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Biopolitics, Risk, and Reproductive Justice: the Governing of Maternal Health in Canada's Muskoka Initiative

Jacqueline Potvin, *The University of Western Ontario*

Supervisor: Baruah, Bipasha, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Women's Studies and Feminist Research

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Abstract

In this dissertation, I examine how Canada's Muskoka Initiative discursively constructs and addresses maternal, newborn and child health (MNCH) as a global development problem. I evaluate how the Muskoka Initiative aligns with, and departs from feminist articulations of sexual and reproductive health, rights and justice. I do this by analyzing how the Muskoka Initiative drew on and reinforced dominant norms of motherhood, and aligned with neoliberal development frameworks. I also examine how the reproductive bodies and lives of women in the Global South were configured as sites of both development intervention and biopolitical governance. My findings are based on a critical discourse analysis of texts from the Government of Canada's MNCH website, and of project descriptions of programs funded through the Muskoka Initiative. I also conducted semi-structured interviews with key informants within the Canadian development sector. My analysis is informed by feminist and postcolonial development theory, and by theories of biopolitics, governmentality, healthism, risk and reproductive justice. My findings demonstrate that maternal health was constructed as a problem of unmanaged risk that could be solved by increasing access to medical services. Canadian interventions sought to increase access to medical services by providing capital and technology; building the capacity of developing countries to deliver services; and promoting particular reproductive health and childcare behaviours among developing world women. Through these interventions, Canada situated itself as a global leader in MNCH. I argue that the Muskoka Initiative adopts a depoliticized, technocratic approach to MNCH that aligns with neoliberal development frameworks while leaving existing structural power relations unexamined. I also argue that MNCH interventions operate as a site of biopolitics, wherein women's reproduction is governed through discourses of medical risk. Women are instrumentalized, and made responsible for the health of themselves, their children, and the population. I conclude that although the Muskoka Initiative contributed to reproductive justice by improving access to medical care and contraception, its contributions were constrained by its adoption of a technocratic, depoliticized approach to health and development; its exclusion of abortion and non-reproductive sex; and its promotion of

particular reproductive choices, including the limiting of developing world women's fertility.

Keywords

Muskoka Initiative, maternal newborn and child health, reproductive justice, sexual and reproductive health and rights, biopolitics, healthism, reproductive governance, critical discourse analysis, global development.

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Chapter 1

1 Introduction

In June 2010, the Canadian Federal Government hosted meetings of the G8 countries in Huntsville, Ontario, and of the G20 countries in Toronto, Ontario. These meetings were memorable for Ontarians particularly because of the protests they sparked from various anti-capitalist, anti-poverty, anarchist, environmentalist and Indigenous rights groups (CBC, 2010; French and Jordan, 2010). Protesters targeted numerous issues, including the cost of the meetings themselves and the failure of the congregating leaders to address the concerns of the world's most vulnerable. Therefore, it is somewhat ironic that one of the achievements highlighted by the Canadian government as a huge success of the meetings was the signing of the Muskoka Initiative, an international agreement on maternal, newborn and child health, which according to then Prime Minister Stephen Harper, would "save millions of lives" and "make a significant, tangible difference to the world's most vulnerable people" (Harper, qtd Elliott and Wintour, 2010). The Muskoka Initiative committed the G8 countries, plus additional signatories and private partners, to fund programs in support of maternal, newborn and child health. Heralded as putting maternal health on the global agenda, the Muskoka Initiative was framed by the Canadian government as both a moral victory and as showcasing Canada's ability to lead on the global stage. Yet reactions to the Muskoka Initiative were mixed, with many critiques focusing on the lack of explicit reference to abortion, despite the international agreement's identification of family planning as an area of action (McMann, 2014; Webster, 2010). In outlining how Canada would fulfill its commitments, the Conservative Government stated that Canada would not provide funding or resources in support for safe abortion, drawing considerable criticism from those who understand safe and legal termination as an integral component of maternal health (Webster, 2010). The Muskoka Initiative thus appeared to occupy a space of tension, explicitly deploying resources to help address women's health, yet in ways that refused to engage with the language of reproductive rights, or gender equality (Tiessen, 2015). In addition to the lack of funding for abortion, some critics questioned the apparent tension between the establishment of maternal, newborn and child health as Canada's 'top development' priority and the (remainder) of the Harper

Government's development policies, which focused on private partnerships, trade and security (Black, 2013). Given these critiques, as well as the controversies surrounding the G8 and G20 summits, the Muskoka Initiative has appeared to some as a savvy political move aimed at bolstering Prime Minister Harper's public image (Brown, 2016); for who could possibly object to helping mothers and children?

During the summer of 2010, I had just completed my undergraduate degree in international development, with a focus on political economy. Despite my new degree, and a growing interest in reproductive rights and health, the attention I gave to the G8 and G20 summits was primarily focused on the surrounding protests, and on my own ideological stance towards the Harper government and the G8 system. Indeed, while I had very much enjoyed my undergraduate program and the community of peers and mentors I had found therein, I was also graduating with a great deal of cynicism and disillusionment with the politics of global development. In particular, I was struggling to reconcile my desire to work within the development sector with the critical scholarship I had encountered in my other major, English literature. I pursued this second major concurrent with my major in international development, and through it, I was exposed to feminist, postcolonial and poststructuralist theories that, in conjunction with perspectives from critical development studies, pushed me to confront the problematic assumptions embedded in much of mainstream development theory and practice. Through my studies, I was learning to critically engage with language as a site of social power, and to question how narratives and representations affect the ways we think about gender, race and the 'Third World'. The result was a growing intellectual curiosity about development studies as a site of neocolonial and patriarchal power, as well as a growing unease with my place as a student of development, and with my plan to pursue a career in this field. This combination of curiosity and discomfort eventually led me to pursue a Master's degree in global gender studies at Leeds University. Jointly offered through the Center of Interdisciplinary Gender Studies and the School of Politics and International Studies, this program offered me the opportunity to further examine the questions and tensions that emerged out of my undergraduate experience.

In the year between my undergraduate and Master's degree, I was gifted a copy of *Half the Sky* by Nicholas Kristof and Sheryl WuDunn (2009). The book's subtitle is "Turning Oppression into Opportunity for Women Worldwide" and it presents stories that highlight the need to 'invest' in women in order to bring about social change. It was immensely popular at that time, likely due in part to an endorsement from Oprah Winfrey. While the gift-giver clearly presumed I would enjoy a book that aligned so closely with my interests in global development and feminism, reading it deepened my disillusionment. I was confused and frustrated by the authors' continued insistence that women were worth helping because of what they could offer others. Women were presented as altruistic and self-sacrificing, using any help they received to care for and elevate their families and communities, while men were presented as financially irresponsible and uncaring, squandering their money on alcohol and cigarettes instead of their children. I was troubled by the book's reliance on racist tropes of men in the Global South as selfish, lazy and dangerous in order to support their argument of women as worthy of investment. Similarly, I was concerned by the book's reliance on stereotypical portrayals of women, which I read as tying women's worth to their roles as wives and mothers, and framing their usefulness as emerging out of their compliance with dominant gender norms of women as altruistic and self-sacrificing. I also recognized that if the same characteristics had been put forward in reference to women in the 'developed' world they would have been deemed patriarchal, offensive and oppressive. I was troubled and curious as to why a top female media mogul who consistently told women they were worthy of their own ambitions, of being selfish, and of asking for 'me time', would promote a book that reified and fetishized the sacrifices made by women in the Global South.

The narratives encountered in *Half the Sky* are not unique. Indeed, their familiarity motivated me to look more closely at dominant discourses of gender and development, helping to shape my Master's dissertation on the use of maternal discourses in popular development campaigns. Throughout this project I gained an understanding of how representations of women and mothers as inherently altruistic are used to situate women in the 'developing' world as members of the 'deserving poor'; as both 'good women' deserving of help and as 'good investments' whose empowerment could be instrumentalized to achieve broader economic goals (Potvin, 2015). For instance, in the

texts analyzed, women's needs were conflated with those of their children, with the emphasis on how improved access to resources such as clean water would help them care for and ensure the health of their children, with little to no reference to women's own health or well-being. Resources and training provided to women through interventions were also presented as being re-invested in women's families, as well as their communities. These representations positioned women as able to break the 'cycle' of poverty through participation in the formal economy, as well as through their roles as mothers and care-givers willing to use the benefits of their participation to lift others up. In analyzing these representations, I encountered work by feminist and postcolonial development scholars who helped me understand that these representations contributed to the discursive construction of women in the developing world as good neoliberal subjects who diligently contribute to their communities, and to the global economy without significantly challenging traditional understandings of women's familial and reproductive roles (Chant, 2012; Cornwall, Gideon and Wilson 2008; Dogra, 2012; Wilson, 2015). Doing this work also provided me with an immense appreciation for how development discourse impacts the kinds of interventions that are understood as appropriate and possible, and how these discourses have translated into interventions that responsibilize developing world women, often adding to their reproductive and productive labour burdens while holding them up as the 'key' to ending poverty (Chant, 2012).

As I completed my MA and began my doctoral degree, I was increasingly interested in how the construction of women in the Global South as 'good' was bound up in their desexualisation. Due to the implicit desexualisation of mothers in western popular discourse, the presentation of women as altruistic, self-sacrificing carers of children appears to situate them as sexually 'innocent' (Dogra, 2012). This is supported by the discourse of women as sexual victims, made vulnerable to the dangers of sex (primarily HIV) due to both a lack of power, and the presumed violence and sexual irresponsibility of their male partners (Jolly and Cornwall, 2010; Miller, 2004). While it is certainly important to acknowledge how women are made vulnerable through sexual violence, the dominance of these representations perpetuate not just sexist ideas of women as sexually passive and men as sexually aggressive and hence dangerous, but also racist presumptions that situate men of colour as particularly dangerous and women of colour as in particular

need of being saved (Jolly, 2007). Where women's sexuality is acknowledged, it is largely through interventions that target the practices of sex workers, who appear as dangerous vectors of disease, endangering the men they sleep with, and eventually, those men's wives (Ditmore, 2008; Kelly, 2011; Scott, 2011). These two dominant discourses situate women as either sexually at risk, or as posing a sexual risk, leading me to conclude that the depiction of women in the development sector relies on a 'Madonna/whore' binary, to borrow and appropriate a Freudian phrase. Yet whether as innocent 'Madonnas' or dangerous 'whores', the emphasis consistently reinforced how helping women could help others, either by stemming the spread of disease, increasing economic output and/or ensuring the care and health of children. Thus, as scholars such as Jolly (2007) and Gosine (2009) have argued, the inclusion of sex and reproduction in global development has been largely focused on how their management can contribute to broader development goals, rather than on sexual and reproductive rights and well-being. As such, mainstream inclusion of issues affecting women's sexuality and reproduction have largely contributed to the overarching instrumentalization of women in development.

As I mulled over these ideas in the early stages of my doctoral program, then Prime Minister Stephen Harper and his maternal health policy once again became a prominent media story. As I watched a report on the 2014 Canadian hosted *Saving Every Woman, Every Child* UN summit, I was again frustrated and disillusioned. As with the skeptics who questioned the motivation behind the 2010 Muskoka Initiative, I was troubled by the Conservative Government's very public support for saving 'women and children' as opposed to pursuing human rights or gender equality. Indeed, I was angry that the Canadian government was capitalizing on the positive narrative of helping the most vulnerable while they continued to deny any support for reproductive rights, specifically for abortion. Although I had originally planned to continue my research on development campaigns by NGOs, I realized that the discourses of the Muskoka Initiative and the post-Muskoka Maternal, Newborn and Child Health (MNCH) policies exemplified many of the maternal discourses I was interested in examining. I recognized how the discourse surrounding the 2014 conference situated women as mothers and as victims, and in doing so, supported a political narrative that justified Canada's development interventions. Furthermore, I recognized that this policy itself was in need of interrogation, in order to unpack how the

focus on maternal health constituted an ideal space through which a conservative government could appear to support women in the 'developing' world while excluding explicit engagement with reproductive or sexual rights, gender equality, or agentic female sexuality. I was also interested in how the narrative of saving women and children appeared, on its surface, to avoid the instrumentalization of women that characterized other representations of women-centered development interventions, even as it excluded the language of reproductive rights. I was ultimately motivated to look more closely at how the Muskoka Initiative framed the project of maternal health, and to what extent it contributed to, or resisted, instrumentalist discourses of women in development, as well as the perpetuation of rigid gender norms and roles.

This dissertation constitutes my attempt to answer these questions. I have done so by conducting a critical discourse analysis of texts that address Canada's activities under the Muskoka Initiative, from 2010–2015. The focus of this analysis has been to examine how the Muskoka Initiative discursively constructs the 'problem' of maternal health, and by extension, what kinds of interventions have been deemed appropriate. My work has further been motivated by my interest in and commitment to reproductive justice, and thus includes consideration of how the Muskoka Initiative may have contributed to reproductive justice by improving access to maternal healthcare, as well as how these contributions may have been limited by the exclusion of reproductive rights, including abortion, as well as its reliance on, and perpetuation of particular understandings of femininity and maternity. In Chapters 2 and 3, I outline in more detail how I have situated my research at the intersection of critical development studies and critical health studies, with scholarship from both fields informing my understandings of how both 'health' and 'development' are discursively constructed as fields of action, and as sites of power and of governance. As such, my analysis has been informed by insights from the theory of biopolitics, which examines how power circulates to manage individual bodies and, by extension, the population. I also draw on the related theories of governmentality and healthism, which provide insights into how this management occurs within neoliberal contexts in which individual freedom is highly valued. I specifically use these theories to examine maternal health programing as a site through which women's bodies are managed, while asking how this management aligns with and contributes to the responsibilization of women in the Global South. Using these

theoretical concepts in conjunction with the framework of reproductive justice, I examine how maternal health programming, as configured within the Muskoka Initiative can contribute to, or limit, the reproductive rights and autonomy of women and communities in the Global South.

1.1 Outline of the Dissertation

In Chapter 2, I begin with an historical overview of how maternal health has emerged as a site of development intervention in order to contextualize my analysis. I outline how population control efforts acted as a precursor to maternal health interventions, configuring women's fertility as a means of achieving demographic goals. I then outline key points in the establishment of maternal health as an issue of global development in its own right, with specific reference to the Safe Motherhood Initiative, the UN Conferences at Cairo and Beijing, the Millennium Development Goals and the Sustainable Development Goals. I then move to specifically address Canadian maternal health policy by outlining the establishment of the Muskoka Agreement at the G8 conference in 2010. I the turn to critical perspectives on the maternal health framework, situating these critiques within the field of critical development studies, and as specifically influenced by feminist and postcolonial engagements with development. In outlining this literature, I address research that understands maternal health programming as part of a broader depoliticization and technocratization of development, including the depoliticization of gender equality through the appropriation of the empowerment framework. I also examine how feminist and intersectional theories of medicalization have contributed to understandings of maternal health as a site of depoliticization, as well as of colonialism. I then turn to scholarship that problematizes the equation of maternal health and women's health, before reviewing critical scholarship that specifically examines the Muskoka Initiative. I conclude this chapter by outlining how my research fits within, and contributes to the critical scholarship on maternal health in general, and on the Muskoka Initiative in particular.

In Chapter 3, I outline the theoretical frameworks that have informed my research project, guiding the formulation of my research questions and my analysis. I begin by outlining how maternal health has been theorized as a site of biopolitics, in which women's bodies are managed as a means of governing the well-being of the population. I examine the

relationship between biopolitics and neoliberal governance, with specific reference to the necessity of 'governance at a distance' within global biopolitics, and specifically, within the field of global development. I look at how neoliberal governance has targeted marginalized populations, and women's reproduction in particular, and outline how these theoretical insights inform my own analysis of maternal health programming. Drawing on critical health scholarship, I also outline theories of healthism, which posit that health has become a moral and civic duty, with specific references to how healthism is gendered through discourses of maternal sacrifice and risk management.

The second section of Chapter 3 is devoted to the theory and practice of reproductive justice, a critical approach to reproductive rights that problematizes straightforward narratives of 'choice' and interrogates the social, political and economic contexts in which reproductive choices are, or are not, made. Taking an intersectional approach, reproductive justice also necessitates consideration of how reproduction is governed differently based on women's social positioning, including race and geographic location, and how this governance contributes to reproductive stratification wherein the reproduction of some is valued and encouraged over the reproduction of others. Drawing connections between reproductive justice, biopolitics and governance I argue that maternal health is an important, yet insufficient component of reproductive justice. Reproductive justice is thus an important framework through which to address the exclusions of the Muskoka Initiative, as well as the particular ways in which it conceptualizes and intervenes in the health of women in the Global South.

In Chapter 4, I present my research questions and methodology, delineating what critical discourse analysis (CDA) entails and why it is an appropriate means through which to address my research questions. I describe the connections between my use of CDA and my theoretical framework, including the role that these theoretical lenses played in informing my analysis. I also outline my specific research process, including how I selected texts for analysis and how I conducted the textual analysis itself. I outline my rationale for including interviews as part of my analysis, recounting how I recruited informants and conducted the interviews, as well as how I included these interviews in my overall analysis. Throughout this section I discuss the rationale behind my methodological choices at each step of the

research project. I conclude the chapter by addressing quality criteria for critical discourse analysis, articulating how I ensured the quality and rigor of my work, including through practices of reflexivity.

In Chapter 5, I present my analytical findings, focusing on the construction of maternal health as a development problem, and the implication of this construction in relation to how it is addressed through development interventions. I begin by examining how maternal health is constructed as a problem that is simultaneously global and specifically situated within the 'developing world'. I draw on textual evidence to demonstrate how the problem of maternal health is identified as one of ending 'preventable' death, and how this goal is accomplished through the appropriate management of medical risks through increased access to healthcare. Healthcare access is itself addressed through interventions that focus on providing training and resources, improving the capacity of developing countries and communities to deliver adequate, 'high quality' medical services to women and children.

In Chapter 6 I present additional findings, outlining how the texts analyzed seek to improve health by targeting women's behaviour. I demonstrate that these interventions focus on encouraging women to seek healthcare when available, and to modify their everyday behaviour, such as child care and feeding practices, in order to manage the medical risks posed to themselves and to their children during pregnancy and childbirth, and due to malnutrition and disease during childhood. I also examine how communities and male partners are targeted by awareness raising activities in order to encourage them to allow women to seek specific forms of medical care.

In Chapter 7, I continue to present my analytical findings, with a specific focus on how Canada is constructed as a development actor. I address how Canada is constructed as a global leader in MNCH, with the expertise and resources to address this problem. Yet alongside this construction of Canada as a global leader, I outline how the discursive construction of Canada as a development 'partner' obscures global power dynamics, while further supporting the legitimacy of interventions.

In Chapter 8 I discuss my findings, analyzing them through my theoretical frameworks. I outline how configuring MNCH as a project of global biopolitics can help illuminate why

women's reproduction is targeted as a site of governance. I also address how the construction of MNCH as a problem of unmanaged risk supports the medicalization of reproduction, and in turn allows for a focus on technocratic, depoliticized interventions. I also address how this depoliticized approach allows for, and is supported by the configuration of Canada as a global leader, and partner in MNCH programming. In particular, I examine how the texts obscure global power relations, and negate the need to engage with Canada's own role in shaping social determinants of health within the 'developing' world.

I continue my discussion by addressing how discourses of risk are used to govern women's reproductive choices, and to present women as both in need of being saved, and as potential responsible, health-seeking subjects. I argue that this configuration positions women as responsible not only for their own health, but for the health of their children, and contributes to the overarching instrumentalization of women within the development sector. I also outline how the conflation of maternal and child health within the text negates the need to address potential tensions between maternal and child health, and obscures the need for abortion. I end the discussion of my findings by outlining how the Muskoka Initiative was able to contribute to the goals of reproductive justice, as well as how these contributions were limited and undermined. I conclude by outlining areas for future research, summarizing my arguments and sharing my own views on the potential for maternal health programming moving forward.

