8, 2010b, p. 2

54 Carrier and Tiessen, 2013; Tiessen and Carrier, forthcoming

official Canadian foreign policy priorities and speeches and replaced with the language of 'equality between women and men'. Yet, gender equality remains central to issues of maternal health. A gender analysis is central to many issues surrounding access to, and control of, maternal health options. Without identifying gender inequality, we cannot know why women are unable to access maternal health services in the first place or how decisions around maternal health care are made. In order for maternal health care programs to be lasting and effective, they must be available to women at the onset. Furthermore, the sustainability of programs through the maternal health initiative relies on a sound understanding of the gender relations that determine access to maternal health care.

The notion of sustainability is central to the maternal health initiative yet excludes gender. The theme of achieving sustainable results in reducing maternal, newborn and child health that is referenced in the Muskoka Flagship Initiative document is seen throughout many of the texts examined. In the Muskoka Declaration, the first point made is that the Initiative is "based on a set of core principles for long-lasting results". The principles listed include "ensuring sustainability of results", "building on proven, cost-effective, evidence-based interventions", including five others. So, in the two guiding policy documents there is reference made to wanting to ensure sustainable, long lasting results in improving maternal and child health. The prospect of obtaining these lasting results is significantly hampered by the failure to acknowledge the centrality of gender equality to maternal health needs. The notion of sustainability is furthermore linked to accountability and efficiency of aid dollars. In a press release in which the Prime Minister announced Canada's contributions under the Muskoka Initiative he stated, "we will design a rigorous accountability framework to measure our progress, track results and ensure that Canadian's aid dollars are used effectively to contribute to a sustainable reduction in maternal and child mortality".⁵⁵

In a press release that discusses Canada's commitments under the Muskoka Initiative, it is stated that "Canada places accountability at the core of its international development efforts and has worked closely with its partners to develop a framework to measure progress, track results and ensure that funding helps partner countries achieve a sustainable reduction in maternal and child mortality rates"... "Since the launch of the Muskoka Initiative in June 2010, Canada has taken decisive actions with its maternal, newborn and child health partners to achieve sustainable and meaningful results for

55 June 25, 2010, PM announces Canada's contribution

mothers and children in developing countries”.⁵⁶ These kinds of declarations that demonstrate a commitment to ensure sustainable results are found in the literature reviewed. It is peculiar that one of the guiding documents for the Muskoka Initiative expresses the necessity of addressing gender equality simultaneously with improving health systems and service delivery but then declares that the Initiative will not address gender equality and related areas. From the multiple references to achieving sustainable results, it seems that this is an important goal. And yet, the efforts needed to achieve this goal are not being explicitly taken.

As such, the Muskoka Initiative further solidified the shift from a development model to a charity approach as it lacks any direct reference to gender equality and fails to address root causes of women’s disadvantaged position in society relative to men, factors which might indicate whether or not women will access health services in the first place. Brodie and Bakker refer to a trend towards the “progressive disappearance of the gendered subject, both in discourse and practice”,⁵⁷ a process we have witnessed in Canada’s foreign policy commitments since 2006 under the Harper Conservatives.⁵⁸ In sum, the Muskoka Initiative fails to penetrate the gendered societal norms that prevent women from accessing health services even when they are available, and has limited potential for improving the quality of life for women who still have little or no say over reproductive rights and child spacing. A focus on gender equality in development programming has the potential to correct for this shortcoming by involving education programmes, and including women in the design and implementation of development projects. While some former CIDA mid-level officials have been able to continue to address gender inequality in their day-to-day work with development communities, several of the participants noted that the MNCH made it exceedingly difficult to address gender issues since the MNCH projects did not lend themselves to gender equality approaches.

Conclusion: The Instrumentalization of Mothers for Canadian Foreign Policy Purposes

The Harper Conservatives have taken advantage of the opportunity to promote the maternal health needs of women as a foreign policy goal. As an opportunistic venture, the Conservatives have used ‘mothers’ as tools of foreign policy objectives. In his analysis of Canadian foreign policy, Liam Swiss has

⁵⁶ Implementing Canada’s commitments under the MI, Sept. 20. 2011

⁵⁷ Brodie, Janine, and Isabella Bakker. “Where Are the Women?.” *Gender Equity, Budgets and Canadian Public Policy* (2008).

