Juggling Demands

Canadian Health Aid to Latin America Since World War II

Klaudia A. Dmitrienko, MA, MHSc

Anne-Emanuelle Birn, MA, ScD

ABSTRACT

Background: Since the development of the Commonwealth's 1950 Colombo Plan (Canada's first official aid program), health-related development assistance has been an important instrument of Canadian foreign policy, allowing it to gain a presence in a range of countries and help to shape international affairs. This pattern is evident in the history of Canadian multilateral and bilateral health aid to Latin America.

Methods: This analysis draws on historical material from the Departments of External Affairs and National Health and Welfare held at the Library and National Archives of Canada regarding Canadian involvement with the Pan American Health Organization (PAHO), and program information from the Canadian International Development Agency's (CIDA) Corporate Reporting Services Group.

Findings: Canada was initially a tentative player in the region. However, as Canadian foreign policy interests shifted towards the region in the 1970s, Canada used both multilateral and bilateral health aid to establish a presence in Latin America that was independent from, yet unthreatening to, United States hegemony in the region.

Conclusion: The impact of Canada's provision of health aid to Latin America via PAHO and CIDA has been largely symbolic, allowing Canada to pursue an independent foreign policy in the region and to foster a positive international image for itself with minimal spending.

MeSH terms: Foreign aid; Canada; Latin America; PAHO; international cooperation; history

La traduction du résumé se trouve à la fin de l'article.

Department of Public Health Sciences, University of Toronto

Correspondence: Anne-Emanuelle Birn, Associate Professor, Canada Research Chair in International Health, Department of Public Health Sciences, Faculty of Medicine, University of Toronto, 155 College St., Room 662, Toronto, ON, Canada M5T 3M7, Tel: 416-946-5792, Fax: 416-978-8299, E-mail: ae.birn@utoronto.ca

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In 1980, the Canadian government was faced with the thorny question of which three Latin American countries to support for election to the Executive Board of the Pan American Health Organization (PAHO). A PAHO member for only nine years, Canada wished to develop a positive international image and balance its alliances in the region. The Department of National Health and Welfare supported Jamaica and Argentina for two of the positions, "on the grounds that these candidates [were] best qualified in international health",¹ leaving the third decision to the discretion of the Department of External Affairs.

External Affairs administrators debated the implications of filling the third spot with Uruguay, Nicaragua or the Dominican Republic, at first backing either the Dominican Republic, "a democratic country with which we have good relations" or Nicaragua, as "this would provide a modest signal ... that we are prepared to maintain cordial relations with that country"² in the wake of the Sandinista revolution. However, concern regarding a possible "shift to the left" on the Executive Board and "Canadian judgment that the region would certainly benefit more if [non-Marxist] policies were pursued" led External Affairs to favour Uruguay.³

Despite this initial support, External Affairs ultimately dropped Uruguay, arguing that it was problematic to back two countries in the Southern Cone but none in Central America and also "awkward to cast two of our three votes for countries with such tarnished human rights records as Uruguay and Argentina" (although it was noted that none of the countries had unblemished records).⁴ Ultimately, Canada took the route of least political offence, and the Canadian delegation was instructed to vote for the Dominican Republic to fill the third seat.⁵

This episode illustrates Canada's position vis-à-vis health aid to Latin America as one of juggling a variety of foreign policy interests in the region. These include: forging a symbolic and independent foreign policy, being unwilling to challenge traditional United States (US) hegemony, developing cordial relations throughout the region, and supporting the general goals and values of the Canadian government. For a country like Canada, with

limited economic or military clout, health aid has served as a diplomatic tool in the context of bilateral relations and allowed the country a voice in international affairs. Providing health and development assistance is thus a means of engendering international prestige and goodwill as well as securing national interests.⁶

This paper examines the political and economic context of the emergence of Canadian health aid to Latin America. Drawing on archival material from the Departments of External Affairs and National Health and Welfare and program information from the Canadian International Development Agency's (CIDA) Corporate Reporting Services Group, we address the ways in which Canadian international health policy towards Latin America has been fashioned from the various tensions of domestic, regional and international pressures and opportunities.

First Steps, Canada's Growing Role in International Health and Development: 1946-67

Canada shares a colonial history with other countries of the Western Hemisphere, but unlike the US, Canada has little history of aggressive intervention in Latin America and the Caribbean.⁷ For much of the early 20th century, Canada pursued trade and investment interests and represented British imperial concerns in the Caribbean.⁸ An independent Canadian foreign policy only began to emerge in the second half of the 20th century, with international mediation, peacekeeping, and the provision of development assistance characterizing Canada's role on the global stage. The awarding of the 1957 Nobel Peace Prize to Prime Minister Lester Pearson for his success in responding to the Suez crisis⁹ was the pinnacle of this golden era of Canadian foreign policy.