1.2 A Note on the Language of 'Developing' Countries

In writing this dissertation, I am mindful of the way in which my own research produces and reiterates particular discourses. In particular, I am cognizant that in addressing particular discursive constructions I risk perpetuating dominant categories, and hence, particular ways of thinking about health, maternity and development. For this reason, throughout the dissertation, I employ scare quotes to indicate when I am using a term I find problematic, but which I use in order to accurately refer to a particular discursive construction or category. Namely, in presenting my findings, I repeatedly refer to 'developing' countries and 'developing world women'. These phrases are problematic in that they refer to entire countries and groups of women as unified categories, obscuring the

diversity that exists within the countries and regions to which these terms refer. As such, the term ‘developing countries’ reifies the distinction between low-income and high-income countries, while eclipsing the social and economic inequality that exists within as well as between these countries. Furthermore, the term ‘developing’ implies a particular, universalized process of ‘development’ that obscures how countries in the Global South have been actively under-developed through processes of colonialism, and through continued economic exploitation. Nevertheless, while I find the term ‘developing’ to be problematic, I use it because this is the term that is used within the texts I have analyzed, and represents a particular discursive category that is constructed in part through these texts themselves.

Chapter 2

2 Literature Review

In the first section of this chapter I provide an historical overview of maternal health as it has been addressed within the context of global development. Beginning at the global level, I outline the framework of population control and family planning as a precursor to the development sector's explicit focus on maternal health, as these frameworks were initially the primary lenses through which reproductive health was addressed. Furthermore, these histories are important in developing an understanding of the connections and tensions that have existed between feminist activists working to put maternal health on the global agenda, and population control advocates that seek specifically to control reproduction and lower fertility rates. I then outline the emergence and early work of the Safe Motherhood Initiative, as well as the 1994 United Nations International Conference on Population and Development in Cairo and in the 1995 Fourth World Conference on Women in Beijing, considered to be significant turning points in the establishment of maternal health as an issue of global development (Eager, 2004; Hodgson and Watkins, 1997). Finally, I examine more recent frameworks for addressing maternal health through their inclusion in the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs).

After providing this overview of maternal health on the global stage, I turn to Canada's specific involvement with maternal health programming, beginning within the unveiling of the Muskoka Initiative at the G8 summit of 2010. I provide details regarding Canada's funding and activities during the Muskoka era, and end by very briefly considering the changes that have occurred since the end of the Muskoka era, including the release of the Feminist International Assistance policy in June 2017.

The second section of this literature review outlines some of the key critical perspectives that have emerged in response to the growing recognition and inclusion of maternal health within the development agenda. I begin this section by situating these critiques within the field of critical development studies, and in particular, as having been influenced by postcolonial and feminist perspectives on development. I then consider the critique that maternal health has been addressed primarily through a biomedical lens that shifts attention

from and depoliticizes issues of reproductive rights and gender equality, as well as social determinants of health such as poverty and environmental degradation. I link this process of depoliticization to processes of medicalization, by which social problems are addressed under the framework of medical treatment and expertise. I address how medicalization has been theorized not only as a component of depoliticization, but also how it has been used to impose particular healthcare models within 'developing' countries. I also consider scholarship that critiques the conflation of maternal health with women's health, and the ways in which maternal health excludes the healthcare of non-reproductive actors. I end by outlining critical scholarship that has specifically addressed the limitations of the Muskoka Initiative.

2.1 Maternal Health as an Issue of Global Development

The World Health Organization (WHO) identifies maternal health as "the health of women during pregnancy, childbirth and the postpartum period" (WHO, n.d.a). Currently, maternal health is recognized as a key component of public health by international governance and development organizations such as the WHO, the United Nations Population Fund (UNFPA), and the World Bank (UNFPA, 2016; World Bank, 2017; WHO n.d.a.). In outlining how maternal health came to be understood as a key development concern, most scholars begin with the 1987 Safe Motherhood Initiative (SMI), described in more detail below. Although I similarly begin my historical overview with the SMI, it is with the recognition that concern for many of the issues now included under the purview of 'maternal health' existed in earlier periods. For instance, Allen (2002) identifies the health of mothers, including during pregnancy and childbirth, as an integral component of the colonial 'civilizing mission' of the 19th and 20th centuries. After the period of formal decolonization that followed World War II, concern for maternal health shifted from the purview of the colonial administration to international development, although it was decades before it re-established itself as a key issue in mainstream development discourse and practice. While during the 1920s and 1930s, 'maternal hygiene' and infant welfare were addressed by the League of Nations Health Organization (Bashford, 2006), during the Post WWII period, reproductive health was predominantly addressed indirectly through both national and international population control initiatives, which associated smaller

family sizes and slower population growth with modernization and economic development (Hartmann, 1995; Takeshita, 2012). Population control policies dominated concerns over reproduction, and women's role in development more broadly, until the 1980s, when the first decade of the WHO's 'Safe Motherhood Initiative' heralded a re-emergence of initiatives explicitly targeting maternal health (Allen, 2002).

2.1.1 Population Control and 'Family Planning'

Prior to the construction of 'maternal health' as a key global development concern during the 1980s, women's reproduction was primarily targeted by development interventions under the auspices of population control and/or 'family planning' (Hartmann, 1995; Harcourt, 2009). These initiatives sought to increase women's access to and use of contraceptives in order to lower fertility rates and slow population growth within what was then considered the 'Third World' (Connelly, 2008). These goals were linked to the popularity of 'demographic transition theory' and the associated understanding of high population growth as a significant barrier to economic and social development, as well as to increasing fear that the growth of racialized 'Third World' populations were outpacing those of white Americans and Europeans (Connelly, 2008; Takeshita, 2012).

Demographic transition theory constituted a key framework through which population theorists understood the relationship between demographic change and economic and social 'development' (Connelly, 2008). Based on observation of demographic trends in European countries, the theory posits that low levels of industrialization and economic growth are associated with high death and birth rates. In contrast, as societies transition into an industrialized state, higher income levels and improved social conditions were associated with longer lifespans and lower birth rates (Connelly, 2008). Although debates existed as to the direction of causality, declining fertility rates came to be understood as a necessary precondition for economic development, as well as a key component of 'modernization' (Hartmann, 1995; Murphy, 2012). This understanding was further influenced by the work of Thomas Malthus, who in the 18th century predicted that the human population would grow beyond the earth's ability to sustain it, leading to increases in natural, but violent 'positive checks' in the form of famine, disease and conflict (Ross,

1998). To prevent these outcomes, Malthus, who did not support the use of contraception, advocated for decreasing the growing birth rate through the exercise of 'moral restraint', in order to combat competition for resources among the lower classes (Hodgson and Watkins, 1997). During the mid 20th century, as population studies garnered momentum and legitimacy as an area of study, Malthusian ideas saw a resurgence. Fearing that increased lifespans in the 'developing' world were not being offset by decreased fertility rates, demographers identified the need to curb fertility rates in the developing world by promoting smaller family sizes and by increasing access to and acceptance of contraception (Connelly, 2008).

Demographic transition theory was founded on interpretations of Europe's demographic history, and has since been critiqued for failing to account for different contexts and historical experiences of non-European countries (Connelly, 2008). Furthermore, although ostensibly aimed at decreasing poverty, the popularity of population control interventions during the mid 20th century must be considered in the context of Cold War anxieties surrounding the growth of 'Third World' populations believed to be susceptible to adopting communist ideologies (Connelly, 2008; Murphy, 2012; Takeshita, 2012). Such anxieties were exacerbated by the decolonization of Africa and the sense that the 'West' was losing its control not only over territories, but populations in the Global South. Contemporary critics have therefore identified population control movements as a means of pursuing modernization and development by reducing the strain of population on developing world economies and environments, as well as a tactic for containing the 'threat' of economically poor, racialized, and potentially communist populations that could pose a threat to (white) American political supremacy (Connelly, 2008; Hartmann, 1995; Takeshita, 2012).

The rise and acceptance of demographic transition theory and of population control as a means of facilitating development allowed for the spread of interventions that targeted the fertility of women in the 'Third World'. In her study of the history of the IUD, Takeshita outlines how this reproductive technology itself was developed as means of providing reliable birth control that could be used throughout the 'Third World'. Central to the IUD's perceived usefulness was that its continued use was not reliant on women themselves, as it required a medical professional for insertion and removal (Takeshita, 2012). Although

sometimes included under the label of ‘family planning’ initiatives, the focus of many interventions was not to increase women’s ability to control or plan their own reproduction, but to control it for them (Connelly, 2008; Takeshita, 2012). This rationale was strategic as fears of overpopulation drew on and reinforced stereotypes of racialized women as over-fertile, and as incapable of managing their own reproduction responsibly (Hartmann, 1995; Takeshita, 2012). Thus, population control measures often relied on coercive means and were carried out with little regard for the desires or health of women themselves. Documented abuses include instances of doctors refusing to remove IUDs when requested, indicative of population control priorities (Takeshita, 2012; Hartman, 1995). Such instances highlight the need to distinguish between ‘family planning’ interventions that do indeed help women ‘plan’ and control their own reproduction and population control efforts that seek to control women’s reproduction as a means of achieving demographic targets (Connelly, 2008).

It is worth noting that population control programs were pursued not only by international organizations, but also by national governments. As demographic theories of development grew in popularity and legitimacy, ‘Third World’ scholars and political leaders were brought over to the United States to learn from western experts why reductions in fertility were desirable, and how they could be brought about (Connelly, 2008). This process contributed to the adoption of population control interventions by national governments who sought to slow the growth of their own populations, either in the name of national development, or to help ensure political control (Connelly, 2008; Hartmann, 1995). National family planning initiatives in countries such as Indonesia illustrate how population control concerns were translated into national projects that continued to rely on the association of smaller family sizes with economic prosperity and with modernization (Newland, 2001).

Connelly (2008) argues that in the 1980s and 1990s, with the thaw of the Cold War, population control movements (which had always been contested) fell largely out of favour. In contrast, other scholars have argued that despite the shift from coercive ‘population control’ to (ostensibly) voluntary ‘family planning’ programs, the ideologies and assumption that underpin demographic transition theory have remained. For instance,

Hodgson and Watkins (1997) argue that although the 1994 Cairo Conference on Population and Development (addressed in more detail below) explicitly acknowledged the need for family planning programs to respect women's reproductive rights and to discontinue the use of coercive measures, the language of the resulting program of action nevertheless reiterated understandings of reduced fertility as contributing to the project of development. Furthermore, the authors problematize understandings of what constitutes 'non-coercive' measures, arguing, as does Hartmann (1995), that offering economically marginalized individuals economic incentives to reduce their fertility can be considered coercive. Ethnographic work on family planning initiatives in the post-Cairo era further problematizes the distinction between coercive and non-coercive measures; for instance, by highlighting how social norms and pressures, particularly when backed by state authority, have been used to shape reproductive decision making (Newland, 2001; De Zordo, 2012). I will return to this problematization in my discussion of neoliberal governance in Chapter 3.

In more recent years, concerns surrounding over-population have continued to resonate, experiencing a resurgence due to growing apprehension about the effects of population on environmental degradation, specifically through climate change (Hartmann and Barajas-Román, 2009. While arguments that slowing population growth is necessary to reduce humans' environmental impact carry significant weight, scholars and advocates have argued that this focus on population is misplaced. These critical voices point to discrepancies in resources consumption, environmental degradation and carbon dioxide emissions along geographical and socioeconomic lines as indicative of the population control movement's flawed logic, particularly given the focus on developing countries (Angus and Butler, 2011; Hartmann and Barajas-Román, 2009; Otzelberger, 2014). For instance, Hartmann questions the efficacy of targeting population control when 20% of the world's population accounts for 80% of global carbon dioxide emissions, suggesting that reducing consumption and environmental degradation by the affluent, including by 'developed' world militaries and corporations, would prove a more effective strategy (Hartmann, 2009, p. 72). Indeed, by focusing on reducing population growth in the 'developing' world, population control movements can address environmental concerns while leaving consumption and degradation patterns amongst the most affluent

unchallenged. The unwillingness of to challenge overproduction and overconsumption by the affluent contributes to the continued popularity of population control, even when it is pursued through voluntary ‘family planning’ initiatives and in the name of reproductive rights and/or sustainable development.

2.1.2 The Safe Motherhood Initiative

Although population control continues to resonate as a (sustainable) development strategy, beginning in the 1980s, maternal health emerged as a primary development concern in its own right. In February 1987, the UNFPA, the World Bank and the WHO, with support from both UNICEF and the Population Council, held the Safe Motherhood Conference in Nairobi, Kenya, bringing together participants from 37 countries, including representatives from NGOs and bilateral aid organizations. The conference aimed to increase awareness of the high number of women dying during pregnancy and childbirth, as well as to remedy perceived international inaction to resolve this problem (Starrs, 2006). Contextual factors prompting the conference included an increasing focus on the role of women in development at this time (as indicated by the UN’s ‘Decade for Women’ from 1976–1985), and the 1985 publication “Maternal Mortality – A Neglected Tragedy” by Allan Rosenfield and Deborah Maine which criticized policymakers and politicians for not prioritizing maternal health within existing programs (Allen, 2002; Starrs, 2006). A central critique of Rosenfield and Maine’s paper was reflected in the subtitled ‘Where is the M in MCH?’. In asking this question, the authors highlighted that maternal health was largely addressed through initiatives that not only combined it with children’s health, but which also treated it as subordinate to children’s health (Rosenfield and Maine, 1985).

The Safe Motherhood Conference resulted in the development of the Safe Motherhood Initiative (SMI), which included a set of preventative and curative measures aimed at halving maternal deaths by the year 2000. It also led to the creation of the Safe Motherhood Inter-Agency Group, which included UNFPA, the World Bank, WHO, UNICEF, UNDP, the IPPF and the Population Council (Allen, 2002; Starrs, 2006). The SMI’s proposed actions aimed to reduce the risks associated with childbirth by increasing access to westernized medical services and overcoming what were characterized as ‘harmful’

cultural attitudes, such as restrictions on women's intake of food during pregnancy (MacDonald, 2013; Allen, 2002). The SMI sought to ensure adequate health care for girls and women, including adequate nutrition and access to family planning and to ensure good prenatal care. This care included early detection of patients considered to be at 'high risk' of medical complications, to provide assistance by trained childbirth attendants during birth, and to ensure access to emergency obstetric care for those in emergency situations (Allen, 2002). Although not the primary concern, the Initiative did take into account socioeconomic risk factors, such as poverty, geographic isolation, and gender inequality, which were named as 'indirect' rather than 'direct' causes of maternal mortality (Allen, 2002). Yet, in practice, donors and key actors did not necessarily take up these 'indirect' causes, tending instead to focus on increasing access to antenatal care (Starrs, 2006). Furthermore, according to Storeng and Béhague (2014), although the SMI initially included political advocates motivated by a desire to improve women's overall social positioning and material wellbeing, politicized elements of the initiative eventually gave way to a narrower focus on reducing maternal mortality through straightforward, technical solutions. Even in the early days of the SMI, Storeng and Béhague argue that:

> The specific term 'safe motherhood' was coined to draw attention to how unsafe motherhood could be, but also because it was deemed an uncontroversial term, disassociated from ongoing debate in fertility control and abortion yet encompassing a range of actions to improve women's health that would not antagonize socially conservative donors or governments (2014).

Part of the work of putting maternal health on the development agenda during this era can thus be understood as making it palatable through the use of strategic, depoliticized frameworks.

Allen (2002) describes how the risks and solutions identified by the Safe Motherhood Initiative were expressed through the fictional narrative of 'Mrs. X', a pregnant woman who, acting as a representational figure, dies during childbirth (2002). After becoming pregnant, Mrs. X is seen travelling down the 'road to death', a road she is kept on by factors such as poor socioeconomic development, excessive fertility, high-risk pregnancy and life-threatening complications. In contrast, Mrs. X is able to leave the road to death through access to family planning and medical care, or through improvements in the status of

women (Allen, 2002). While Allen describes this narrative as one that was quite effective in mobilizing support, she argues that ultimately the narrative "hides more than it reveals" (2002, p. 5). Recalling her initial encounter with the narrative of Mrs. X during this era, Allen states that:

> Although we are told that social and demographic characteristics of Mrs. X's life – her unwanted pregnancy, her illiteracy, her poverty, her rural address – contributed to her demise, we are not offered much insight into how they did so. Nor are we told anything about the context in which decisions that affected her survival were made. Instead, we are presented with a partial telling of the events that led to her death, one that seems crafted to suggest that the "real" solutions to the problem are for the most part, biomedical (2002, p. 5).

Allen's reading of the Mrs. X narrative further indicates that while contextual factors were included in the discourse of 'safe motherhood', biomedical solutions continued to be prioritized. Used extensively in the years that followed that Safe Motherhood Conference, the narrative of Mrs. X has since been criticized for homogenizing the experiences of 'developing world women' and for promoting western biomedicine and 'modernization' as the most important solutions to maternal mortality (Allen, 2002; MacDonald, 2013). This critique of maternal health as being pursued primarily through the biomedical frameworks will be addressed in more detail below.

Ultimately, the SMI failed in its goal of halving maternal deaths by 2000; by 1996 maternal deaths had, in fact, increased (Allen, 2002). This failure has been largely attributed to a lack of political will, as well as to an inadequate response to the increasing effects of HIV/AIDS (MacDonald, 2013). Furthermore, Allen argues that the SMI failed because it focused on risk factors that did not always resonate with women's lived experience of pregnancy, childbirth and motherhood, nor with their social and cultural frameworks. Despite these limitations, the SMI played a significant role in bringing maternal health on to the global development agenda, and is largely considered the beginning of the international development community's explicit engagement with maternal health as both a development goal, and a development indicator (Starrs, 2006). In 2004, the inter-agency group became the Partnership for Safe Motherhood and Newborn Health, which merged with the Child Survival and Partnership, and with the Healthy Newborn Partnership in

2005, re-instating the explicit intertwining of maternal and child health highlighted in Rosenfield and Maine's 1985 critique (Storeng and Béhague, 2014). In 2007, the resulting partnership held the Women Deliver conference to mark the 20th anniversary of the Safe Motherhood Initiative, and it continues to operate as an important site for actors to collaborate on maternal health.

2.1.3 The UN Conferences in Cairo and Beijing

Following the Safe Motherhood Conference of 1987, the UN Conferences in Cairo (1994) and Beijing (1995) are also recognized as significant points in the establishment of maternal health on the global agenda. As with the Safe Motherhood Conference, these conferences brought together actors from various geographic and institutional locations, including women's health organizations and advocates from the Global South (Petchesky, 2003; Schechter, 2005). As discussed above, despite a continued emphasis on the need to stabilize world population by reducing fertility rates, the Cairo Programme of Action is considered a turning point in approaches to family planning due to its explicit recognition of women's reproductive rights, including the ability to control their own reproduction (Harcourt, 2009; Hodgson and Watkins, 1997). Eager identifies the Cairo conference as helping to establish reproductive rights and health as the "new norm that should guide global population policy", stating that:

> In the Cairo Programme of Action there is an entire chapter dedicated to reproductive rights and health, but in previous UN global conference documents on population there is not even a single mention of the phrase *reproductive rights* (2004, p. 147).

Furthermore, the Cairo Program of Action explicitly enshrined maternal health as a key component of reproductive health and rights, and included the reduction of maternal mortality as one of its stated objectives (Eager, 2004; El Feki, 2004).