⁵⁸ Carrier, Krystel and Rebecca Tiessen. (2013). ‘Women and Children First: Maternal Health and the Silencing of Gender in Canadian Foreign Policy’, in Heather Smith and Claire Turenne Sjolander: *Canada in the World: Internationalism in Canadian Foreign Policy*, Don Mills: Oxford University Press.

argued that the instrumentalization of gender equality has been used as “a tool for generating support for international objectives or for staged or overt demonstration of international leadership”.⁵⁹ More recently, argues Swiss, the Conservatives have used the maternal health initiative to “...shore up support for international goals around maternal and child health ... to achieve broader policy aims”⁶⁰. In the case of the maternal health initiative, it is not women who are used as tools as foreign policy goals but rather ‘mothers’, a term that resonates with a conservative constituency in Canada.⁶¹ Yet, the objects of a Canadian foreign policy on maternal health are not even mothers. The focus of the maternal health programs is a focus on the delivery of healthy babies. The role of mothers, then, becomes one of ‘walking wombs’.

The use of the language of mothers is significant in this analysis. Documents, speeches and policy papers surrounding the maternal health – or Muskoka – initiative nearly exclusively refer to the beneficiaries of these programs as mothers and children. The failure to make reference to women speaks to the failure to recognize the complex and multifaceted identities of women. It further ignores the fact that not all women who require maternal health services are – or will become – mothers. In so doing, the exclusive reference to mothers essentializes all women in relation to their biology. Furthermore, the references to mothers and children are highly paternalistic, particularly the ongoing references to ‘saving lives’. It is clear from the policy documents that attention to gender equality is not a priority and the omission of gender has been purposeful, a declaration that was made explicit under the Harper Conservatives. The omission of gender equality programming is, however, highly problematic and reflects the Harper Conservatives’ official shift in policy discourse from ‘gender equality’ to ‘equality between women and men’. However, even the language of equality is omitted from the maternal health initiatives. Attention to the sources of inequality, absence of rights and options, and other causes of gender inequality are ignored and assumed to be irrelevant to maternal health programs. The reality, however, could not be any further from the truth.

A focus on maternal health is a focus on women’s bodies and as such, it shapes the context and nature of the policies and debates. Framing maternal

59 Swiss, Liam. “Gender, Security, and Instrumentalism: Canada’s Foreign Aid in Support of National Interest?.” *Struggling for Effectiveness: CIDA and Canadian Foreign Aid (2012)*: 135.

60 Swiss, Liam. “Gender, Security, and Instrumentalism: Canada’s Foreign Aid in Support of National Interest?.” *Struggling for Effectiveness: CIDA and Canadian Foreign Aid (2012)*: 135.

61 Brown, Stephen and Michael Olender. (2013). “Canada’s Fraying Commitment to Multilateral Development Cooperation”. In H. Besada & S. Kidornay (Eds.) . *Multilateral Development Cooperation in a Changing Global Order*. New York: Palgrave Macmillan, pp. 159-88); Smith & Heap, 2010; Wells, Paul. Abortion: Harper’s vigilant global audience. *Macleans*. September 22, 2011. <http://www2.macleans.ca/2011/09/22/abortion-harpers-vigilant-global-audience/>

health as exclusively motherhood essentializes and treats mothers as objects of development assistance and as instruments of policy making; casting women as near exclusively vulnerable bodies rather than active agents who have options and choices. This focus often produces policies that use women and mothers as instruments of government policy making, and also as objects of policy attention rather than involving them in the design and implementation of programs. In this article I employed the notion of embodiment in relation to maternal health as an embodied experience since pregnancy is both a natural and cultural experience. However, the use of foreign policy approaches to maternal health has further made the embodiment of pregnancy a political issue. A failure to understand the causes of maternal health problems, specifically the cultural and political factors that facilitate gender inequality, reduces the MNCH initiative to a set of approaches geared to targeting the symptoms of gender inequality; thereby, largely reducing maternal health programming to a set of medical interventions that can ‘save lives’. Commitments to maternal health programs offer much scope for changing the lives of women and mothers. However, the discourse surrounding Canada’s commitments to the MNCH Initiative points to a limited, weak and problematic focus on mothers as objects of development assistance.

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Rebecca Tiessen

School of International Development and Global Studies

University of Ottawa

email: rtiessen@uottawa.ca