It was in this period that Canada's foreign aid program was founded: Canada began to furnish technical assistance to various Commonwealth countries via the Colombo Plan of 1950.⁶ Health aid – predominantly the provision of medical equipment and public health training both in Canada and locally – formed part of this assistance which grew steadily from the mid-1950s through the 60s. However, with the exception of Commonwealth

Caribbean countries, Canadian aid overlooked the Americas region.

The Case of Canadian Membership in the Pan American Health Organization

In spite of Canada's geographic location and history of economic ties to the Caribbean, its relations with Latin America were slow to develop. Culturally tied to Europe and politically linked to Britain, Canada neither saw itself, nor did others see it, as a country of the Americas. After WWII, Canada began to identify with North America as its economic ties with the US grew. However, Canada's links with the Commonwealth and La Francophonie (an international network of French-speaking organizations and governments) kept its foreign policy attention focussed elsewhere.

US dominance in the region also dissuaded Canadian engagement with Latin America.¹⁰ Canada never recognized the US's self-declared right to intervene in the countries of the Americas (as outlined in the 1823 Monroe Doctrine), yet did not criticize US influence in the region in order to avoid conflict with this ally and trading partner. Canada refrained from involvement in many of the pan-American organizations that developed in the late 19th century, such as the Pan American Union (now the Organization of American States - OAS) and, notably, the Pan American Sanitary Bureau (PASB, renamed PAHO in 1958).

Established as the International Sanitary Bureau of the Americas in 1902 and renamed the PASB in 1923,¹¹ the Bureau served as the region's (and the world's) first international health agency. Following the creation of the World Health Organization (WHO) in 1948, it was agreed that the PASB would form WHO's regional body for the Americas. Canada enthusiastically adopted membership in WHO and Canadian Deputy Minister of Health Brock Chisholm became WHO's first Director General. However, when asked to join PASB, Escott Reid, Deputy Under-Secretary of State for External Affairs, replied that Canada was "reluctant to do so because ... membership ... might make it difficult to avoid becoming involved in the Pan American Union."¹²

In an additional 1949 memo, J.W. Holmes of the United Nations Division of

Canada's Department of External Affairs argued that the country had no "more reason for associating with Bolivia or Guatemala on matters of health than with Norway or France... We should only be involving ourselves in the inevitable series of Latin-American conferences for which we would be put to great expense."¹³ This question of the relevance of the PASB's work combined with financial concerns, unease regarding the PASB's integration with WHO, and unwillingness to become embroiled in Latin American disputes all contributed to Canada's official position of distance regarding the PASB.

Despite its refusal to join, Canada sent observers to PASB meetings. Initial reports by these observers attempted to justify Canadian aloofness. In 1953, Canada's official observer to the seventh meeting of the Pan American Sanitary Organization (PASO, the umbrella organization that administered PASB) communicated PASB Director Dr. Fred Soper's repeated request that Canada become a full member, linking this request to the fact that "the organization needed more money."¹⁴ The report underscored that "Canada, if it were a member ... would presumably contribute more than it would receive."¹⁴ It was not until the political advantages of membership became evident that a closer relationship with, and a financial commitment to, PASB/PAHO was considered.

The potential advantages of PAHO membership were first noted by the Department of National Health and Welfare (NHW), which served as the main liaison between the Canadian government and PAHO. An observer report from the mid-1950s emphasized Canada's "definite interest in the existence, in the Central and South American countries, of such diseases as smallpox, rabies, tuberculosis, diphtheria, aphthous disease, etc."¹⁵ Dr. B.D.B. Layton, Principal Medical Officer of the International Health Section of NHW, also lamented in 1958 that, despite general respect among PAHO member countries for Canadian expertise, the continued avoidance of Latin American affairs was threatening Canada's reputation as a generous nation and leader in the health field. Layton held that joining PAHO would "check the progressive deterioration of our national prestige."¹⁶ NHW officer Allan McEachen also supported Canadian mem-

bership in PAHO, noting that his department was "being penalized through the loss of valuable information ... [and was incurring] expenditures for studies which, through active participation in PAHO, might well have been avoided..."¹⁷

But External Affairs remained reluctant. In a 1967 memo to Minister of External Affairs Paul Martin, Dr. Layton acknowledged the cost of joining PAHO but stressed the advantages:

"Membership in PAHO would cost us about \$500,000 a year ... The material returns to us will ... be nebulous ... but it would ... allow us to:

- a) Participate in a hemisphere technical organization which is doing increasingly useful work in the health field...
- b) ... improve our chance of election to [WHO's] Executive Board as well as providing us with greater opportunity to influence WHO's programme and budget.
- c) Further demonstrate our announced policy of developing closer relations with Latin America in technical fields without prejudicing ... our attitude to membership in the OAS.
- d) Reflect still further our interest in an international organization working in a field of particular concern to the provinces."¹⁸

Layton's support notwithstanding, Minister Martin's handwritten response to this memo questioned whether Canada "would benefit from this expenditure,"¹⁸ and he refused to approve entry to PAHO, leaving Canada in the anomalous position of being a member of WHO but not of WHO's regional body for the Americas. External Affairs' ongoing opposition to PAHO membership was bolstered by concerns that Canada was "being pulled into the OAS by the back door"¹⁹ and resistance to the financial commitment involved (in 1969, Canada's contribution would have been approximately \$840,000,²⁰ or roughly 4.6 million in 2005 dollars).

While the desire to maintain distance from the OAS may have been the primary concern in the 1950s, the fact that Canada was free to join PAHO without joining the OAS suggests that financial constraint was the main justification for the delay in Canada's membership. Indeed, a 1965 memo to the Minister of External Affairs "recognized that joining PAHO would

represent a substantial [permanent] annual expenditure."²¹ In the mid-1960s, External Affairs did not feel that such spending was required "simply to demonstrate Canada's belief in international cooperation, since Canada's reputation on this score [could] hardly be challenged by anyone."²¹ Unbeknownst to the memo's author, both Canada's relations with Latin America and its approach to aid were about to change dramatically.

Canada's New Hemispheric Focus and the Strengthening of Relations with Latin America via Health Aid: 1968-84

A shift in Canada's relations with Latin America was sparked by newly elected Prime Minister Pierre Trudeau's 1968 request for a review of Canadian foreign policy. The resulting policy document, *Foreign Policy For Canadians*, advocated a vision of Canada as a "distinctive North American country firmly rooted in the Western Hemisphere" and called for increased development assistance and the promotion of Canadian business interests as the key to strengthening relations with Latin America.²² The new policy sought to build upon prior ties forged by Canadian Chartered Banks, businesses, religious orders, and voluntary agencies and was encouraged by a desire to diversify Canada's trading partners,²³ a commitment to ideological pluralism in the hemisphere, and by Trudeau's personal interest in the region.²⁴ The Canadian public's awareness of Latin American issues due to the role of Canadian non-governmental organizations working in the region also increased pressure for official Canadian aid and development assistance. The simultaneous desire to increase ties with Latin America yet avoid offending the US may also account for Canada's initial involvement in Pan American institutions dealing with ostensibly neutral issues of health and development.

With the publication of the 1970 foreign policy review, the Cabinet Committee on External Policy and Defense approved External Affairs' and National Health and Welfare's proposal that Canada join PAHO.²⁵ Canada announced its intention to join PAHO at the 18th Pan American Sanitary Conference held in September 1970²⁶ and became an official member in

1971. PAHO membership enabled Canada to expand its multilateral aid programs to Latin America, but it also served a symbolic role, with Canada presenting itself as an engaged hemispheric partner concerned with regional well-being. PAHO membership also provided Canada with "experience in the 'inner circles' of Latin American affairs ... without the more serious ... step ... of membership in the OAS."²⁷

Canadian involvement in PAHO grew throughout the 1970s. By 1978, a government memorandum lauded Canada's contributions to PAHO's regional programs and raised the expectation that Canada would shortly "take a still more active interest as a member of PAHO's Executive Committee."²⁸ Canadian conduct within PAHO largely mirrored its broader foreign policy tendencies. For example, Canada's Commonwealth identity encouraged support for Caribbean Commonwealth nations in their bids for PAHO positions and requests for health aid. Canada's contributions to PAHO programming also displayed particular areas of national expertise, including: "technical assistance in rural water and sanitation programs, nursing and dental health education, health worker training, the development of food and drug standards and the emergency preparedness program of the Americas."²⁹