The inclusion of maternal health in the Cairo Programme of Action has been attributed to the activism and advocacy of women's health organizations (Petchesky, 2003; Harcourt, 2009; Eager, 2004). Petchesky outlines how these groups drew on the work of women of colour within the United States, (addressed in more detail in Chapter 3) who had been

fighting to broaden the reproductive rights agenda from an almost exclusive focus on access to contraception and abortion, and to include a much broader range of socioeconomic and medical issues, such as poverty and racism (Petchesky, 2003; Ross and Solinger, 2017). This influence is reflected in the broad definition of maternal health included within the Cairo Programme, which acknowledges not only the need for access to medical services during pregnancy and childbirth, but also throughout women's lives (Petchesky, 2003). Within the Programme, maternal health is therefore linked not only to reproductive and sexual rights, but is also situated within the context of the human right to sufficient healthcare. However, while advocates attempted to further situate reproductive and maternal health within the broader contexts of national healthcare infrastructure, as well as macroeconomic relations, their focus on structural and economic inequality was largely absent from the Cairo Program of Action. Similarly, pushback against conservative groups such as the Vatican led to limited engagement with issues of abortion access (Schechter, 2005). Nevertheless, the Cairo Conference and Programme of Action marks an important moment in the recognition of maternal health as a key aspect of women's reproductive and human rights.

During the 1995 Fourth World Conference on Women, held in Beijing, both reproductive rights and maternal health continued to be acknowledged as a key issue affecting women's wellbeing. The Beijing Platform's chapter on women's health explicitly recognizes women's rights to the highest standard of health throughout their lives, and access to healthcare was linked to issues of gender equality, education, work, political participation, community development and sexuality (Petchesky, 2003; Riddell-Dixon, 2001). Yamin states that the language of the Beijing Platform "constituted a major step towards recognizing that women's health a matter of power relations as much as biological or behaviour factor" (2013, p. 235). Commitments were again made to reduce maternal mortality rates, and although abortion was not recognized as an appropriate means of family planning, acknowledgement was made of the need to address the consequences of unsafe abortion on women's health (Riddell-Dixon, 2001). Significantly, while maternal health was recognized within conference documents, Petchesky (2003) points out that the allocation of resources following Beijing continued to focus on family planning. This allocation highlights both the potential discrepancies between international agreements and

the actions that are taken, while indicating a continued prioritization of family planning over more complex and politically contentious approaches, such as the development of accessible, universal health programs.

As with the SMI, the conferences in Cairo and Beijing have been subject to significant reflection and critique. Significantly, Yamin argues that in the years following Beijing:

> Women's reproductive rights remained at the level of abstract concepts or rhetoric, divorced from the operational questions that health planners and providers faced, as well as the realities individual women confronted in their daily lives (2013, p. 235).

In the 1999 five-year review of Cairo (Cairo+5), Harcourt identifies a "tacit understanding" that the "stringent economic politics imposed by the global economic order" were incompatible with the conference's program of action (Harcourt, 2009). Specifically, she speaks to the recognition amongst participants that structural adjustment programs and cuts in state spending affected states' ability to provide health services, undercutting a reproductive health agenda that relied upon access to medical services. Yet despite this recognition, Petchesky (2003) argues that macroeconomic issues were still largely ignored in the Cairo+5 key action document. While the document addressed sexual and reproductive health, and included the goal of raising the percentage of births assisted by skilled attendants to 90% by 2015, there was little attention to how these goals could be pursued except through reliance on the private sector (Petchesky, 2003). As such, the Cairo+5 document illustrates the shift away from integrated, context rich and rights-based approaches to maternal and reproductive health, and towards the framework of service provision that characterized the Millennium Development Goals.

2.1.4 Maternal Health in The Millennium Development Goals

In September 2000, the United Nations hosted a meeting of world leaders in New York, resulting in the production of the Millennium Development Declaration (Fukuda-Parr, 2017). The declaration set out a series of shared normative values, as well as quantitative goals, which would later be revised and developed into the Millennium Development Goals (MDGs). NGOs and other civil societies organizations were consulted during this process

and contributed to the identification of key priorities (Brinkerhoff, Smith and Teegen, 2007). Representatives of NGOs, along with member of UN agencies, the World Bank, the IMF and private sector organizations also served on thematic task forces, each of which presented recommendations in 2005 outlining how the MDGs could be best achieved (Sachs, 2005). Despite this involvement, some critics have questioned the impact NGOs and civil society organizations were able to have in the establishment of the NGOs, arguing that their voices were not necessarily given significant weight, especially in comparison to other actors (Yamin, 2013; Harcourt, 2009).

The overarching intention of the MDGs was to halve extreme poverty globally by the year 2015, a goal which would be achieved through the pursuit of measurable targets that were established as global development priorities (UNDP 2015). These priorities include explicit recognition of maternal health in goal number 5, entitled "Improving Maternal Health", which consisted of the following targets and indicators: (from UNDP 2015):

- Target 5A – Reduce by three-quarters the maternal mortality rate
    - Indicator 5.1: Maternal Mortality Ratio
    - Indicator 5.2: Proportion of births attended by skilled health personnel
- Target 5B – Achieve Universal Access to Reproductive Health
    - Indicator 5.3: Contraceptive prevalence rate
    - Indicator 5.4: Adolescent Birth Rate
    - Indicator 5.5: Antenatal Care Coverage
    - Indicator 5.6: Unmet need for family planning

Through goal 5, the MDGs further solidified the recognition of maternal health as a global development priority. The inclusion of maternal health is important, as the MDGs have played a significant role in shaping development discourse, policy, and action within national governments as well as multilateral institutions (Clarke and Feeny, 2013; Fukuda-Parr, 2017). Yet while the inclusion of maternal health has been viewed positively, there have also been concerns that the goal is articulated as 'maternal' rather than 'reproductive' health, despite the inclusion of reproductive health in target number two (Yamin, 2013). This language choice has been interpreted as a means of depoliticizing reproductive health, and appeasing critics who associated the language of reproductive health with access to

abortion. It is therefore also significant that while reproductive health is included under the umbrella of goal number 5, reproductive rights are not. The naming of MDG 5 has thus been read as an outcome of the backlash against reproductive and sexual rights that emerged during and following the UN conferences in Cairo and Beijing (Harcourt, 2009). As Harcourt notes:

> It was easier to speak about maternal death in a technical medical way that could be measured, rather than enter into the messy and politically more radical sexual and reproductive rights agenda (2009).

This statement speaks to the shift within MDG discourse from a focus on human rights to a focus on service provision and quantifiable measurements.

Although the MDGs are recognized as helpful in highlighting the need for maternal healthcare, they have been critiqued as adopting a narrow approach that fails to contextualize maternal health within the broader reproductive health framework, as well as the need for healthcare throughout the life-course (Yamin, 2013; Harcourt, 2009; McPherson 2016). Furthermore, the impact of contextual factors, including gender inequality and socioeconomic status were deemphasized, while biomedical approaches were favoured (McPherson, 2016), a critique I revisit in greater detail later in this chapter. These concerns echo broader critiques of the MDGs of narrowing the development agenda in their attempt to establish easily measurable, time-bound targets (Fukuda-Parr, 2017). Furthermore, the shift away not only from reproductive health, but also reproductive rights, has been linked to the diminished role of women's organizations and advocate groups in the establishment of the MDGs, as compared to the Cairo and Beijing conferences (Harcourt, 2009; Yamin, 2013). Notably, although the MDG report states that Goal 5 was successful in reducing the maternal mortality rate by 45%, the goal of reducing the maternal mortality ratio by three quarters (from 1990) was not met, nor was the target of providing universal access to reproductive health (UNDP 2015).

2.1.5 Maternal and Reproductive Health in the Sustainable Development Goals

With the end of the Millennium Development Goal timeline in 2015, the United Nations created a new normative framework in the Sustainable Development Goals (SDGs). Like the MDGs, the SDGs constitute a set of measurable, time-bound goals agreed upon by members of the global community. Although in some ways a continuation of the MDGs, the SDGs differ in that they were created with an overarching focus on sustainable development, meaning development that "meets the needs of the present without compromising the ability of future generations to meet their own needs" (UN, 1987, p. 43). As such, the SDGs are seen as, to some degree, more aligned with environmental concerns, while also taking a more integrative approach to development and poverty reduction than the MDGs (Le Blanc, 2015).

The SDGs were the result of consultations, meetings and decision making by UN member nations and additional stakeholders. The process began in 2012, at the Rio+20 conference, which resulted in a document titled 'The Future We Want' and the establishment of the Open Working Group, designed to "prepare a geographically fair, equitable and balanced proposal" for the post-2015 development agenda (Carant, 2015). In the intervening years, multiple consultations were made, including open consultations in the form of online surveys and forums, as well as targeted consultations with representatives from marginalized groups such as the LGBT community, trade unions, displaced persons and local decisions makers (Carant, 2015; Fox and Stoett, 2016). The goals themselves were initially released in June 2014, and were finalized in September 2015 at the UN Sustainable Development Summit in New York City (Fukuda-Parr, 2017).

Within the SDGs, maternal health is no longer included as one of the primary goals, but instead is incorporated under Goal 3, entitled "Ensure healthy lives and promote well-being for all at all ages" (UN, n.d.a). Under this goal, target 3.1 seeks to: "By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births" (UN, n.d.a). Reproductive health is also included under Goal 3, with target 3.7, which aims to:

> By 2030 ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (UN, n.d.a).

Reproductive health is also included under Goal 5, entitled "Achieve gender equality and empower all women and girls". Within this goal, target 5.6 seeks to "ensure universal access to sexual and reproductive health and reproductive rights". Furthermore, several additional goals include references to health that have implications for maternal and reproductive health, even though they are not named specifically. These include the goals that aim to provide access to universal health coverage (3.8); end the epidemics of AIDs, tuberculosis, and malaria (3.3); and achieve environmentally sounds management of chemicals and wastes in order to minimize adverse impacts on human health (12.4) (UN, n.d.a). These goals are indicative of the SDGs construction as a network of linked goals and targets, and the recognition that development issues can not be targeted independent of one another (LeBlanc, 2015).

The integrative nature of the SDGs addresses, to a certain extent, concerns that within the MDGs, maternal health was isolated from other relevant issues (Yamin, 2013; McPherson, 2016). Thus, the SDG framework is seen as having the potential to highlight how maternal health, reproductive health and sexual health are interconnected, not only with each other, but with broader economic, environmental, political and social concerns. Yet while acknowledging the potential and importance of this work, Le Blanc (2015) argues that due to the sheer number of possible connections between the SDGs, many potential links are not made explicit within the SDG framework itself. Additionally, although the SDGs provide a tool for policy makers and practitioners to acknowledge interdependence between development components, this focus may not necessarily translate into practice. Finally, the SDGs, while in some ways much broader than the MDGs, nevertheless maintain a focus on quantifiable achievements that can be (somewhat) easily measured, which necessarily narrows their focus and potentially limits which aspect of health and rights they are able to address (LeBlanc, 2015).

2.2 Canada's Commitment to Maternal, Newborn and Child Health

In this next section, I address Canada's specific commitments to maternal health, beginning with the 2010 G8 summit that marked the launch of the Muskoka Initiative. Although Canada has been involved in maternal health programming prior to 2010 (for example, see Riddell-Dixon, 2001), this period marks the beginning of Canada's explicit identification of maternal health as it's primary development priority, as well as its recognition as a leader in maternal health programming. In this section, I address major events and commitments that characterized the Muskoka era, which is the period that my own analysis takes as its focus. I briefly outline how Canadian programming has changed with the end of Muskoka and the change in government leadership that occurred in 2015, the implications of which will be discussed in more detail in my conclusion.

2.2.1 The 2010 G8 Summit and Launch of Muskoka

Beginning in 2010, the Canadian government has made a concerted effort to establish Canada as a world leader in global maternal, newborn and child health, placing MNCH at the center of Canada's development agenda. This prioritization of MNCH can be traced to the 2010 G8 summit held in Huntsville Ontario, where the Muskoka Initiative was unveiled, and where then Prime Minister Stephen Harper announced his goal to make maternal and child mortality Canada's "top development priority (Mackrael, 2014). At the summit, the Canadian International Development Agency (CIDA) is credited with having taken a leading role in the creation of the Muskoka Initiative, an international document that committed signatories to addressing maternal, newborn and child health on a global scale. Aiming to prevent the death of 1.3 million children under five years of age, and the death of 64 000 'mothers' [1], the Muskoka Framework has been framed as an important guiding document both for the global community, as well as for the Canadian government (Government of Canada, 2015). From 2010 to 2015, the phrase 'Muskoka Initiative' has been used to refer to the specific funding and activities undertaken by the Canadian

[1] It is not specified if these mothers will be targeted at a particular moment in their reproductive lives (e.g. childbirth, pregnancy).

government in fulfilling its international commitments. Thus, for purposes of clarity, for the remainder of this dissertation I will refer to the international document signed as the Muskoka Initiative as the 'International Muskoka Initiative', using the 'Muskoka Initiative' to refer to the five-year plan implemented by the Canadian government to guide its funding activities.

The 2010 G8 Conference and the signing of the International Muskoka Initiative resulted in a commitment of $7.3 billion to improve maternal and child health from participating countries, with $1.1 billion coming from Canada itself (Keast, 2017). In its commitments, the International Muskoka Initiative continued the biomedical focus that characterizes previous global initiatives, emphasizing prenatal care; attended childbirth; postpartum care; health education; treatment and prevention of disease including prevention of mother-to-child transmission of HIV; immunization, basic nutrition, safe drinking water and sanitation (Muskoka Declaration, 2010). The International Muskoka Initiative also included the goal of increasing access to family planning for 12 million couples (Government of Canada, 2015). The Muskoka Initiative spanned from 2010–2015 and includes explicit reference to the Millennium Development Goals, stating that it is "related to MDGs 4 and 5, as well as elements of MDGs 1 (nutrition) and 6 (HIV/AIDS, malaria)" (Muskoka Declaration, 2010). In addition to the G8 countries, the Muskoka Initiative was supported by the United Nations, as well as the Bill and Melinda Gates Foundation (UN, n.d.b).

In the years following the G8 summit, the Canadian government continued to emphasize global maternal, newborn and child health as a development priority, identifying three areas of focus to which funding would be directed: improving nutrition; reducing the burden of disease; and strengthening health systems (Government of Canada, 2015). Between the years of 2010–2015, Canada committed $2.8 billion, to be distributed bilaterally, as well as to multilateral and non-governmental organizations who would use the funds to implement their proposed projects. A list of programs funded through the initiative were available on the website of the Department of Foreign Affairs, Trade and Development (formerly CIDA, now Global Affairs), and were analyzed as part of this dissertation (see Appendix B). Although family planning was included in Canada's

commitments, family planning programs received only 1.4% of Canada's funding under the Muskoka Initiative (Payton, 2015) and abortion services were explicitly excluded (Keast, 2017).

2.2.2 Saving Every Woman, Every Child: Within Arm's Reach Summit

In May of 2014, Canada's commitment to MNCH was again brought into the spotlight with the hosting of the *Saving Every Woman, Every Child: Within Arm's Reach* summit in Toronto. During this conference, Primer Minister Harper renewed the Canadian government's commitment to maternal, newborn and child health, pledging $3.5 billion for the period of 2014–2015 (Do, 2014). The international conference brought together political leaders, as well as participants from civil society, academia, philanthropic organizations and business in order to address how the maternal health agenda should move forward (Government of Canada, 2014). Building on the Muskoka Initiative, this conference outlined the Canadian government's commitment to continue its focus on health services, specifically prioritizing health, nutrition and disease prevention, with a particular focus on HIV/AIDS, TB and malaria (Do, 2014; Government of Canada, 2014). According to a news release on the Prime Minister's website, the Canadian commitment to maternal health would also continue to focus on "country-led" solutions, working with "a select number of developing country partners" while prioritizing interventions that have a "focused and measurable" impact (Government of Canada, 2014).

In the months following the *Saving Every Woman, Saving Every Child* summit, the Harper government committed $200 million of the formerly pledged $3.5 billion to the World Bank's Global financing Facility, a fund aimed at reducing maternal mortality and improving data collection (Panetta, 2014). In February 2015, Prime Minister Harper also participated in a roundtable discussion on maternal, newborn and child health with philanthropist Bill Gates, during which he made a renewed commitment to improve data collection on vital statistics in order to bolster MNHC efforts (Payton, 2015).

2.2.3: Beyond Muskoka: the Feminist International Assistance Policy

In 2015, as I was beginning my research, Canada underwent a federal election that resulted in a change of government. The Conservative Harper Government was replaced by the Liberal Trudeau government, who brought with them their own political frameworks and goals. During the transition, the new Government communicated that it would both retain Canada's commitment to MNCH while also addressing limitations of the previous Government's approach, namely, by including support for reproductive rights. In June of 2017 the Trudeau Government released the Feminist International Assistance Policy (FIAP), which, while including recognition of maternal health, significantly broadened Canada's development priorities. In addition to acknowledging both gendered analysis and reproductive rights (explicitly including contraception and abortion), the core areas of FIAP include: Gender equality and empowerment of women and girls; human dignity; growth; environment and climate action; inclusive governance and peace and security (Government of Canada, 2017). As with the Muskoka Initiative, reactions to FIAP have been mixed. While it is not within the purview of this dissertation to engage in a full investigation of FIAP, in my concluding chapter, I consider the implications of my analysis of the Muskoka Initiative within the FIAP era, including how FIAP represents both a significant break from, and a continuation of its predecessor.

2.3 Critical Perspectives on Maternal Health

Having provided a brief overview of how maternal health has been addressed within both global and Canadian development policy, I now turn to the dominant critiques of the maternal health framework. While women's health activists, scholars and political leaders have worked diligently to have maternal health recognized as a key component of women's reproductive and human rights, they have also critiqued how maternal health as been taken up within the global development sector. In the following section I outline key criticisms of maternal health as a development framework, beginning by situating these critiques in the frameworks of critical development studies, specifically postcolonial and feminist perspectives on development. I outline how maternal health has been theorized as a framework that depoliticizes issues of reproductive rights and gender equality, often

excluding social determinants of health while rendering maternal health a ‘technical’ problem with a straightforward solution. I further consider feminist critiques of maternal health as perpetuating the medicalization of pregnancy and childbirth, as well as postcolonial arguments that this medicalization can serve to enforce western knowledge and authority while legitimizing control over colonized women’s bodies. I address critiques that focus on how maternal health homogenizes women’s experiences, and can lead to an exclusion various issues related to reproductive and sexual rights and health. I finish this section by reviewing critical perspectives on the Muskoka Initiative itself, and by outlining how my own research contributes to critical scholarship on maternal health as a problem of global development.

2.3.1 Critical Perspectives on Development

Critical scholarship on maternal health programming is often situated within the field of critical development studies. Critical development studies draws from poststructuralist theories that understand knowledge as constructed, and as bound up in dominant relations and systems of power. As such, rather than trying to uncover the most effective ways of pursuing social and economic development, critical development studies interrogates and disrupts the taken-for-granted assumptions that underpin mainstream development, including the meaning of development itself (Veltmeyer and Parpart, 2011). Work within critical development studies includes scholarship that draws from various schools of thought, including (but not limited to) Marxism, postcolonialism, anti-racism, feminism, and environmentalism (Veltmeyer and Bowles, 2018). Given this variety, critical development studies can be thought of as sharing a constructivist and critical orientation, rather than as constituting a cohesive body of scholarship.

Critical engagements with maternal health programming have tended to draw specifically from feminist theory, including feminist approaches to development. These approaches attempt to move beyond mere inclusion of women in development projects, and seek instead to examine how experiences of poverty interact with gender relations, roles and norms, as well as how development interventions and policies are influenced by, and perpetuate particular gender ideologies (Pearson, 2005). As such, feminist development theory interrogates how development may act not only as a site of, or vehicle for gender

empowerment, but also how it may act as a means of perpetuating patriarchal norms and power relations (Kabeer, 1994). Feminist development theory critically engages with the dominant ways in which both women and gender have been included and configured in mainstream development theory.

In addition to drawing from feminist development theory, critical perspectives on maternal health have drawn from postcolonial development theory, which examines "the material and discursive legacies of colonialism" within the contemporary era (McEwan, 2009). Postcolonial theorists have specifically questioned how 'development', as both a concept and a field of action, draws on and perpetuates colonial ideals and power relations. Postcolonial scholars have highlighted how the narrative of 'development' itself, understood as a progression from traditional social systems and experiences of material deprivation to a state of 'modernity' and 'prosperity' rely on and reiterate the assumed superiority of western cultures and ways of living (Kothari, 2005; Wilson, 2012). This narrative of development associates western values, norms and lifestyles with 'progress', situating them as universal goals to which all people should (and do) aspire. Furthermore, although postcolonial development theory has tended to focus on issues of representation, it has also included consideration of how representations inform policy and how theses policies themselves act as a means by which power is exerted over the economies, populations, and resources of the 'developing' world (Kapoor, 2008). As scholars such as Li (2007) and Kothari (2005) argue, even when interventions are rooted in good intentions, aimed at helping those most in need, they rely on the assumption that western development experts hold superior knowledge and understanding of what development entails and how it can be brought about. This reification of western expertise grants the development sector the authority to determine what actions can and should be taken, impacting the material lives of marginalized communities (Li, 2007; Kothari, 2005). Significantly, postcolonial theory challenges these hierarchizations and assumptions, and deconstructs their impact not only on discursive understandings of the 'developing' world, but also its material conditions.

The theoretical work of postcolonial scholars has also included explicit engagement with the intersections between colonialism, race and gender. Mohanty's fundamental work

"Under Western Eyes" (1991) has been crucial in outlining how women in the 'Third World' have been positioned as passive and oppressed, in direct juxtaposition with the figure of the enlightened and empowered woman of the 'developed' world. She argues that these representations have been used to justify interventions in the 'Third World' by western actors, mobilizing the (seemingly) feminist narratives of uplifting oppressed women to legitimize intervention. More recently, scholars such as Dogra (2012) and Wilson (2012) have noted concerted attempts by development organizations to avoid representations of 'developing' world women as passive victims, at times in direct response to these critiques. Yet as Wilson (2012) argues, this shift has led to the emergence of a new discourse of 'developing' world women as appropriately productive neoliberal subjects, happily engaged in 'work' that is in reality often gruelling and dehumanizing. Wilson argues that these representations romanticize the extraordinary measures marginalized women undertake in order to survive the conditions of extreme poverty, while obscuring the marginalization and exploitation they experience and which make this work necessary. These representations contribute to the construction of women in the 'developing' world as capable of lifting themselves, their families and communities out of poverty. They therefore align with neoliberal frameworks of poverty reduction that focus on individual capacity building rather than systemic change, addressed in greater detail below.

2.3.2 The Depoliticization of Maternal Health and the Technocratization of Development

As outlined above, the rise of maternal health as a development issue has been associated with a movement away from explicit engagement with reproductive and sexual rights, including abortion (Petchesky, 2003; Harcourt, 2009). Tracing the history of maternal health from the SMI to the MDGs, Harcourt conceptualizes its trajectory as a movement away from political questions of women's bodily autonomy to technical questions of how to effectively deliver services (2009). As previously noted, this move has been understood as a strategic one, with maternal health considered a politically safe way of advocating for women's health while avoiding the need to address controversial questions regarding contraception and abortion, and by extension, potential resistance from actors who stand

firm against these rights (Harcourt, 2009; Petchesky, 2003). Furthermore, the increasing focus on service provision disconnects issues of health from broader questions of gender inequality and economic marginalization, which are much more difficult to address (Petchesky, 2000).

The depoliticization of maternal health can be linked to the overarching technocratization of development. Technocratization refers to the process by which development is rendered as a series of straightforward, technical problems requiring technical expertise and solutions, rather than as a set of complex political problems requiring inquiry into global and local power dynamics and radical, systemic solutions (Ferguson, 1990; Li, 2007). Technocratization can thus be understood as both an outcome and means of depoliticization, with Li arguing that "rendering problems technical renders them apolitical" (2007). Significantly, this rendering of a problem as 'apolitical' refers to a shift in the framing of this problem that denies and obscures, rather than dismantles or avoids, the political systems in which it is embedded. Thus, while technocratization can be understood as contributing to the discursive depoliticization of development, it is nevertheless bound up in, and often serves to maintain particular political systems and power structures. For instance, technocratization creates a clear field of intervention in which experts can work, reifying 'expert' technical knowledge and reinforcing the authority of development experts while leaving existing systemic issues unquestioned and intact (Li, 2007). From a postcolonial perspective, technocratization reifies the knowledge and authority of development experts to act on developing world populations. In doing so, a lack of attention is given to the systemic issues that contribute to economic and social marginalization (Mitchell, 2002).

The neoliberal focus on efficiency and individual responsibility has been identified as a key factor in the technocratization of development, including the technocratization of gender equality and empowerment initiatives. As a term that is often used to describe an array of economic and social values, neoliberalism can be a difficult concept to define. In relation to development, I use neoliberalism to indicate a market-driven approach to development that especially values economic efficiency, individual entrepreneurialism, and market privatization (Cornwall, Gideon and Wilson, 2008). These are elements that

currently characterize the international development sector, creating a neoliberal context in which development programs that can demonstrate their ability to maximize measurable outcomes while minimizing organizational and/or state costs are valued and supported (Cornwall, Gideon and Wilson, 2008). It is within this context that inclusion of women in development has been marketed as 'Smart Economics'; as a good investment with high returns (Chant, 2012). Yet, as outlined below, such approaches are considered 'smart' in part because they outsource the costs of service provision to women, adding to many women's burden of labour without challenging structural oppression (Chant, 2012).Within this context, both empowerment and altruism are attractive discourses to development institutions because they demonstrate how technical interventions that 'empower' women (presumably) lead to a proportionally significant increase in women's contributions to development.

The instrumentalization of women that characterizes the gender equality as 'smart economics' frameworks is not a recent phenomenon. Despite ongoing critiques, instrumentalist arguments for including women in development have consistently dominated development discourse since their deployment by the Women in Development (WID) advocates of the 1980s (Pearson, 2005). Indeed, as addressed in section 2.1.1 early 'family planning' initiatives targeted women due to understandings that doing so would contribute to development by slowing population growth. Nevertheless, contemporary analyses of instrumentalization have linked this discourse to the dominance of neoliberal development frameworks, and the development sector's associated preoccupation with efficiency, productivity and individualism.

Chant (2012) argues that the development sector's current preoccupation with gender equality and women's empowerment depends on the neoliberal framing of gender equality as 'smart economics'. Within this framework, gender equality is presented as a worthy goal due to the economic benefits that will accrue through women's increased participation in the workforce. As stated, this framing continues a long tradition of instrumentalization, in which women's inclusion in development has been consistently justified through appeals to what they can offer 'development' (Pearson, 2005). Furthermore, as I have outlined in my previous research, this instrumentalization also relies on gender stereotypes, and

specifically on the presumption of maternal altruism, which posits that women will use any resources they receive to benefit other, particularly their children (Potvin, 2015).

The discourse of maternal altruism can be linked to studies that have demonstrated a correlation between maternal income and child survival rates, and that have found evidence that women are more likely than men to allocate household expenditure to food (see for example Kennedy and Cogill, 1987; Thomas, 1990). Critics of the maternal altruism discourse do not necessarily question the validity of these findings, but rather problematize the assumption that they result from a natural 'maternal instinct', suggesting instead that women are often socialized into altruism through differences in gendered expectations, obligations and responsibilities (Kabeer, 1994). Furthermore, although altruism is often framed as a positive attribute, it is important to consider how socialization into self-sacrificing behaviours negatively affects women's well-being by limiting their access to, and use of resources. Acknowledging the potential social and cultural motivations behind seemingly altruistic behaviour can also help make visible the role that development discourse and programming can play in reinforcing gendered expectation of altruism, and in using it to take advantage of women's unpaid labour. For instance, in her research on social policy in Latin America, Molyneux (2006) has argued that programs that depend on women's unpaid labour to achieve child-oriented development goals end up increasing women's burden of care while reinforcing and institutionalizing women's roles as self-sacrificing mothers. Her findings can be linked to Chant's (2010) conceptualization of the "feminisation of responsibility" which she uses to refer to the growing burden of family and community care on women within the 'developing world'. This concept helps highlight how development projects that justify inclusion of women based on their ability to contribute to development goals can end up exploiting these women, capitalizing on women's altruism rather than relieving their 'altruistic burden' (Brickwell and Chant, 2010). Similarly, projects that help women 'mother' more efficiently may bring positive results for these mothers, but without contributing to systemic changes in gender roles and power relations (Swain, 2010).

The discourse of gender equality as 'smart economics' aligns with and builds on the popularity of women's empowerment in neoliberal development discourse and practice.

Central to discourses of empowerment is the assumption that while development interventions are necessary to 'empower' individuals, it is these empowered individuals themselves who will bring about development. As discussed above, from a postcolonial feminist perspective, acknowledging the agency of those living in poverty to work towards their own development goals can be understood as a positive alternative to constructing these women solely as helpless victims. Indeed, 'empowerment' initially emerged as a concept to recognize and reclaim the power of marginalized individuals and communities (Batliwala, 2010). However, as Batliwala (2010) argues, rather than acknowledging the political agency of those living in poverty, current understandings of empowerment instead tend to place responsibility for achieving 'development' on vulnerable individuals and communities, often without allowing them to define their own development goals. Thus, instead of a radical recognition of power, empowerment has come to be understood as a technical fix that individualizes responsibility without disrupting the relations or systems of power. As such, gender equality and women's empowerment have been rendered individualized, technical solutions that further support the technocratization of development. Contemporary empowerment discourse risks increasing women's responsibilization without significantly challenging gender or economic inequalities, including those that characterize the development sector itself (Eyben and Napier-Moore, 2009).

The critical scholarship on women's instrumentalization, including the technocratization of empowerment and the feminisation of responsibility provides important context for analysis of maternal health programming. As outlined above, a key critique of maternal health programming has been its use as a depoliticizing framework that displaces reproductive and sexual rights by focusing instead on the delivery of health services. This framework not only depoliticizes questions of reproductive and sexual rights, but also renders health itself an issue of technical intervention, often treating health as disconnected from broader political, economic and social contexts.

2.3.3 The Depoliticization of Social Determinants of Health

Part of how maternal health has been made a 'technical' problem is through the obscuring of social determinants of health. Social determinants of health are the "economic and social

conditions that shape health of individuals, communities, and jurisdictions as a whole" (Raphael, 2016, p. 3). In other words, social determinants of health include the various factors that influence health, not only in terms of one's ability to access healthcare, but also by shaping the everyday conditions in which one lives. The lack of attention paid to these conditions, including poverty, gender and environmental degradation, has been a key critique of maternal health programming that focuses almost exclusively on increasing access to services, including the Muskoka Initiative itself (Keast, 2017). For instance, the MDGs have been critiqued for treating maternal health as a stand-alone issue, focusing on the delivery of healthcare services without necessarily engaging in how health inequities are produced, or at least exacerbated by social and economic inequalities, including gender inequality (Petchesky, 2000; Harcourt, 2009).

Poverty has come to be recognized as a particularly important social determinant of health broadly, and in relation to maternal health (Giurgescu, 2017; Najafizada, Bouregeault and Labonté, 2017). For instance, poverty can make it difficult or impossible for particular individuals and communities to access adequately nutritious food, contributing to poor nutrition and by extension, poor health (Gottlieb and Joshi, 2013; Tarasuk, 2016). Poverty can also shape access one's ability to access healthcare, even when direct costs of healthcare are mitigated by universal coverage. This is because in addition to the potential costs of treatment, indirect costs such as transportation, access to childcare, and the ability to take time off of work can all create economic barriers to healthcare access (McGibbon, 2016). Poverty can also act as a social determinant as those who live in poverty are more likely to live in unsafe or inadequate housing (Bryant, 2016), and to come into contact with harmful pollutants either in their homes or their places of work (Galabuzi, 2016). The stress of living with the day to day challenge of poverty, and precarious employment have been recognized as having a negative impact on both mental and physiological health (Benach, et al. 2014; Galabuzi, 2016). Significantly, the effects of poverty as a social determinant intersect with other forms of social exclusion, including racism, to compound these negative effects (Galabuzi, 2016).

As a social determinant of health, poverty has also been recognized as playing a crucial role in maternal health outcomes and inequities. Poverty operates as a social determinant

of maternal health by limiting access to healthcare, as well as to important resources such as food and housing (Filippi et al. 2006; Johnson, 2016). Furthermore, by impacting women's ability to access necessary resources, poverty and social marginalization contributes to the everyday stresses women experience when pregnant, further impacting their health (Bermúdez-Millán et. al. 2011; Johnson, 2016). Within the context of the United States, poverty has also been linked to existing health concerns, such as increased incidence of diabetes, depression, and reliance on illicit drugs, that ultimately impact pregnancy outcomes (Nagahawatte and Goldenberg, 2008).

Significantly, in examining how poverty operates as a social determinant of maternal health, it is important to examine no only individual poverty, but also the ability of 'developing' countries to implement health policies and services, as well as the macroeconomic processes that contribute to inequality and poverty at both the national and the individual level (Petchesky, 2000). Thus, while poverty is considered a social determinant of health, so too can economic and social welfare systems, as these also shape everyday experiences and health outcomes. Similarly, gender can act as an important social determinate of health, both broadly, and in specific relation to maternal health, as gender norms and power relations can further affect access to resources (Kim and Saada, 2013; Marmot et. Al. 2008; Sen and Östlin, 2007). Gender may also influence everyday behaviours, increasing vulnerability to violence and/or contact with harmful environments (Petchesky, 2000; Phillips, 2005).

Increasingly, environmental conditions have also been recognized as a key determinant of health (Schulz and Northridge, 2004), including maternal and child health (WHO 2015b). Environmental degradation has been recognized as affecting health through increasingly direct contact with harmful pollutants, as well as by impacting social and economic contexts. For instance, climate change and resource scarcity have been linked to the escalation of conflict, as well as the displacement of populations and the creation of 'environmental refugees' (McMichael, Barnett and MicMichael, 2012). Perspectives on environmental determinants of health include consideration of how social and economic processes (such as industrialization) affect the natural environment, and vice versa. For example, in a study by Federman and Levine, (2010, p. 559) it was found that growth of

manufacturing employment in polluting industries led to significantly poorer infant health outcomes in several Indonesian districts. The authors posit that these poor outcomes were likely exacerbated not only by increased exposure to pollutants, but also by changes to the urban environment brought about by this growth, including limited access to quality housing and sanitation. Additionally, climate change has been specifically identified as influencing maternal health through water quality, with an increased incidence of maternal hypertension in Bangladesh being linked to climate induced salinity intrusions into low-lying coastal regions (Khan, et. Al, 2011). As such, there has emerged a call for maternal health interventions to analyze and address environmental factors as a key component of maternal and child health (WHO n.d.b).

Much of the literature on social determinants of health focuses on highlighting the links between various social and economic factors, and health outcomes. While this approach seems to necessitate a more politicized engagement with health in development, Raphael (2016) argues that merely attributing outcomes to social determinants "says little about how these poor-quality social determinants of health come about" (2016). A politicized approach to social determinants thus moves beyond linking determinants such as poverty, gender inequality and environmental degradation to health outcomes, and instead interrogates how these conditions are produced, and why they affect certain individuals and communities differently. An example of what this kind of analysis can look like is provided in Mitchell's (2002) historical analysis of an outbreak of malaria in Egypt during the 1940s. While this outbreak is generally understood as a biological occurrence, Mitchell argues that it came about at least in part due to changes in the area's political systems, and agricultural practices. Specifically, Mitchell outlines how new large-scale irrigation systems allows for the spread of malaria carrying mosquitos into new areas, while a concentration of resources contributed to the incidence of famine that in turn increased the vulnerability of malnourished populations to the disease once it spread. Mitchell understands the epidemic as the outcome of the relationship between the 'natural' environment and economic, and the political practise that changed this environment while increasing and stratifying vulnerability to the virus, often along existing socioeconomic lines. Significantly, Mitchell argues that the focus on how the disease was and could be treated has obscured the impact of technological advancement and political and social

change in shaping and magnifying its impact. His analysis highlights the need to think critically about how processes of 'development' can impact the health of individuals and communities, shaping social determinants that in tern effect health outcomes.

Even though social determinants of maternal health have been acknowledged by global institutions such as the WHO and UNFPA, maternal health programming has been critiqued for its continued focus on increasing access to healthcare without engaging with broader social determinants (Petchesky, 2000; Harcourt, 2009). Both Harcourt (2009) and Petchesky (2003) argue that despite attempts by feminist activists to bring greater acknowledgement of economic inequality and poverty into the Cairo+5 Conference, these issues were ultimately sidelined in favour of greater focus on healthcare access. Both the MDGs framework (Harcourt, 2009; McPherson, 2016), and the Muskoka Initiative (Keast, 2017; Tiessen, 2015) have similarly been critiqued for their limited engagement in social determinants of health. For this reason, feminist scholars have pointed to the need for a more nuanced and politicized approach not only to reproductive rights, but also the social, economic and political systems that shape women's reproductive experiences (Petchesky, 2000). The theoretical framework for reproductive justice, developed by women of colour activists, represents a response to this need, situating both reproductive rights and maternal health within the broader matrices of economic, racial, and gendered oppression. This theoretical framework will be outlined in detail in Chapter 3.

2.3.4 Depoliticization and Colonization through the Medicalization of Reproduction

The ignoring and obscuring of social determinants of health within maternal health programs have also been linked to the process of medicalization. Medicalization refers to "the process by which medical definitions and practices are applied to behaviours, psychological phenomena, and somatic experiences not previously within the conceptual or therapeutic scope of medicine" (Davis, 2010). Scholarship on medicalization examines how various issues have come to incorporated into the domain of medicine, including reproductive issues such as pregnancy and childbirth (Brubaker and Dillaway, 2009; Cahill, 2001). Although perspectives on medicalization vary, a key critique is that medicalization brings social problems under the purview of medicine, seeking to address

symptoms without necessarily addressing the underlying causes (Birn, 2011). Addressing the medicalization of global health, Clark argues that it:

> Ignores or excludes context and reduces explanations for problems to the physical realm, overlooking social, cultural, psychological or environmental factors that contribute to or influence why a phenomenon occurs (2014).

In other words, within this iteration of medicalization, sometimes called biomedicalization, social determinants of health are addressed through a biomedical framework, rather than a social or political framework. Health is thus understood as a biomedical problem, that can be addressed through the application of technical, medical knowledge. In this way, biomedicalization can be understood as contributing to the depoliticization and technocratization of development.

Although literature on medicalization in the sphere of global health policy is limited, the concept resonates with feminist critiques of maternal health policies that focus on biomedical approaches at the expense of social determinants of health. These critiques are further influenced by feminist scholarship on the ways in which medicalization has been used to disempower women during pregnancy and childbirth, and to bring women's bodies under the control of medical 'experts'. The existing literature on medicalization therefore provides an important critical perspective on global maternal health programming, and contributes to the critiques of women's health advocates who have argued for a more nuanced and contextualized understanding of maternal health as the outcome of various social, political and economic factors. Feminist perspectives on medicalization, outlined below, demonstrate how medical expertise has been used to govern women's reproduction, infringing on their ability to made autonomous decisions about their physical well-being and reproductive experiences (Cosminsky, 2012). Finally, ethnographic work in the Global South, and in colonized communities in the Global North, highlights how medicalization is used to enforce particular hierarchies of knowledge, and to govern marginalized communities of women. In these context, women negotiate their desire for medical care with the resistance to medicalization.

Feminist scholarship on medicalization has tended to focus on the ways in which characteristics and processes associated with the female body have come to be thought of

as medical problems in need of management through access to medical care (Cahill, 2001). These include menstruation, menopause, pregnancy, childbirth and even contraception (Tone, 2012). Such scholarship has traced the shift from thinking about pregnancy and childbirth as existing within the 'private' domain of womanhood, dealt with by women through women-centered midwifery, to being thought of as a medical problem that must be managed through the male-dominated sphere of medicine (MacDonald, 2006). Within the Canadian context, McLaren (1997) associates this historical trajectory with the growth of medicine as a profession and the desire for medical doctors to establish and maintain their sphere of influence. In this context, the medicalization of reproduction was also associated with the medicalization of contraception and abortion, which also moved from the feminized sphere of midwifery to the masculine sphere of medicine (McClaren. 1997). This move aligned with religious and political forces that sought to extend control over women's reproduction through the criminalization of contraception and abortion, in part due to eugenic ideology and fears of 'race suicide' as fertility rates among white, middle class women fell in comparison to those working class women and women of colour.