Forging an Independent Foreign Policy Path

After a decade of involvement with PAHO and other regional institutions (although until 1990 not the OAS), Canada's fear of becoming embroiled in Latin American disputes faded and the Canadian government became willing to counterpoise US policy in the region. Canadian-Cuban health cooperation was one demonstration of Canada's commitment to maintaining relations with Cuba following its revolution despite the US policy of sanctions and embargo,³⁰ with a 1970s External Affairs memo noting that "[n]umerous exchanges of experts and health officials have been carried out. As well, Cuban doctors and technicians have been trained in Canada..."³¹

This Canadian deviation from US policy in the region was encouraged by pressure from domestic human rights groups, church organizations, and labour unions

concerned about the increasingly repressive political conditions in Latin America. As a result of their lobbying,³² Canada became the largest provider of asylum to Chileans displaced by Augusto Pinochet's 1973 military coup. The arrival of approximately 7,000³³ Chilean refugees in the mid-1970s (the first significant wave of Latin American immigration to Canada)³⁴ strengthened Canadian-Latin American solidarity networks and established Canada as a country supportive of ideological diversity and committed to an independent foreign policy in the region.

In a similar vein, at the 26th Meeting of the Directing Council of PAHO in 1979, the Canadian delegation announced that "the Canadian people and the new Government of Canada sympathize very deeply with the people of Nicaragua" and pledged \$1 million in aid;³⁵ Canada also advocated increased PAHO aid to rebuild Nicaragua's health system.³⁶ This burgeoning support for Nicaragua's new Sandinista government marked a divergence from US policies of suspending aid to Nicaragua in 1981 followed by a trade embargo.³⁷ Canada, by contrast, remained a steady partner in terms of aid and trade to Nicaragua through the 1980s, reaping commercial and symbolic benefits from continued engagement.³⁸

In the early 1980s, Canada actively employed its role in PAHO to address tensions in Central America, with at least one government official noting, "If PAHO can be used as a political instrument in support of the peace process in Central America it should be encouraged to do so, with Canadian material support."³⁹ A mere fifteen years after joining PAHO – an organization it initially eschewed in order to avoid regional politics – Canada was using its PAHO membership to influence events in the region and develop a foreign policy independent from the United States.

The Canadian International Development Agency (CIDA) and the Role of Bilateral Health Aid

Canada's bilateral health assistance to Latin America through CIDA grew alongside its multilateral involvement in PAHO. Created in 1968, CIDA launched Canada's first bilateral aid program to Latin America in 1970. The International Development

CIDA Health-Related Projects in Latin America, 1970-2004

Figure 1. All CIDA projects in Latin America in the health and population policy sectors
Source: CIDA's Corporate Reporting Services Group; data accessed on April 12, 2005.

Research Centre (IDRC), a Canadian Crown corporation supporting developed-developing country research partnerships, was formed in the same year. Both organizations emphasized the increasing role of development assistance, including health aid, within Canadian foreign policy.

While most of Canada's early aid was allocated to mining, forestry, telecommunications and power generation,⁴⁰ CIDA supported a steady increase in health-related development projects in Latin America from 1972-2005 (see Figure 1), starting with the installation of medical facilities and maternity and child health care centres in 1972.⁴¹ Both the number and diversity of health-related aid programs in Latin America grew, with the 31 health-related CIDA projects sponsored in the region in the 1970s (see Figure 2) increasing to over 660 programs in the 1980s.⁴² Canada's bilateral health aid to Latin America paralleled the country's multilateral role in PAHO; together, these efforts provided a presence and positive image for Canada in a region of increasing commercial interest and strategic importance. Indeed by 1985, total Canadian exports to Latin America had reached \$2,360 million Canadian, up from \$1,950 million in 1975 and \$314 million in 1965.³³

The Contemporary Context: 1985-2006

By the mid-1980s, Canada's involvement in Latin American health cooperation was fully institutionalized. Canada was an active member of PAHO and had developed diverse bilateral health aid programs to the region via CIDA. Despite the shifts in political power resulting from the electoral victories of Progressive Conservative Brian Mulroney in 1984 and the subsequent Liberal governments of Jean Chrétien (1993-2003) and Paul Martin (2003-2006), Canada's policy of engagement with Latin America has not wavered. Notwithstanding cuts to overall development assistance funds in the early 1990s, the general trend of Canadian-Latin American health relations has been one of increasing Canadian multilateral and bilateral involvement in the region.