Feminist scholarship has continued to problematize the medicalization of pregnancy and childbirth within the contemporary context, offering critical perspectives on maternal health frameworks that emphasize biomedical concerns and medical treatment. Within the context of the 'developed' world, evidence of medicalization is identified in the high rates of hospital birth and Cesarean sections, as well as increased medical surveillance and management of pregnancy through medical technology such as ultrasound and prenatal testing (Rapp, 1999; Malacrida, 2015). Feminist critics of medicalization have argued that that over-medicalization disempowers the individual giving birth, as control and authority over the childbearing experience shifts from them to the medical professionals (Rosenthal, 2006; Parry, 2008). For this reason, the 'natural' birth movement, which rejects over-medicalization, is often understood and experienced as a means by which women can reclaim power over pregnancy and childbirth (Parry, 2008; Moore, 2011; Worman-Ross, 2013). Furthermore, some scholars have argued that the extension of medical surveillance into pregnancy has allowed for a greater centering of the fetus in medical frameworks, which configure women as vessels rather than agentic subject whose own health is at stake

during pregnancy and childbirth (Lupton, 2012; Parry, 2006). Medicalization has been linked to reproductive governance, a theoretical lens that I explore further in Chapter 3.

It is important to note that despite the critiques of medicalization, these critiques do not necessarily encompass a rejection of medical care itself. Scholarship that centers the experiences of women demonstrates that women both pursue and resist medicalization during pregnancy and childbirth. As noted, medicalization is challenged by some through the 'natural' birth movement, which seeks to re-center women in the birthing experience while configuring childbirth as a 'normal' and 'natural' even that women are equipped to handle without extensive medical interference (Cheyney, 2008). As such non-medicalized or 'natural' births facilitated by midwives can be a site of empowerment for women, who experience it as a means of taking back control over reproductive experiences, making decisions for themselves, and sometimes emphasizing birth as an accomplishment, or an experience that brings them closer to their understanding of what it means to be a woman (Moore, 2011; Parry, 2008).

Despite the ways in which 'natural' birth can be experienced as empowering, feminist research has also questioned how the natural birth movement has tended to reify 'the natural' while reinforcing problematic discourses of women as inherently closer to 'nature' by virtue of their biological womanhood and reproductive capacity (Johnson, 2016; Takeshita, 2017). Furthermore, Johnson (2016) points to the way in which the discourse of natural childbirth in North America often appeals to a romanticized notion of pre-medicalized birth that reinforces racist stereotypes that situate women in the Global South as more closely aligned with nature and 'traditional' forms of femininity. Johnson further argues that such discourses are particularly problematic in the face of high maternal health rates in the Global South, where women often lack access to formal medical care. She argues for a more nuanced approach to medicalization that accounts for the way in which medical care is experienced and valued differently based on geographic, economic and social positioning.

Johnson's (2016) own research on women's experiences of and attitudes towards medicalized birth across the North/South divide provides an important comparative

perspective to the existing scholarship on medicalization and reproduction. Based on interviews with women from Canada, the United States, Cuba and Honduras, Johnson argues that critical stances towards medicalized childbirth are more often held by women who occupy positions of economic, social and racial privilege, and is more prominent within the context of the Global North. She argues that in contexts where access to medical care is limited, women may not be able to afford to adopt the critical approach to medicalization held by women of relative affluence within the Global North; women who, even when choosing a natural birth, generally have access to medical care if needed. Furthermore, while for many women living in the Global North, encounters with the medical establishment may be experienced as disempowering, for those living in, or who have immigrated from the Global South, access to medical care may be experienced as empowering, and/or as a source of social capital and a marker of status. Johnson's work highlights the need to adopt a nuanced and intersectional approach to medicalization that can account for women's varied experiences with, and negotiation of medicalized reproduction.

Like Johnson, Gary (2002) argues against the conflation of medicalization with medical care, and posits that feminist critique of medicalization need not constitute a rejection of medical care or technologies per se, but rather the ways in which medicalization has been used to as a form of oppression against marginalized individuals and groups. She encapsulates this perspective in her statement that:

> We want medicine when we need it or find it potentially useful; after all, it sometimes helps us save lives and prevent or cure disease. However, we don't want human beings, either individually or as communities, to be subject to medicalized thinking and institutional practices when this kind of thinking or practice is oppressive, misguided, inappropriate and so forth – and that is a lot more of the time than many people would like to believe (p. 263).

As such, Gary (2002) highlights the danger of conflating a critique of medicalization and the rejection of medical care per se. Instead, she clarifies that critiques of medicalization must focus on how the construction of particular issues and experiences as biomedical problems can act as a "means of social control that interlocks with other practice of

domination to increase the damage caused to the lives of marginalized people" (Gary, 2002, p. 264).

While Johnson's research suggests that critical approaches to medicalization are more commonly associated with positions of privilege, these critiques have nevertheless been brought to bear on global health initiatives that prioritize biomedical approaches to maternal health at the expense of both social determinants, and of traditional birthing practices. For instance, Cosminsky (2012) outlines how the World Health Organization's understanding of pregnancy and birth as a medicalized process that must be managed through appropriate medical care has led to the disenfranchisement of midwives in Guatemala, as well as the loss of local birthing knowledge and practices. Based on ethnographic research on midwifery within Guatemala, Cosminsky critiques the medicalized framework adopted by the WHO, and in particular its policy of attempting to eliminate the use of traditional birth attendants (Cosminsky, 2012). This stance was adopted due to the failure of training programs aimed at traditional birth attendants to produce measurable changes in maternal and child mortality rates. Yet Cosminsky argues that the WHO's decision did not take into account how social determinants of health may help explain the persistence of high mortality rates. Furthermore, in conducting ethnographic research on experiences of childbirth in Tanzania, Allen (2002) found that some of the women who had been provided training as part of WHO initiatives did not identify as traditional birth attendants, and some did not have any prior experience supervising births. She also critiques the WHO's opposition to training traditional birth attendants, arguing that the limited effect of these programs may have been due to such oversights.

Significantly, in February of 2018, the WHO released a statement outlining recommendations to avoid unnecessary medical interventions which addressed key concerns surrounding medicalization. Namely, the statement recognizes that women are increasingly subject to medical interventions that are not medically necessary, and seeks to reduce "unnecessary interventions" (WHO, 2018a). The statement emphasizes that "birth can be an unpredictable and risky event and that close monitoring and sometimes medical interventions may be necessary", while also acknowledging that "even when interventions

are needed or wanted, women usually wish to retain a sense of personal achievement and control by being involved in decision making, and by rooming with their baby after childbirth" (WHO, 2018a). This statement appears to respond to concerns that maternal health programs contribute to medicalization as a form of disempowerment, and to lay the groundwork for a more women-centered approach to medical programming. How these recommendations will translate into practice within maternal health interventions is yet to be seen.

Cosminsky's (2012) ethnography highlights the tensions that exist between midwives and medical professionals within the Guatemalan context, as well as the ways in which midwives and women negotiate the criminalization of traditional birth practices. This research highlights how criminalization creates an additional barriers for women who do not want, or who are unable to access formal medical care. Similarly, Smith-Oka (2012) outlines how the use of traditional birth attendants and resistance to the authority of medical professionals is used to position low-income mothers in Mexico as 'bad mothers' who are in need of being controlled. This construction is based on understandings that women have a moral and civic duty to reduce medical risk not only to themselves, but to their children, an expectation that is outlined in greater detail in Chapter 3. Both studies highlight how medicalization is imposed through public health and development interventions that fail to recognize the cultural, social, and even medical value of midwifery work, reinstating a hierarchy between western biomedicine and local forms of knowledge while disregarding women's autonomy over their birthing experiences.

Ethnographic and historical work on medicalization has also demonstrated how medicalization is bound up in processes of colonialism. Although the explicit language of medicalization may not always be used, research has tied processes of medicalization to the exertion of colonial control over women's bodies and reproduction. In Allen's (2002) research on maternal health programming in Tanzania, she outlines how colonial projects deployed narratives of health and hygiene as part of the civilizing mission, through which the superiority of colonial medicine was situated as evidence of the superiority of European knowledge, and as rationale for the governing of women's bodies. Kaufert and O'Neil (1990) similarly demonstrate how medical expertise was used to control the reproduction

of Indigenous women in Canada's North, through a policy that required women to be flown to south in order to receive what was considered appropriate medical care. This process aligns with the colonial control over Indigenous reproduction, and the devaluation of Indigenous knowledge and culture. In some areas, Indigenous communities are resisting colonial medicalization by returning to traditional birthing practices, which are combined with western forms of medical care (Van Wagner, Epoo, Nastapoka and Harney, 2007). These hybrid approaches demonstrate how anticolonial approaches to medicalization do not necessarily constitute a rejection of medical care, but rather resistance to the way in which it has been used to devalue Indigenous cultures, control Indigenous women, and weaken Indigenous communities.

The critical perspectives offered by feminist research on medicalization challenge the role that maternal health programs may play in contributing to the technocratization and depoliticization of development through an emphasis on biomedical treatment. Furthermore, they demonstrate that while medical care is important, and desired by women within both the Global North and Global South, medicalization has at times been deployed as a means of exerting control over women's bodies, including within colonial contexts. These critiques have led to a greater understanding of the need for maternal health programs to provide healthcare in ways that are empowering.

2.3.5 Exclusions and Obscurations of Conflating Women's Health with Maternal Health

In addition to the critiques of maternal health that have focused on it's depoliticization and technocratization, critical scholarship has called attention to who and what has been excluded from the 'maternal health' framework, particularly when 'maternal health' has been conflated with 'women's health'. As outlined above, many women's health organizations have advocated for maternal health as part of a comprehensive approach to reproductive rights and health, which insists that women have access to healthcare throughout their lives (Petchesky, 2003). This approach is important in part because health interventions during pregnancy are more likely to be successful if women have had access to proper medical care in the years before becoming pregnant, including during their childhood (Petchesky, 2003). Yet it is also important because women's medical needs

expand beyond their reproductive roles and lives. Indeed, the conflation of maternal health and women's health has been critiqued as potentially excluded and obscuring the needs of women who are not (currently or at any point) engaging in biological reproduction, and yet who are still in need of health care, including sexual and reproductive healthcare and services such as contraception and abortion (Jolly and Cornwall, 2010; Miller, 2000). Furthermore, the conflation of women's health and maternal health excludes the healthcare needs of trans men who may require access to maternal and reproductive healthcare, including contraception and abortion.

From a different perspective, Garrett (2007) has argued that a focus on maternal health can potentially lead to greater investments in health services than interventions that focus on communicable diseases, thus benefiting those who require non-reproductive health services. She argues that maternal mortality acts as a "sensitive surrogate for the overall status of health-care systems" given that:

> Pregnant women survive where safe, clean round-the-clock surgical facilities are staffed with well-trained personnel and supplied with ample sterile equipment and antibiotics. If new mothers thrive, it means that the health-care system is working, and the opposite is also true (2007, p. 33).

While investments in maternal health may therefore have a greater impact on overall health, other scholars have suggested that a focus on maternal health is in danger of excluding those who require alternative forms of healthcare. Jolly and Cornwall (2010) have gone so far as to state that, in some areas, "access to healthcare is far easier for those who reproduce than those who do not, especially in an age where the (vitally important) imperative of saving mothers' lives has eclipsed the need for decent healthcare provision for all genders" (p. 670). Furthermore, Miller (2000) has argued that the subsuming of sexual health, and even sexual rights, under the framework of reproductive and/or maternal health has "disappeared an array of people of varying ages and non-conforming sexual identities, as well as non-reproductive sexual practice" (p. 70). Those excluded include older women who are past reproductive age as well as those whose sex is perceived as non-reproductive, including women who have sex with women and men who have sex with men (Gosine, 2005; Miller, 2000). Furthermore, woman and mothers who do not conform

to normalized ideals of motherhood, such as sex workers or adolescent mothers may also be excluded from maternal health and rights discourses and programing. Finally, when reproductive and sexual health is framed as 'maternal health', both reproductive and sexual health are understood as "women's issues" rather than being seen as situated within larger matrices of gender relations (Gosine, 2005; Miller, 2000).

In focusing primarily on maternal health, political questions of women's autonomy over their (reproductive) bodies can also be obscured, as are the needs of men and women engaged in intimate relations that are not (or is not perceived as being) appropriately reproductive. Acknowledging that reproductive rights advocacy lays important groundwork for advocacy and sexual rights, Miller (2000) nevertheless argues that the conflation of sexual rights with reproductive rights have made it difficult to address sexual rights as valuable in and of themselves.

With the further conflation of reproductive rights with maternal health, sexual rights have become even more obscured. Even when female sexuality is explicitly addressed within the development sector, this work tends to focus on the number of women's sexual partners, or their use of contraception, without necessarily contextualizing these factors within the broad system of social and gender relations in which sexual practices exist (Jolly, 2007). This is problematic, not only because it excludes the sex which people have for pleasure, but it also ignores the ways in which sexual norms affect other areas of people's lives (Armas, 2007).

In response to some of the limitations identified in the development sector's approach of addressing sexuality through the lens of maternal and reproductive health, the 'sex for pleasure' critique emerged as a way of challenging and providing an alternative to dominant, risk and health-based frameworks. The sex for pleasure lens is not a critique of maternal health programming per se, but rather a critique of a prioritization of maternal and reproductive health in the absence of addition efforts to address sexual health and rights more broadly. Although sexual health frameworks have been important means by which advocates for sexual minorities in particular have been able to advocate for greater access to resources, critics have pointed to the dangers and erasures of risk-based approaches

(Armas, 2007; Gosine, 2005). This conflation has also allowed reproductive health programming to be co-opted by conservative attempts to control women's sexuality and reinforce patriarchal gender norms (Saunders, 2003; Miller 2004). For instance, development discourse tends to position women as sexually passive and as predominantly the victims of sexual violence, and/or their partners' sexual promiscuity (Jolly, 2007; Miller 2004). Such positionings obscure women's sexual agency and excludes the importance of sexual pleasure and intimacy as part of women's lives, relationships and well-being. In response, rights-based approaches that explicitly recognize the right to positive and autonomous sexuality, rather than focusing only on protection from risk, have been promoted as a means by which to expand the way in which development conceptualizes and address sexual health and rights. Such a framework would also help expand understandings of (women's) health and rights beyond the realm of maternity and reproduction.

2.3.6 Critical Perspectives on the Muskoka Initiative

While Canada's prioritization of MNCH has been met by praise and appreciation by some[2], the approach taken within the Muskoka Initiative has been the subject of significant critique. In particular, the exclusion of abortion from the Muskoka Initiative prompted critiques from journalists, NGOs and advocates who argued that not only was abortion a reproductive right, but also a key component of reproductive and maternal health (McMann, 2014; Sitsabaisan, Laerdière and Ashton, 2013; Webster, 2010). In an article published in the Lancet shortly after the announcement of the Muskoka Initiative, Charles Larson, then the director of the Centre for International Child Health at the British Columbia Children's Hospital is quoted as stating:

> If you are looking at evidence-based public health practice you cannot ignore the impact of unwanted pregnancies and abortions. Access to safe abortions is an important part of good maternal health practice. If you are going to pursue a policy of denying safe abortion there is not doubt about it, you will increase maternal mortality (Larson in Webster, 2010).

[2] See for example, Plan, 2015; the Canadian Press, 2014

Such critiques draw in part on estimates that complications from unsafe abortions are responsible for 4.7%-13.2% of maternal deaths annually (De, 2014; WHO, 2018b). Although the Canadian government justified the exclusion of abortion as a means of avoiding politicized debates that might diminish support for Muskoka on the global level, critics have argued that the exclusion is at least in part attributable to the anti-choice values of the Conservative Party, as well as the Party's relationship with the religious-right (Jex, 2017; Wells, 2011). My own analysis addresses this exclusion, extending these critiques by situating the exclusion of abortion within the context of the Muskoka Initiative's broader discursive framework.

The Muskoka Initiative has also been critiqued for attempting to improve maternal, newborn and child health without engaging in the root causes of maternal and child mortality, such as poverty and gender inequality (Tiessen, 2015; Black, 2013; Huish and Spiegel, 2012). These critiques have been explored in significant depth in two discourse analyses of the Muskoka Initiative that have been published in the past three years. In her discourse analysis of Government documents related to the Muskoka Initiative, Tiessen (2015) argues that the Muskoka Initiative treats 'women' as a homogenous category, without addressing how their reproductive experiences and decisions are shaped by dominant gender norms or relations of power. She argues that this erasure of gender within the Muskoka Initiative aligns with a broader trend within Canadian development policy during the Harper era, during which the language of 'gender equality' was largely replaced with the language of 'equality between men and women' (Tiessen, 2015; Tiessen and Carrier, 2015). Tiessen argues that this shift in language is indicative of the Government's focus on women as a demographic category, rather than on understandings of gender as a series of roles and relations. This framework is observable in the Muskoka Initiative's focus on saving women's lives through maternal health programming, without engaging with how maternal health might be shaped by gender inequality.

Tiessen's analysis also identifies and critiques the Muskoka Initiative's conflation of 'women' with 'mothers'. She argues that the texts consistently treat women in the Global South as "walking wombs" whose primary role is to give birth and care for children. This conflation not only excludes important aspects of women's healthcare, but also reinforces

dominant gender norms through its association of femininity with maternity, and its assumption that all women are, will be, or were once mothers (Tiessen, 2015). Tiessen further contends that the Muskoka Initiative not only essentializes women in the Global South as mothers, but also as vulnerable, passive and helpless. This homogenized and essentialized representation of women underpins the paternalistic discourse of 'saving lives' that permeates the Muskoka texts, and that casts Canada in the role of saviour. Tiessen's analysis is important not only because it identifies gender as a key exclusion of the Muskoka Initiative, but because it ties this exclusion to broader discourses of essentialism that justify Canada's narrow approach to maternal health.

In her analysis of texts related to the Muskoka Initiative taken from the Prime Minister Harper's website, as well as the website for the Department of Foreign Affairs, Trade and Development (DFATD), Keast (2017) also identifies gender as a key exclusion. Keast states that the exclusion of gender constitutes a "missed opportunity" for the Canadian government to "1) recognize the importance of gender equality in maternal health initiatives and 2) advance women's rights and gender equality in a progressive and sustainable way" (2017 p. 50). Furthermore, Keast identifies the exclusion of any reference to race, ability, or sexuality from the texts analyzed as indicative of the Muskoka Initiative's failure to engage in intersectional analysis and/or programming. She argues that this failure led to a lack of acknowledgement of the ways in which various social factors influence maternal health outcomes. She links this lack of intersectional, gendered analysis to an overall depoliticization of maternal health within the Muskoka Initiative, reflected in the Initiative's emphasis on measurable outcomes. As such, she states that:

> The emphasis on accountability and results leads to a policy centred narrowly on the technical aspects of maternal and child mortality, which allows Canada to appear remain committed to gender equality through the coding of maternal health programs as addressing gender equality (Keast, 2017, p. 52).

Her critique that maternal health programming is presumed to address gender inequality due to its focus on women, despite its adoption of a depoliticized approach to gender and development, resonates with critiques of global initiatives such as the SMI and MDGs, outlined above, and explored in greater detail in section 8.2.

Keast's work on the Muskoka Initiative also highlights how it deploys discourses that construct Canada as a global development leader. This discursive construction is also addressed in Tiessen's (2015) analysis, in which she argues that the language of "saving lives" situates women in the developing world as passive recipients of development, while casting Canada as their active, agentic saviour. Both analyses point to the importance of considering how development discourse and practice relies on and reiterates the authority of particular development actors, as well as the role such discourses play in the process of nation building for implementing countries. Indeed, in addressing the disconnect between Canada's overarching focus on pursuing development through issues of trade and security, and its public prioritization of maternal and newborn health, Proulx, Ruckert and Labonté (2017) posit that that latter was largely motivated by efforts to build Canada's international identity and reputation.

2.4 Contributions of this Doctoral Project

When I began the research for this dissertation, there was very little published academic research on the Muskoka Initiative. The work that has emerged in the intervening years has provided invaluable insights into how maternal health was understood and addressed within the Muskoka Initiative. The insights offered by Tiessen and Keast's work in particular align with and extend the critical scholarship on maternal health from the Safe Motherhood Initiative to the Millennium Development Goals. Through the use of additional theoretical lenses, my own doctoral research further builds on and extends their critical scholarship, further elucidating the limitations and the possibilities of maternal health policy and programming.

My doctoral research provides an additional critical discourse analysis of texts associated with the Muskoka Initiative. In conducting my analysis, I have drawn theoretical insights not only from critical development studies, but also from critical health studies. Specifically, I draw on the theories of biopolitics, governmentality and healthism, extending and nuancing critical scholarship on the Muskoka Initiative by brining it into conversation with perspectives on global development as a site of governance. My theoretical lenses help elucidate not the Muskoka Initiative's exclusion of abortion, gender and other social determinants of health are bound up in the instrumentalization of women,

the governance of women's bodies, and the individualization and feminisation of responsibility for public health. Furthermore, I examine these findings from the perspective of reproductive justice, working to move forward the conversation regarding if and how maternal health programming, as part of the development sector, might act as a site to work towards reproductive justice and why it has, in the case of Muskoka, largely failed to realize this potential.

Chapter 3

3 Theoretical Frameworks

This research is informed by two distinct, yet complimentary theoretical frameworks. The first is Foucault's theory of biopower, including its application to global biopolitics, and the related theorizations of risk and healthism as technologies of neoliberal governance. The second is the theory of reproductive justice, and its emphasis on elucidating how marginalized women's reproduction has been, and continues to be, governed. Although these frameworks have emerged from distinct academic and activist contexts, both have been used to examine and highlight how women's reproductive lives are targeted as sites of governance in order to achieve particular political ends. Both frameworks are also helpful in articulating a critique of the 'choice' frameworks that have come to dominate discussion of both reproductive health and rights in neoliberal contexts. In this chapter, I outline each of these theoretical frameworks and delineate how they are relevant to, and have informed my analysis.

I begin this chapter by outlining Foucault's theory of biopower, including the emergence of 'the population' as a field of governance, and the contemporary reliance within global biopolitics on neoliberal forms of governance 'at a distance'. I also address how biopolitics has been used to analyze the governance of 'at-risk' populations within the sphere of global development, with particular attention to family planning and maternal health programs. I suggest that this theoretical understanding can help elucidate how women's bodies are governed through such programs in order to pursue population level changes, such as infant and child mortality rates. Furthermore, these theories can help us understand how expert knowledge such as statistics and risk assessments are used not only to identify particular populations as in need of governance, but specifically, to justify the management of their reproduction.

In this chapter, I also outline how, while biopower relies on various forms of power, within the development sector technologies of self-governance are of particular significance. The circulation and reinforcement of particular norms through development programs and development discourse act as a key form of governance. Connecting these ideas to both the

neoliberal models of development discussed in my literature review, and to neoliberal frameworks of health, I also examine how risk discourse is used to govern health behaviour, and to individualize health both as a personal responsibility and as a duty of citizenship, processes that are captured in the concept of healthism. I further explore how healthism can be applied to maternal health, with particular reference to how healthism and risk are gendered in ways that responsibilize women for the well-being not only of themselves, but of their children. I end this section with a summary of how this theorization strengthens contemporary understandings of how development serves as a space of reproductive governance.

The second section of this chapter is devoted to the theory of reproductive justice. I highlight many of the convergences between reproductive justice and biopolitics as frameworks of analysis, with a particular focus on how they contribute to the problematization of reproductive 'choice'. I also demonstrate how reproductive justice focuses analysis on the experiences of marginalized women and communities who experience particular forms of reproductive governance based; for instance, on understandings of race, ability, and class. By focusing on the systemic ways in which reproductive decisions are constrained, I suggest that reproductive justice both aligns with and strengthens a biopolitical approach to maternal health.

3.1 Biopower and Biopolitics

My research draws on Foucault's theorization of biopower and neoliberal governmentality, with particular attention to the ways in which these concepts have been used in feminist, development and critical health scholarship. Foucault defines biopower as the form of power that aims to govern human life (1990). Biopower is operationalized through two complementary poles: anatamo-politics, which takes as its object the disciplining of individual bodies, and biopolitics, which focuses on the regulation of the population as a whole (Foucault, 1990). Foucault distinguishes biopower from sovereign power, the latter of which is wielded through the sovereign's ability to punish subjects through death (Foucault, 1990). While sovereign power is conceptualized as a purely repressive form of power, biopower is both repressive and productive, compelling its subjects not only to abstain from certain behaviours, but also to engage in others. Furthermore, while sovereign

power is imposed from a centralized actor, biopower is relational and diffuse, and is exercised through a variety of institutions, permeating all aspect of our public and private lives (Foucault, 1990).

In theorizing anatomo-politics and biopolitics as the dual poles of biopower, Foucault is clear that these poles are not antithetical, but are rather co-constitutive. Furthermore, Foucault identifies sex as the "pivot of the two axes"; that is, as the site where anatomo-politics and biopolitics meet and through which individual bodies are disciplined in order to maximize the well-being of the population (Foucault, 1990, 145). Feminist scholars have expanded upon this theorization of sex as biopolitical to examine how the maternal/reproductive body is disciplined and regulated as a means of managing the population. For instance, Weir's (2006) work examines how the emergence of knowledge surrounding the 'perinatal' period during the early 20th century led to the construction of pregnancy as a site of medical governance aimed at decreasing infant mortality. Within this construction, the management of individual women's bodies during pregnancy was situated as a means by which to ensure the well-being of the population, as measured through the infant mortality rate. The targeting of individual women during pregnancy exemplifies how the well-being of the population is pursued through the management of individual bodies, and specifically, the medical management of women's reproductive bodies during the perinatal period (Weir, 2006). Weir's work illustrates how maternal health emerged as a key point of convergence between the anatomo-politics of the body, and the biopolitics of the population. Similarly, Moore (2013) outlines how maternal health and care practice became the target of disciplinary interventions in England during the turn of the 20th century, with the explicit purpose of helping to produce a more robust British 'race' that could serve and uphold the military Imperial project. In both examples, maternal and fetal health are intertwined, allowing for the maternal body to become a site of individual intervention aimed at improving not just the health of an individual child, but of the population at large. Although both examples take the 'developed' world as their focus, they highlight how the maternal body has been theorized at the nexus of individual discipline and population level management, representing an important site of biopolitical analysis.

3.1.1 Biopolitics, Race and Reproduction

While biopolitics endeavours to maximize the well-being of the 'population', the population itself should not be understood as one, indistinguishable mass. Rather, Foucault (2003) posits that ensuring the well-being of the population depends on the delineation of who is included in the 'population', and who is understood as posing a risk to the population either from outside of it or from within it. He theorizes that racism has played a central role in creating cleavages in society that prescribe whose well-being is to be maximized, and whose well-being must be sacrificed in order to ensure this maximization. He ties this prescription to popular (if erroneous) understandings of Darwin's theory of evolution, by which those who are weakest within a species pose a threat to its overarching survival, and must therefore be left to die (Foucault, 2003). Foucault argues that it is the understanding of certain segments of 'the population' as a risk to the overall survival of humanity as a species that has justified both war and genocide within a system of power that is otherwise largely focused on fostering life (Foucault, 2003).

Foucault's articulation of the relationship between biopolitics and race has been used to analyze the rise of eugenics during the 20th century. From a biopolitical perspective, eugenics movements can be understood as a response to the perceived threat to humanity posed by those deemed 'unfit' (Murphy, 2012). Within eugenic thinking, the human race was believed to be made stronger through the eradication of those who were deemed biologically inferior, whether due to race, intelligence, ability, health or economic status (Dyck, 2013). Significantly, even when eugenic movements did not involve directly killing those who were deemed a threat to the population, the danger posed by their supposed biological inferiority was believed to be contained through the curtailing of their reproduction (Murphy, 2012). As such, eugenics also operated at the pivot of the axes between anatomo-politics and biopolitics, disciplining individuals' reproduction in order to maximize the well-being of the population.

Stoler's (1995; 2002) work on the biopolitics of colonialism provides important insights into how the regulation of sex and reproduction has operated as a means of maintaining racial purity, as well as racial hierarchies. Applying Foucault's theories to colonial and post-colonial Indonesia, Stoler (2002) draws on extends his theoretical work on biopolitics

and race to outline how biopolitics was used to govern colonized and colonizing populations differently. In this context, the management of the population included, at certain points, the sexual segregation of white colonizers from racialized populations, and the devaluation of relationships between European men and Indonesian women which had previously been formally recognized (2002). These practices operated as a means by which to maintain racial distinctions in order to uphold the rationality of white supremacy and, by extension, European Imperialism. Stoler's work highlights the need to examine how racialized segments of the 'population' have been targeted differently based on understandings of race as a set of biological characteristics, and of non-white populations as posing a threat both to the racial purity of colonizers, and by extension, their power. Biopolitics as such can be understood as working to uphold racial distinctions, drawing on and supporting colonial discourses in part through the identification of colonized and racialized populations as in need of sexual and reproductive management.

Given the relationship between biopolitics, race, and reproduction, the family planning initiatives of the mid-nineteen-hundreds can be understood as a form of biopolitics that sought to protect the health of the global 'population' by curbing the reproduction of racialized and economically marginalized populations within the 'Third World' (Murphy, 2012). From a biopolitical perspective, population control activities can be understood as attempts to preserve the racial 'purity' of the human race by stemming the growth of non-white populations. These interventions can also be understood as attempts to protect humanity from the environmental threat of 'over-population', which has problematically been located within expanding 'Third World' populations (Bashford, 2006). These same projects also sought to contain the military threat posed by these same population, and particularly, by their perceived vulnerability to communist ideology (Murphy, 2012). Murphy argues that 'family planning' programs operated both as a means through which to pursue economic development (based on demographic transition theory), and as a biopolitical project aimed at protecting white, western 'populations' from the military, environmental and racial threats believed to be posed by expanding 'Third World' populations.

3.1.2 Biopolitics and Global Development

Since biopolitics seeks to manage and regulate 'the population', Foucault links its emergence to the rise, during the eighteenth century, of fields of expertise that took 'the population' as their object of study. These demographic fields of knowledge construct the population as manageable through statistical analysis, as well as through interventions aimed at influencing large scale demographic indicators such as life expectancy and rates of disease (Foucault, 2004a). Through the enactment of administrative and managerial strategies, biopolitics regulates the population, intervening in these demographic indicators as a means through which to maximize well-being (Foucault, 2004a). For instance, as indicated above, both Weir (2006) and Moore (2013) point to the advent of infant mortality rates as a key factor that allowed for the construction of maternal bodies as sites through which the health of the population could be managed.

Given the importance of health indicators, including infant and maternal mortality rates, within the contemporary development sector, it too can be understood as a site of biopolitical governance, wherein interventions seek to maximize health and well-being by producing changes these demographic indicators (Casper and Simmons, 2014). Indeed, critical scholarship within the field of development studies has increasingly used a biopolitical lens to analyze the development sector's growing preoccupation with regulating bodies and managing population health. (Harcourt, 2009; Pigg and Adams, 2005; Mezzadra, Reid and Samaddar, 2013). For instance, there has been considerable scholarship on the biopolitics of HIV/AIDS programs, including the ways in which individuals are expected to regulate their sexual practices in order to control the spread of the disease both nationally and globally (Burchardt, 2013; Dilger, 2012; Elbe, 2005). Scholars have also interrogated the biopolitical management of women who work in the sex industry, again, largely with the aim of minimizing the spread of HIV/AIDS to the 'population at large' (Berman, 2010; Kelly, 2011; Scott, 2011). While these studies often examine national contexts, they also demonstrate how biopolitics increasingly operates at the global scale.

Although Foucault originally developed his theory of biopower in relation to European nation-states, scholars have extended his framework in order to interrogate how life is

governed at the level of the global (Bashford, 2006). Bashford (2006) traces the emergence of a global biopolitics to the early twentieth century, and the establishment of international institutions such as the League of Nations' Health Organization. Bashford argues that during this era, world health was conceptualized not only in terms of the 'international', that is, in terms of contagions that could spread across borders and between national populations, but in terms of a world population that could be managed on a global scale. Thus, global biopolitics can be thought of as a form of power that not only reaches across borders to intercede in the health of 'other' populations, but also as a form of power taking as its object a specifically global human population.

3.1.3 The Biopolitics of Reproduction and Maternal Health within Global Development

Within critical development studies, a growing body of scholarship has used the theoretical lens of biopower to elucidate the development sector's preoccupation with reproduction. This scholarship situates the maternal body as a key site of biopolitical governance, targeted primarily through family planning and maternal health programs. For example, Takeshita examines the biopolitics of birth control technologies, explicitly identifying family planning interventions as a means by which 'developing' world populations have been managed through the disciplining of individual women's reproduction. Specifically, through IUD insertions, both voluntary and coercive, the eugenic project of limiting 'third world' populations was pursued (Takeshita, 2012). Harcourt, similarly, has argued that the 1994 Cairo Programme of action operated as a form of biopolitical management that regulated women's reproduction through the deployment of family planning interventions aimed at decreasing the size of developing world populations, and through maternal and child health interventions that sought to increase the health of these populations (2009). Ethnographic work on the implementation of family planning programs in Indonesia (Newland, 2001; Hunter, 1996) and Brazil (de Zordo, 2012) has also highlighted how these programs target individual reproductive practices and fertility in the name of national development projects aimed at improving 'development' by decreasing national fertility rates. These aims were informed by the association of small family sizes with 'modernity',

as well as with the Malthusian informed ‘demographic transition theory’, as outlined in my literature review.

In her work on the biopolitics of development, Harcourt highlights how contemporary maternal health programs generate “modern reproductive bodies’ that are “produced, managed, and administered through both micro and macro level strategies of domination” (2009, p. 60). She argues that these programs seek to measure the health of the ‘social body’ by measuring maternal mortality rates, as well as other statistical, population level indicators that are taken as demonstrative of the health of the nation. These indicators reveal what is considered ‘healthy’ or of quality within the population, giving insight into what traits are deemed desirable and should be promoted, and which traits should be discouraged. They also configure reproduction in relation to a set of measurements that can then become the target of program interventions, resulting in the emergence of maternal health as “a key area to be supervised, managed, and administered through goals and indicators agreed to by technical experts” (Harcourt, 2009, p. 61). In a similar vein, Casper and Simmons examine the use of infant mortality rates in the Millennium Development goals, which situate infant mortality as a way of measuring the wellbeing of the nation (2014). They argue that the focus on infant mortality as a measurement is used to justify development interventions that target women’s bodies, without necessarily prioritizing women’s need and interest. Central to this process is how infant mortality as a statistical indicator is used to identify populations who are ‘at risk’ and hence in need of intervention and management. This work therefore highlights how population health indicators work as a governing discourse that justifies interventions in maternal health to promote the well-being of the population, as well as interventions that specifically target communities deemed ‘at-risk’.

3.1.4 Managing Vulnerable Populations Through Risk

While biopolitics endeavours to maximize the health of the ‘population’ at large, as noted above, segments of the population may be targeted and governed differently, in particular if they are deemed to pose a risk to the population at large. Racialized and colonized populations have at times been subject to specific biopolitical interventions, including family planning interventions, that have been understood not only as promoting their well-

being, but also as mitigating the threat that they pose to the dominant group. In addition, populations who are deemed at especially 'at risk' may also be uniquely targeted for regulation. As discussed in my literature review, the identification of particular groups as 'at risk' during pregnancy and childbirth has been used to impose a medicalized framework of reproduction and to justify state intervention into the birthing practices of marginalized communities. This process is exemplified by the removal of Indigenous women from Northern communities in Canada, based on the construction of these populations as particularly 'at risk' through record keeping practices engaged in by the Canadian government (Kaufert and O'Neil, 1990). This example illustrates how risk discourse operates as a politicized process rather than simply as an objective assessment; in this case, devaluing Indigenous birthing practices while justifying the colonial management of Indigenous reproduction. In addition to rationalizing the management of birthing practices, the identification of marginalized populations as 'at risk' can also be understood through the lens of eugenics and reproductive stratification, the latter referring to the implicit ways in which the reproduction of certain communities is discursively and materially encouraged, while that of others is discouraged (Ginsburg and Rapp, 1995). In the Canadian context, Tait (2008) has critiqued how policy and service interventions aimed at reducing fetal alcohol syndrome (now known as fetal alcohol spectrum disorder or FASD) in Canadian Indigenous communities have relied on and reiterated discourses that position Indigenous women as irrational and irresponsible reproductive subjects. Furthermore, she argues that resistance to women-centered approaches and a focus instead on protecting the fetus as contributed to an overarching emphasis on managing FASD by promoting contraception use among Indigenous women. This emphasis relies upon the understanding that Indigenous women are almost universally affected by, and vulnerable to, passing on FASD to their children. This construction of FASD aligns with medicalized approaches to reproductive health and fails to consider and engage with social determinants of Indigenous health, such as colonialism and economic poverty. Rather, high rates of FASD are used to identify Indigenous women as a population 'at risk' and hence, as in need of reproductive governance.

3.1.5 Neoliberal Governmentality

The concept of governmentality is central to Foucault's theory of biopower, and denotes "the way in which one conducts the conduct of men" (Foucault, 2004b, p. 184). Governmentality encompasses "the ensemble formed by institutions, procedures, analyses and reflection, the calculations and tactics that allow the exercise of this very specific albeit complex form of power" (Foucault, 1991, p. 102). Understood in this sense, governance[3] encompasses the variety of technologies used to govern our lives and includes a consideration of how power operates through self-regulation within neoliberal societies. Within neoliberal contexts, the role of the state is understood primarily as ensuring citizens' freedom rather than administering their lives, thus limiting the (legitimate) use of repressive force (Peterson and Lupton, 1996). In this context, governmentality operates primarily through technologies of power that rely on the individual to activate their own agency to regulate themselves in accordance with established and accepted norms, as well as economic and political imperatives (Peterson and Lupton, 1996; Li, 2007). As rational actors, neoliberal subjects are expected to act in their own self-interest, thus governance can be achieved through the construction of particular choices and behaviours as necessarily in the individual's self-interest, while others are constructed as contra this self-interest, and hence, as irrational. Significantly, within this framework, those who fail to comply to such norms are understood as being unwilling to, or incapable of self-governance, and are opened up to the sovereign power of the state (Li, 2007; Weir, 2006). Such configuration contributes to the justification of more direct, and even coercive management of women's reproduction, such as those conducted within the population control movements of the mid-20th century (Takeshita, 2012; Weir, 2006). Therefore, although my research focuses on neoliberal 'governance at a distance', it was also conducted with an awareness that maternal bodies are targeted through various modes of power/knowledge. Following Weir, I recognize that biopower operates not only through neoliberal forms of governance, but also through the continued deployment of the

[3]Although Foucault used the world 'government' to refer to this concept, some scholars use governance to indicate the same concept. I have chosen to use the term governance in this thesis to avoid confusion during discussions of specific governments, such as the Canadian government.

sovereign power of the state (2006). These techniques work in collusion to exercise power over life.