Yet this involvement may be viewed as more symbolic than substantive. Despite the growth in the numbers of programs and amount of funding for health aid in Latin America, in every period the region has received far less Canadian aid than either Asia or Africa.³³ For example, for the 2003-2004 fiscal year, CIDA's America Branch received 7.3% (\$162.1 million) of total aid disbursements, approximately half of that provided to the Asia Branch and a

CIDA Health-Related Programs in Latin America, by Category, 1970-79

Figure 2. All CIDA health-related programs in Latin America, 1970-79
Source: CIDA's Corporate Reporting Services Group, data accessed April 12, 2005.
Analysis by author.

third of that provided to the Africa and Middle East Branch.⁴³ This weak showing in dollar terms calls into question the extent to which Canada's aid to Latin America has meaningfully contributed to improving health and reflects the relatively low priority of Latin America in Canada's foreign policy agenda.

We are also entering an era of change regarding Canada's foreign policy in general and development policy in particular. Following an extensive consultation process where considerable support for raising the profile of development and "Canadian values" in Canadian foreign policy was expressed, the Government of Canada released a new foreign policy review in April 2005.⁴⁴ *Canada's International Policy Statement: A Role of Pride and Influence in the World* reiterates "strengthening Canada's influence in the Western Hemisphere" as a priority⁴⁵ and identifies the health sector as a key area for involvement. However, CIDA has announced that it intends to limit two thirds of its bilateral programming to only 25 countries by 2010. Of the countries selected, only 4 are within Latin America: Bolivia, Guyana, Honduras, and Nicaragua.⁴⁶ Especially troubling is the exemption of Haiti from this list, as Canada's francophone identity has resulted in a significant donor relationship with Haiti in the past,⁴⁷ Canada has a sizeable Haitian immigrant population,

and Haiti currently is the "largest recipient of Canadian assistance in the hemisphere, particularly in the areas of health, education and agriculture."⁴⁸ Due to this reduced number of Latin American countries receiving Canadian health aid and the unpredictability of the direction of foreign policy under the newly elected Conservative government of Prime Minister Stephen Harper, the future of Canadian-Latin American health cooperation is uncertain.

Canadian Foreign Policy and Health Aid to Latin America

While not a traditionally important region for Canada's foreign policy, Latin America has garnered growing Canadian interest over the past four decades. Canada's historical relationship with PAHO in particular reflects the larger patterns of Canadian foreign policy and health aid to Latin America: a long period of reticence and non-involvement followed by steadily increasing participation. Canada has been a tentative player in the region, from the earliest days of not wanting to become entangled financially or politically in Latin American affairs, owing to the hegemonic role of the United States.

Nonetheless, multilateral and bilateral health programming to Latin America and the Caribbean via PAHO and CIDA

have allowed Canada to carve a niche for itself. Through health aid, Canada has established itself as a 'good' regional partner, opened up possibilities for increased trade, and exercised independence from US positions. The focus on health has highlighted "the [proclaimed] just and humane nature of Canada's foreign policy,"⁴⁹ providing a relatively neutral entry point for Canadian involvement in a region dominated by the US. The provision of health aid to Latin America is thus an avenue through which Canada has pursued its own foreign policy and fostered a positive international image, albeit in symbolic more than substantive terms.

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RÉSUMÉ

Contexte : Depuis l'élaboration du Plan de Colombo du Commonwealth en 1950 (le premier programme d'aide officiel du Canada), l'aide au développement liée à la santé s'est avérée un instrument important de la politique étrangère canadienne, un instrument qui permet au Canada d'être présent dans divers pays et de jouer un rôle sur la scène internationale. C'est clairement ce qui s'est passé dans l'histoire de l'aide sanitaire multilatérale et bilatérale du Canada en Amérique latine.

Méthode : Notre analyse est fondée sur les documents historiques des ministères des Affaires extérieures et de la Santé nationale et du Bien-être social conservés à la Bibliothèque nationale et aux Archives nationales du Canada portant sur le rôle du Canada au sein de l'Organisation panaméricaine de la santé (OPS). Nous avons aussi consulté l'information sur les programmes détenue par le Groupe des rapports de l'Agence canadienne de développement international (ACDI).

Constatations : Au départ, le Canada était hésitant quant à son rôle dans la région. Mais lorsque les intérêts de la politique étrangère canadienne se sont recentrés vers l'Amérique latine au cours des années 1970, le Canada s'est servi de son aide multilatérale et bilatérale en matière de santé pour se doter d'une présence à part entière dans la région, sans pour autant menacer l'hégémonie des États-Unis.

Conclusion : La prestation par le Canada d'une aide sanitaire à l'Amérique latine par le biais de l'OPS et de l'ACDI a eu principalement un impact symbolique, en permettant au Canada de mener une politique étrangère indépendante dans la région et de se donner à peu de frais une image positive sur la scène internationale.