By shaping the way we speak and think about the world, discourse operates as a key technology of governance. Polzer and Power define discourse as "a form of social action encompassing speech, written text, as well as practices through which people organize, use and circulate knowledge and texts" (2016, p. 14). Since knowledge is produced and circulated through discourse, discourse therefore shapes how we are able to understand the world, our place in it, and how we should act in response to it. As such, discourse "limits what is sayable and provides certain conceptualizations of an object while excluding others" (Ziai, 2016, 20). Furthermore, Ziai argues that:

> By offering certain subject positions within discourse and portraying certain ways of behaviour as just and legitimate, [discursive power] can also influence fields of action and even preferences for action (2016, p. 19).

By shaping our understandings of reality, discourse plays a key role in constructing particular decisions and behaviours as possible, legitimate, and/or desirable, while others are constructed as untenable and/or undesirable. Through this process, discourse contributes to the construction and perpetuation of particular norms against which subjects are expected to comply. Within the spheres of both development and health, expert knowledge plays a key role in establishing and circulating discourse, and hence norms, including by defining what constitutes health and development, and what behaviours are most likely to bring them about (Ziai, 2016; Peterson and Lupton, 1996). As a technology of governance, discourse plays a crucial role in establishing which decisions and actions are 'rational', and hence, will be pursued by rational, self-interested actors. Although these discourses may be challenged, they often circulate as common knowledge, influencing both how a subject will act, and how their actions will be perceived by others. In this sense, discourse governs action, while also creating the parameters by which certain subjects are identified as irrational, and in need for more direct forms of governance (Polzer and Power, 2016).

Although repressive power may be enacted against subjects who are seen as unwilling or unable to exercise self-regulation, Li (2007) argues that global development institutions and organizations generally do not have access to the sovereign power of the state, and must therefore rely on dispersed and self-activated means of governance. She argues that contemporary development institutions must achieve their goals not through overtly coercive measures, but by "educating the desires and reforming the practices of the target population" (Li, 2007, p. 16). This form of governance in turn allows for the naturalization of development goals, which are understood as universal and innate desires of entire populations rather than socially constructed goals promoted by development institutions and supported by individual states (Li, 2007). The 'education of desire' is a crucial element of neoliberal development projects that seek to intervene in the lives of 'developing world' populations while maintaining their freedom.

The process of governing developing world populations can be seen in the development sector's turn towards 'human' approaches to development which emphasize improving human capabilities and empowering individuals. As discussed in my literature review, these approaches focus on improving individuals' resilience and capacity for action in order to help them survive and, ultimately, escape a life of poverty while also contributing to the overall project of economic and/or social development (Batliwala, 2010; Shani, 2012). In addition to individualizing and depoliticizing issues of poverty and underdevelopment, human development projects also include the establishment of new norms, 'building capacity' in part by encouraging subjects to engage in particular choices and actions. Global development projects that focus on empowerment and human capacity building can be understood as a form of governance that seeks to manage the population by 'educating the desire' of developing world subjects in order to (re)construct them into rational, self-interested actors who will engage in particular economic, social, health and even reproductive behaviours (Li, 2007; Shani, 2012). Significantly, this configuration relies on and reiterates understandings of those in the developing world as not (yet) rational, and not (yet) capable of self-governance (Li, 2007; Shani, 2012). Reminiscent of the civilizing mission, developing world populations are constructed as in need of intervention from those who better understand what kinds of behaviours individuals can and should engage in to promote their own well-being, and by extension, economic and social

development. Although empowerment as a concept originally sought to recognize the power held by even the most marginalized, as it has been taken up in neoliberal development frameworks, it instead reiterates the power disparity between those in need of empowerment ('developing' world subjects) and those who are capable of empowering them ('developed' world subjects) (Batliwala, 2010).

Although human development approaches can represent attempts to push back against development approaches that focus on macroeconomic factors at the expense of lived experience, they can also represent sites through which development is configured as a project of governance and, in turn, made the responsibility of 'under-developed' populations, who are constructed as able to overcome poverty and social exclusion through engagement in the 'right' kinds of behaviour. As such, governmentality is a key component of the individualization, depoliticization and technocratization of development. In conducting my analysis, I have taken particular note of how maternal health interventions target individual behaviours. While I recognize that such interventions may indeed be useful in helping to improve health, my analysis is concerned with how these interventions might locate the problem of maternal health in the actions of individuals, and how this individualization may contribute both to the depoliticization of development, and the responsibilization of 'developing' world women.

3.1.6 Governing Maternal Bodies through Development Discourse and Policy

The theoretical frameworks of biopolitics and neoliberal governmentality helps us to understand how development discourse, including human development discourse, acts as a site of neoliberal governance and population management. The individual focused, technocratic approaches to development that I outline in my literature review can be understood through these theoretical lenses not only as means by which development is depoliticized, but also as means by which developing world populations are managed and responsibilized. Frameworks of gender equality as 'smart economics' (Chant, 2012) can in turn be understood as situation gender empowerment as a means by which women can become rational, self-regulating actors who will govern themselves in accordance with dominant (economic) norms. This presumed self-regulation is extended to reproductive

decision making, due to the association between gender equality and smaller family sizes, and the assumption that smaller family sizes promote both individual prosperity and national development (Chant, 2012; Switzer, 2013). As Newland's (2001) Indonesian-based research on family planning services demonstrates, these presumed connections between gender equality, economic growth, and lower fertility, can also function as a reproductive norm against which women are expected to self-regulate. Her work found that family planning programs actively advocated for smaller family sizes by associating them with modernity and economic prosperity, both for individual households, and for the nation as a whole. As such, family planning initiatives actively promote the smaller family sizes as a reproductive norm that women are expected to comply with through regulation of their own fertility. Newland's work highlights how family planning programs participate in neoliberal governance, managing women's reproduction in the absence of practices deemed coercive.

As addressed in my literature review, some population control and family planning initiatives have relied on, repressive, sovereign power to govern reproductive behaviour. Examples include the enforcement of China's one-child policy during the 20th century (Greenhalgh and Winckler, 2005), and the enactment of forced sterilization during India's emergency period (Williams, 2014). In these examples, the sovereign power of the state was enacted to discipline maternal bodies in the name of population control. In Canada, sovereign power has been used to govern reproduction through the forced sterilization of Indigenous women (Stote, 2015), and through the operation of eugenic boards in Alberta and British Columbia (Dyck, 2013). Both interventions relied on the construction of targeted groups as in need of direct reproductive governance, enacted through sovereign rule, due to their inability to govern themselves in accordance with accepted reproductive norms. These constructions were used to justify direct forms of intervention by provincial governments and the medical sector, exemplifying how sovereign power is wielded against 'illiberal' subjects who fail to self-regulate according to reproductive norms (Weir 2006).

Historically, the relationship between 'development' and population control has relied on the power of national regimes who could mobilize the support of repressive sovereign power to enact direct/coercive 'family planning' measures, at times with the support of

funding and expertise provided by western states (Connelly, 2008). In the contemporary era, the use of coercive measures to control fertility has been largely rejected by the development sector, as indicated by the 1994 Cairo Programme of Action and the adoption of international norms surrounding reproductive rights. Significantly, although the Cairo Programme of Action stipulates that family planning programs must refrain from employing coercive measures, debates continue regarding what constitutes coercion (for instance, whether economic incentives offered to the economically impoverished are considered coercive), a question that is further complicated by understandings of neoliberal governmentality. From the perspective of governmentality, family planning measures, even those that are explicitly non-coercive, can be understood as sites of reproductive governance whereby certain actions are encouraged.

Scholarship that examines discourses on population control and maternal health as sites of governance and biopower has often considered the construction and promotion of norms that are positioned as promoting individual health and development. For instance, Allen's (2002) work on maternal health programming in West Tanzanian villages examines how norms concerning maternal health and its associated risks shape maternal actions, experiences and outcomes during childbirth. Linking contemporary development programs with imperial projects that targeted racialized mothers as part of the colonial 'civilizing mission', Allen (2002) examines how these programs deploy particular norms of motherhood and health to govern maternal bodies in the name of improving the health of the population. Similarly, Hunter's (1996) work on the effects of the Indonesian Applied Family Welfare Program on a village in Northeast Lombok highlights how maternal and child health programming acted as a site of biopower through which the Indonesian state sought to manage the welfare and productivity of its population through the disciplining of women's bodies. Her work demonstrates how participation in maternal health programs was incorporated into cultural ideas of responsible motherhood, and tied conceptualizations of women's citizenship to their ability to fulfil their roles as wives and mothers (Hunter, 1996). Since participation in these programs was voluntary, Hunter argues that women's participation relied on self-regulation in accordance with the norms being circulated linking maternal health to both modernity and good motherhood.

Drawing on the work of Allen and Hunter, my research considers maternal health programs, including family planning initiatives, as sites of biopower and of neoliberal governance. In conducting my analysis I have been attuned to how these programs draw on and reiterate particular norms of motherhood, health and reproduction, and how these norms act to govern women's reproductive choices. In particular, these theories inform my understanding that simply because a program is voluntary or free from coercion, it does not mean that it is devoid of power relations, or of governance.

3.1.7 Risk, Healthism and the Duty to be Well

Over the past three decades, a significant body of research has been produced outlining how risk operates in neoliberal contexts, both as a framework for understanding social problems, and as a technology of governance (Polzer and Power, 2016; Peterson and Lupton, 1996; Hannah-Moffat and O'Malley 2007; Saukko and Reed, 2010). Although theoretical understandings of risk vary, scholars of governmentality have demonstrated how risk discourse constitutes a particular way of understanding threats (for instance to health, to security), and shapes our ability to respond and protect against these them (Hannah-Moffat and O'Malley, 2003). While as a tool of governance, risk can operate differently depending on context, neoliberal discourses of risk reinforce the individualization of responsibility (for health, for development), configuring individual subjects as able to protect themselves against harm through rational and responsible risk management (Polzer and Power, 2016). As Ruhl (1999) outlines, the neoliberal model of risk differs from the social insurance model, as in the former, "collective responsibility is replaced by [a model] in which individuals are ultimately apportioned responsibility, even for things (crime, health, job training) which are social in their scope" (Ruhl, 1999, p. 102). The neoliberal model of risk places responsibility on the individual, who is expected to manage risk through responsible and healthy behaviour.

The individualized model of risk draws on and reinforces the configuration of the contemporary neoliberal subject as a 'rational' individual who pursues their own self-interest by making decisions that are understood as bringing the highest level of benefit at the lowest cost, including, by minimizing risk (Peterson and Lupton, 1996). Thus, within the field of critical health studies, governmentality is useful in analyzing how public health

regimes compel citizens to achieve a healthy body through compliance with normative 'healthy', risk-minimizing behaviour (Peterson and Lupton, 1996; Polzer and Power, 2016).

The individualization of risk is linked to the overall individualization of responsibility for health, conceptualized by Crawford through his theory of healthism. Crawford defines healthism as:

> The preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help (1980, p. 368).

Healthism names the individualization of responsibility for health, and the configuration of health and well-being as the outcomes of individual decision making. Significantly, Crawford outlines how healthism operates as a form of medicalization, wherein everyday behaviours such as diet, exercise, employment and even thought processes are understood through the lens of health, and specifically the health outcomes they are expected to produce. Although there is acknowledgement within healthism that health is influenced by external, environmental factors, responsibility is placed on the individual to manage these risks by modifying their behaviour. While healthism may operate as a means by which individuals can feel like they are in control of their own health, particularly in contexts where social support for health may be lacking, ultimately healthism distracts from the need for structural change by situating the individual as capable of ensuring health by responding rationally to external risks. In this way, healthism resonates and aligns with contemporary discourses of empowerment, discussed in my literature review, responsibilizing individuals for the outcomes of their choices rather than examining the contexts in which these choices are made.

Significantly, the rise of healthism aligns with the emergent construction of health as both a personal responsibility and as a civic 'duty to be well' (Greco, 1993). As Peterson and Lupton (1996) note, the transition from welfare interventionism to neoliberalism has seen discourses of rights to health increasingly paired with discourses of duty to be well, a

transition that has also noted within the Canadian context (Polzer and Power, 2016). In neoliberal contexts, subjects are not only expected to maximize health in the name of their own self-interest, but are also compelled to pursue good health through the construction of the healthy body as a sign of both moral goodness and good citizenship (Greco, 1993). Because of understandings that "a useful citizen engages in work, participates in social relationships and reproduces", individuals are expected to keep themselves healthy enough to engage in these activities (Peterson and Lupton, 1996, p. 61). While citizens are entitled to health services, they are also obligated, as good citizens, to remain healthy and by extension 'productive' members of society.

3.1.8 Maternal Healthism and Responsibilization Through Risk

In conducting this research, I have drawn on frameworks of risk, governance and healthism in order to understand how these technologies of governance rely on and align with expectations of maternity, including of maternal sacrifice. Despite relying on the seemingly 'neutral' figure of the rational, self-interested individual, healthism and the discourses of risk through which it is deployed, operate in ways that are highly gendered (Hannah-Moffat and O'Malley, 2007). The gendered nature of risk can in part be understood by conceptualizing risk as tied not only to medical knowledge regimes, but to social roles and expectations, including those surrounding motherhood (Johnson, 2016). Although the gendered effects of risk can be observed in various contexts, for the purpose of this project I am most interested in how gendered discourses of risk and health have manifested in relation to pregnancy, childbirth and motherhood.

As previously discussed, given the positioning of women as responsible for the biological and social reproduction of the population, pregnancy and childbirth have emerged as key sites of governance. In addition to being governed through norms regarding family size, women are also governed through discourses of health, risk and pregnancy, which shape what is understood as acceptable and responsible behaviour for women who are or might become pregnant. When pregnant, women are expected to become exceptionally risk-adverse, and to take significant measures to protect their own health, and by extension, the health of the fetus (Lupton, 2012; Ruhl, 1999). This expectation relies on the construction of pregnant women as responsible for fetal health, which itself relies on the neoliberal

model of individualized risk outlined above (Ruhl, 1999). As discussed, within individualized models of risk, risk is understood as a set of dangers that can be guarded against through responsible decision making. This framework allows for the configuration of undesirable fetal outcomes, including stillbirth and infant death, as the outcome of poor maternal decisions (Ruhl, 1999). By this logic, poor fetal outcomes can be taken as evidence of a woman's inability or unwillingness to self-govern, justifying more direct means of reproductive governance, including criminalization (Weir, 2006). Notably, certain women, such as Black and Indigenous women, are pre-configured as illiberal subjects, incapable of self-regulation and have been subject to increased surveillance and reproductive governance even in the absence of poor birth outcomes (Roberts, 1997; Weir, 2006).

The model of risk that responsibilizes pregnant women for the health of their fetus/newborn further extend to gendered expectations of parenting that situate mothers as responsible for the health of current, as well as future children (Lowe, 2016; Ogle, Tyner and Schofield-Tomschin, 2011). Within this context, pregnant women and mothers are compelled to maintain their own good health as well as the health of their children in order to be understood as 'good mothers' as well as good (reproductive) citizens. This expectation is what I refer to as 'maternal healthism'. Maternal healthism is significant in that it problematizes neoliberal ideals of reproductive freedom and choice by demonstrating how pregnant women's choices are governed through discourses of pre-natal risk and health, perpetuated through expert medical knowledge as well as dominant expectations of maternal sacrifice and 'responsible' reproductive decision making.

The responsibilization of pregnant women through maternal healthism relies on gendered expectations of maternal sacrifice. As Ruhl observes, a woman who is seen as failing to protect her fetus by failing to adhere to expert medical advice:

> is made to feel both irresponsible (how could she be so cavalier about her future baby's health?) and guilty (she is placing her own desire ahead of her baby's well-being in clear contravention of our model of self-sacrifice) (1999, p. 104).

Thus, for pregnant women, maternal healthism encompasses not only a duty to protect the health of oneself and one's fetus, but a responsibility to protect the health of the fetus even at the expense of one's own well-being. This expectation complicates the seemingly gender-neutral understanding of individuals as self-interested, risk-minimizing actors, as women are expected to act in contravention of their own interest in order to ensure the health of the 'other' for whom she is responsible. This understanding of maternal healthism as moral obligation to one's future child, and as a duty of reproductive citizenship can help us understand how women are uniquely governed through discourses of risk as they intersect with discourses of 'good motherhood' and 'maternal sacrifice' (Lowe, 2016; Polzer and Power, 2016).

As addressed in my literature review, expectations of maternal altruism and sacrifice have been central to the construction of women in the developing world as 'good' investments and as good women, and underpin the framework of gender equality as 'smart economics'. This discourse is strengthened by the positioning of women in the developing world as particularly aligned with 'traditional' femininity, including expectations of maternal altruism and sacrifice. In conducting my analysis, I have drawn on the theoretical lenses of risk, governance and healthism to interrogate how these technologies of governance intersect with expectations of maternal altruism and sacrifice with specific reference to maternal and child health.

3.1.9 Summary of Biopolitics and Neoliberal Governmentality

The existing body of critical scholarship on maternal health as a site of biopolitics and neoliberal governance demonstrates that women's bodies are targeted as sites through which population level change is pursued. In conducting my own analysis, I situate maternal health and family planning programs as sites of population management that rely on and re-entrench the governing and instrumentalization of women's reproduction within the 'developing' world. As such, my analysis is informed by recognition that maternal bodies have been situated at the nexus of the individual and the population (Moore, 2013). By approaching my research from this biopolitical perspective, I am both drawing on and contributing to this body of research, examining how maternal bodies are regulated through Canadian maternal health programs, as well as the implication of this regulation in terms

of development programming to serve as a site of reproductive justice. In doing so, I am also putting the theoretical concept of biopolitics into conversation with gendered understandings of risk as a form of governance. Using concepts of governmentality, risk, and healthism to understand Canada's maternal health programming as a site through which women's health and reproduction are governed, I am interested not only in examining how reproductive norms are deployed through these programs but how they might serve to undermine, or promote reproductive justice.

3.2 Reproductive Justice

In addition to theories of biopower and neoliberal governmentality, this research is also guided by the theory of reproductive justice. Reproductive justice is a political and analytic framework that, like biopolitics, moves beyond dominant narratives of individual reproductive 'choice' by calling for more careful consideration of how interconnected systems of power shape the political, social and environmental contexts in which reproductive decisions are (or are not) made (Ross and Solinger, 2017). Reproductive justice specifically resists dominant 'pro-choice' frameworks as the primary lens through which reproductive oppression has been analyzed and resisted within feminist movements and scholarship, both because of how this lens has been used to center abortion access as the central factor affecting reproductive lives, as well as its perpetuation of neoliberal frameworks of individualized choice that neglect the structural constraints that shape these choices both on individual and community levels (Ross and Solinger, 2017). This critical stance towards individualized choice-based frameworks is an important point of connection between the reproductive justice framework and the theories of biopolitics and governmentality that I have outlined above. In this section, I outline the key tenets of reproductive justice, as well as their relevance to maternal health, and to global development. I also delineate how I have deployed this framework alongside my theoretical commitment to biopower in order to inform and guide my research project.

3.2.1 Beyond 'Pro-Choice' Resistance

In their comprehensive outline of reproductive justice theory and activism, Ross and Solinger (2017) define the central tenet of reproductive justice thusly: "all fertile persons

and persons who reproduce and become parents require a safe and dignified context for those most fundamental human experience." (p. 9). In seeking to fulfill this tenet, reproductive justice situates reproductive justice within the broader framework of social justice, interrogating the economic, social, and political context in which reproduction is situated. Furthermore, reproductive justice rests on three primary principles "1) the right *not* to have a child; 2) the right to *have* a child and 3) the right to *parent* children in safe and healthy environments" (Ross and Solinger, 2017, p. 9). In addition to these three central principles, the reproductive justice framework "demands sexual autonomy and gender freedom or every human being" (Ross and Solinger, 2017, p. 9). By adhering to these overarching principles, reproductive justice offers a less binaric, more integrated framework for addressing reproductive rights and oppression than is offered by the dominant 'pro-choice' approach.

As both an analytic framework and activist movement, reproductive justice emerged out of women of colour's resistance to reproductive oppression in their lives and their communities. Although its roots go back much further, reproductive justice was first explicitly articulated in 1993 as a set of guiding principles for opposing reproductive injustice, and for problematizing the dominant 'pro-choice' framework through which these oppressions were primarily being addressed. As such, reproductive justice provides both a critique and an alternative to dominant reproductive choice frameworks, and to the reproductive rights activism that had become synonymous with the 'pro-choice' movement (Ross and Solinger, 2017). Aligning with the problematization of individual 'choice' provided by critical health theorists reviewed in the previous section, the reproductive justice movement critiques the 'pro-choice' framework as adopting and perpetuating an individualized approach to reproductive rights that neglects the intersecting structural factors that shape and limit choice beyond the realm of legal access. Furthermore, this individualized and decontextualized approach to reproductive rights has allowed mainstream movements to overlook how different forms of reproductive regulation have been used to target different communities, not only in distinct ways, but often for distinct purposes. (Ross and Solinger, 2017). For instance, while white women continue to see our reproduction governed in ways that promote and even force the reproduction of a white population, Black women in the American context have increasingly seen their

reproduction governed in ways that prevent and criminalize reproduction (Ross and Solinger, 2017). This relates to the way in which biopolitics has been theorized as promoting the well-being and survival of certain segments of the population, while restricting others. Within the American context, direct reproductive restrictions have included the surveillance and criminalization of pregnant women who engage in 'risky' or 'harmful' behaviour; the moral panic associated with racialized, drug using mothers and the forced sterilization (permanent and temporary) of women on welfare (Roberts, 1997). More indirectly, Black women's reproduction is shaped through the cultural devaluation of Black motherhood through stereotypes such as the 'welfare queen', and through economic barriers that prevent women from accessing maternal healthcare and the resources needed to raise a child (Roberts, 1997).

Intersectional approaches to reproductive oppression and rights are necessary to elucidate the ways in which various manifestations of reproductive control and coercion perpetuate and reinforce white supremacy and class difference. By adopting an intersectional approach and centering the experiences of racialized and otherwise marginalized women, the reproductive justice framework explicitly engages with how "the control and exploitation of women and girls through our bodies, sexuality and reproduction is a strategic pathway to regulating entire populations" (ACRJ, p. 2). The reproductive justice framework resonates with theoretical work on biopolitics that interrogates how the regulation of women's bodies acts as site through which the population is managed, including through the targeting of marginalized women's reproduction.

As a theoretical framework and an activist movement, reproductive justice challenges the individualized and often de-politicized framework of the 'pro-choice' movement. Not only is this individualized framework understood as inadequate for addressing the ways in which entire communities are targeted for reproductive governance, it is also seen as failing to account for the various material, social and cultural constraints that affect what choices are available to marginalized women. Whereas the pro-choice framework has historically focused on legal, and to a certain extent economic, access to reproductive services such as abortion, reproductive justice demands a more explicit engagement with the structural constraints that limit women's reproductive health options. In this sense, the reproductive

justice framework resonates with the analysis of neoliberal governance through self-regulation. Both theoretical frameworks necessitate an examination of how social norms and ideals work to shape which 'choices' are deemed appropriate, rational and possible. A biopolitical perspective helps clarify how norms are established through expert knowledge, and how these norms encourage and restrict specific reproductive behaviour. Significantly, reproductive norms are not constructed as universal, but are instead used to govern women differently. Reproductive justice thus necessitates consideration of how norms and expectations rely on dominant understandings of intersecting social categories such as race and class in order to provide a more complete and nuanced understanding of how reproductive choices are guided and constrained.

3.2.2 A Critical Perspectives on Reproductive Technologies

In problematizing and seeking to move beyond the 'choice' framework, the reproductive justice framework looks beyond what options are legally available to consider the broad range of structural factors that act as barriers to women's reproductive autonomy. Central to this perspective is consideration of how reproductive technologies such as contraception, abortion and sterilization, which are commonly understood as expanding women's reproductive choices, have been deployed to restrict and the reproductive autonomy of particular individuals and by extensions, communities (Ross and Solinger, 2017; Roberts, 1997; Higgins, 2006). This critique aligns with work done by feminist scholars on the biopolitics of reproduction, including Takeshita's (2012) aforementioned analysis of how the IUD was specifically deployed as a means by which to control 'Third World' women's reproduction. This critique also resonates with critiques of medicalization which have demonstrated how medical authority has been used to justify colonial control over Indigenous reproduction (Allen, 2002). Together, these critical perspectives highlight how discourses of choice and access obscure the ways in which various technologies draw on and reinforce reproductive stratification; that is, the valuing of some women's reproduction over the reproduction of others, and the material effects of this valuation on the reproductive capacity of individuals and communities (Roberts, 2009). Such insights have informed my own analysis, which considers the unique ways in which women in the

'developing' world may experience reproductive governance, as well as the consequences of this governance for their communities.

In problematizing and seeking to move beyond the pro-choice framework, reproductive justice activists and scholars have also challenged how the mainstream reproductive rights movement that has configured reproductive choice almost exclusively as the right to choose abortion (Ross and Solinger, 2017; Smith, 2017). By centering the historical and contemporary experiences of marginalized women, reproductive justice advocates argue that access to abortion is of particular concern to upper and middle-class white, able bodied women whose reproduction has been encouraged as part of the project of white nation building (Ross and Solinger, 2017). For women whose reproduction has and continues to be marginalized and discouraged, the right to have children and to parent one's children is just as important as the right not to have children (Ross and Solinger, 2017; Roberts, 1997). Although reproductive justice as a framework includes abortion access as a key component of reproductive justice it is configured as necessary but insufficient for ensuring reproductive justice for all. Reproductive justice makes space for inclusion of a multitude of questions, including (but certainly not limited to) issues of coerced sterilization; policies linking social assistance to family size; foster care systems and access to maternal health care. Ross and Solinger argue that, by taking an intersectional and interdisciplinary approach, reproductive justice "connects the dots between many social justice issues that seem unrelated to reproductive rights and to traditional views of reproductive politics" (Ross and Solinger, 2017, p. 169). In doing so, the framework allows for consideration of how various, interconnected forms of oppression intersect in the reproductive management of particular populations, calling on activists and advocates broaden our view of reproductive rights beyond the continued focus on abortion access.

3.2.3 Reproductive Justice and Maternal Health

Reproductive health, including maternal health, is an integral component of the reproductive justice framework, which demands that people who reproduce be able to do in safety and dignity (Ross and Solinger, 2017). Health disparities and inequities are therefore of key concern to the reproductive justice movement, as are the specific ways in which individual women's reproductive experiences and choices are affected by their

differential access to healthcare services. Yet as with abortion, a reproductive justice perspective situates reproductive and maternal health as necessary but inadequate for achieving reproductive justice. Rather, reproductive justice highlights how situating the problem of poor health solely in terms of lack of access to services, or in a lack of adequate knowledge and motivation to engage in healthcare practices, obscures the social determinant of health, including of reproductive health (ACRJ, 2005). By framing issues of reproductive health as an issue of access to healthcare, access-focused frameworks address the outcome of poor health, rather than focusing on the factors that produce health problems. The reproductive justice framework challenges mainstream reproductive health strategies that focus almost exclusively on increasing access to, and education regarding healthcare services, explicitly centering social and material factors such as environmental damage and racism, that affect both reproductive health and reproductive autonomy (ACRJ, 2005).

Health frameworks that focus exclusively on increasing access to healthcare service also often fail to acknowledge and unpack how the medical establishment itself has and continues to function as a site of reproductive governance. As Ross and Solinger argue, women often experience the formal medical establishment as sexist and patronizing, both due to the (often unconscious) sexism of medical professionals, as well as the ways in which health care access is determined by patriarchal "political calculations regarding what medical services our society – and women in particular – need and deserve" (2017). It is important to consider what exactly constitutes 'healthcare', as well as how it is administered and what it includes.

In addition to acting as a site of sexism, the medical establishment can also act as a site of racism and classism, through which the reproductive stratification outlined above is enacted. Indeed, the development of gynecology as a body of knowledge and medical practices is predicated on coercive and often violent experimentation carried out on black, enslaved women during the mid-nineteenth century (Roberts, 1997). More recently, during the 1990s, the medical discourse surrounding the 'crack baby' epidemic led to increased surveillance of Black mothers within the United States by medical staff, particularly within hospitals where these women went to seek care (Roberts). This surveillance had a profound

effect on the reproductive experiences of Black women, who were targeted for testing and interference at much higher rates than their white counterparts (Roberts). As these examples illustrate, ensuring access to healthcare services is an inadequate means of ensuring reproductive health or right, particularly in contexts where healthcare providers may themselves be implicated in perpetuating reproductive injustice. Reproductive justice includes advocacy for increased access to quality healthcare for all, while also assuming a critical stance towards the medical establishment as a potential site of reproductive stratification and oppression (Ross and Solinger, 2017). Read in conjunction with scholarship outlined above on the role of medical knowledge and practice in governing reproduction, this framework highlights and reaffirms the need not only to promote access to medical services, but to interrogate how, why, and to what end such access is promoted.

3.2.4 Reproductive Justice and Global Development

Although the reproductive justice movement was developed primarily within the context of the United States, its insights and implications are of considerable significance to the field of global development. As discussed in my literature review, during the 1994 International Conference on Population and Development at Cairo, women's health organizers and advocates were already drawing on insights from the burgeoning reproductive justice movement (Petcheksy, 2003). These insights informed the strong advocacy among women's health organizers for inclusion of maternal health in the articulation of reproductive rights within the resulting Cairo document. As debates continue regarding the depoliticization of maternal health, particularly as embodied in the movement from rights-based to health-based frameworks, these insights continue to resonate. Furthermore, as outlined above, reproductive justice insists on the reproductive right not only to not have children, but also to have children and to parent these children in safe and health environments. This instance provides a strong stance from which to critique population control practices, including the renewed interest in population control as a way of addressing both poverty and environmental degradation (Hartman and Barajas-Román, 2009). As a framework that examines the social and economic roots of reproductive stratification, rather than focusing only on access to particular reproductive technologies, reproductive justice provides a useful framework through which to examine the racial,

economic and gendered assumptions at work in the development sector's relationship with reproductive practices, including, but not limited to, maternal health.

3.2.5 Summary of Reproductive Justice

As with many critical research projects, I understand this dissertation as both a piece of academic scholarship, and as an inherently political work. By adopting a reproductive justice framework, I have committed to a particular analytic framework, as well as to working towards knowledge production that can enhance our ability to work towards reproductive autonomy, health and dignity for all. This framework includes an intersectional analysis that takes into account how social categories such as race and class influence reproductive experiences; a critical stance towards neoliberal discourses of individual 'choice'; and a commitment to moving beyond, and interrogating, demands for access to healthcare as the only component necessary to ensure reproductive health. In applying a reproductive justice framework to my analysis of Canada's global maternal health policy, my goal is to help create a stronger understanding of the possibilities and limitations of such policies to contribute to dismantling reproductive justice at the global level. Ultimately, it is my hope that the insights this work provides will contribute to the creation of policies and programs that will make reproductive justice a reality.

Part of a commitment to reproductive justice is a commitment to centering the lives and experiences of marginalized women. In conducting my analysis, I have considered the implications of Canadian development policy for girls and women in the Global South. This consideration has included acknowledgement of how maternal health interventions have targeted women in the Global South for reproductive governance, and what possibilities these interventions offer (if any) to promote reproductive justice. In adopting a reproductive justice approach, my analysis has been informed by a need to move beyond the promotion of choice and access, and to consider additional factors that might shape and constrain women's reproductive health and autonomy. I have utilized theories of biopolitical and governmentality to help me in this critique, examining how development interventions operate as a potential site of biopolitical governance. I have also sought to recognize how various components of reproduction are interconnected, not only with each other, but also to issues seemingly outside of the realm of reproduction. As such, although

my project focuses specifically on maternal health policy, this focus is informed by an understanding of maternal health as part of an interconnected web of issues and constraints affecting reproduction, including poverty, racism, and environmental degradation. Furthermore, the way in which reproductive justice frameworks problematize abortion-centered reproductive rights movements alongside the body of work described above that interrogates the management of bodies through reproductive technologies and practices other than abortion has helped me to broaden my own analysis of the Muskoka Initiative beyond a focus on the exclusion of funding and support for therapeutic abortion. Instead, I have viewed this exclusion as part of a broader project of reproductive management, while considering the implications of maternal health policy not only for women's ability to choose not to have children, but on their ability to exercise bodily autonomy and parental rights in alternative configurations.

Chapter 4

4 Methodology

4.1 Research Questions

Informed by the theoretical frameworks laid out in Chapter 3, my research project has been guided by the following research questions:

1) How is maternal health discursively constructed as a problem for global development? How has this construction shaped how maternal health has been governed within Canadian development programming?
2) How does this discursive construction draw on and/or reinforce dominant norms of motherhood and/or female sexuality? What reproductive norms and encouraged and/or discouraged, and how do these norms contribute to reproductive governance and stratification?
3) How does Canadian development programming situate the bodies, and the reproductive and sexual lives of women in the Global South as sites for development intervention? How do these programs act as a site of biopolitics, through which women's bodies and reproductive lives are regulated?

In conducting this research, my research questions changed slightly, with the initial focus on sexuality shifting to a more explicit focus on motherhood and reproductive practices. This shift occurred because my findings demonstrated that references to sexuality were largely absent from the texts analyzed. Although some inferences can be made through consideration of such absences, they nevertheless necessitated a shift in focus towards reproductive practices. Furthermore, as I conducted my analysis it became apparent that in addition to putting forward particular discursive constructions of women within the Global South, the texts analyzed were engaged in the discursive construction of Canada itself as a development actor. My research questions were expanded to include a consideration of how Canada is discursively constructed, and how this construction served to legitimize Canadian-funded development interventions that support particular configurations of maternal health as a development problem.

To answer my research questions, I conducted a critical discourse analysis (CDA) of two sets of texts related to the Canadian government's maternal health initiative, as it existed from 2010–2015. In this chapter, I provide an overview of CDA as a methodology, including the theoretical foundations on which my use of CDA is based. I outline my rationale for choosing CDA as my research methodology, and for my focus on texts from the Government of Canada's maternal health website and on project descriptions of programs funded under the Muskoka Initiative, as presented on the Department of Foreign Affairs, Trade and Development website. I also present my rationale for including interviews with key informants working on maternal health policy and programming and outline the process for recruiting and selecting interview participants. Finally, I provide an overview of the criteria that are used to judge the quality of CDA and how I addressed these in my research project. This section includes a description of how I used reflexivity to account for my positionality, and the role this positionality played when conducting this research.

4.2 Critical Discourse Analysis as Methodology

The purpose of CDA is to elucidate how particular discursive frames shape social practice, and to work towards disrupting dominant assumptions embedded in discourse in order to make possible new ways of thinking and acting in the world. Hence, critical discourse analysis:

> is not about exploring "the" content or meaning of the text. Rather, it is about explaining how certain things came to be said or done, and what has enabled and/or constrained what can be spoken or written in a particular context (Cheek, 2004, p. 1147).

CDA is therefore an appropriate means by which to pursue my research objectives. In adopting CDA, I have sought to identify and critically examine what is assumed and taken for granted in the discursive construction of maternal health and development within Canadian development programming under the Muskoka Initiative. Guided by my theoretical frameworks of reproductive justice and biopower, my analysis examines how

these discursive constructions position the bodies of 'developing' world women as sites of intervention, and the reproductive choices of these women as sites of governance through which the health and wellbeing of the population can be improved. My analysis further situates these discursive constructions within their broader political and economic contexts, interrogating how they align with and are bound up with larger dominant political rationalities of neoliberalism.

Although CDA may take different forms depending on the theoretical traditions being draw upon, my use of CDA is specifically derived from scholars whose approach is informed by Foucauldian theories of discourse and power. Foucauldian approaches to CDA treat language as a form of social practice and explore the processes by which discursive representations shape conceptualizations of reality with material consequences (Fairclough and Wodak, 1997, p. 258). Within this methodological approach, discourse is understood as providing "a set of possible statements about a given area, and organizes and gives structure to the manner in which a particular topic, object, process is to be talked about" (Kress, qtd in Cheek 2004 p. 1142). As a form of social practice, discourse is understood as not only representing reality, but also as playing a role in "the very construction and maintenance of that reality itself" (Cheek, 2004, p. 1144). This role in part manifests through the ways in which discourse shapes not only how we understand the world, but how we in turn understand ourselves as capable of acting in response to it. As Laliberte Rudman and Dennhardt state, "how an object, such as mental health, or a group of people, such as First Nations youth, is discursively constructed shapes the ways in which practices are constructed and enacted in relation to that phenomenon" (2015). Discourse can be understood as a phenomenon that "enables and limits how this issue is thought about, what can be done about it, and who has the authority and responsibility to act" (Dennhardt, 2013, p. 68).

By allowing for certain ways of thinking about an issue, and excluding others, discourse shapes how we respond to social problems such as maternal health, or more broadly, global development, and what the possibilities for response are for those who the discourse seeks to construct. Indeed, critical analysis of development discourse has become a significant subfield within the study of global development, and is often used to interrogate how the

project of ‘development’ is itself a discursive construction that shapes accepted responses to the variety of social problems understood as existing under its purview (Ziai, 2016). This critical lens on development stemmed largely from the work of postdevelopment scholars in the 1990s whose examination of development as a discursive construct was informed both by Foucauldian understandings of discourse as a social practice, and by the work of postcolonial scholars such as Edward Said. Their work has delineated the ways in which discourses produced by the developed world (or the West) not only perpetuate particular understandings of ‘developing’ world populations, but that these discursive understandings have functioned as the basis for rationalizing interventions in the Global South by the specific actors within the Global North (Escobar, 2011; Mohanty, 1991).

Although there are various forms of discourse analysis, critical discourse analysis (CDA) is specifically characterized by an engagement with relationships of power and a focus on issues of social justice. Rejecting the assumption of texts as neutral, CDA recognizes that ‘if language use contributes to the (re)production of social life, then logically, discourse must play a part in producing and reproducing social inequalities’ (Richardson, 2007). As a critical methodology, CDA aims to ‘contribute to understandings of how discourses create and maintain power relations and inequalities by holding particular ways of thinking and acting in place while excluding others’ (Dennhardt, 2013, p.68). CDA acts as a tool through which to critically question not only how discourse shapes particular ways of thinking and acting, but how in doing so, they may create, maintain, or possibly disrupt relations of power and inequality. A central component of this inequity is to ask who is constructed as able to speak on a topic, with what authority, and in alignment with what forms of rationality (Cheek, 2004).

As Cheek argues, discourses are never homogenous; “at any point in time, there are a number of possible discursive frames for thinking, writing, and speaking about aspects of reality” (2004, p. 1143). It is therefore important to acknowledge that discursive frames are not coherent, and that texts often contain multiple, often contradictory discourses. Cheek also states that “not all discourses are afforded equal presence, and therefore, equal authority” (2004, p. 1143). In examining development discourse, I have considered which discursive frames are privileged, and which speakers are constructed as authoritative, while

also recognizing that these frameworks and their authority are nevertheless contested. As much as possible, I have attempted to remain open to a multiplicity of discourses, and specifically to discursive constructions that may seek to trouble dominant understandings of development issues and actors.

4.2.1 Theoretically Informed Critical Discourse Analysis

It is often noted that CDA has no standardized, concrete methodological steps that are widely shared by researchers. Indeed, Cheek argues that developing CDA as a generalizable, standardized method would limit its ability to guide research that challenges discursive assumptions (2004). Rather, according to Laliberte Rudman and Dennardt, CDA requires an "approach that is creatively customized for each study to translate its theoretical underpinnings into productive analysis methods" (2015, p. 142). Without a standardized list of steps, researchers must therefore "develop an approach that makes sense in light of their particular study and establish a set of arguments to justify the particular approach they adopt" (Philips and Hardy, 2002, p. 74). My analysis has therefore been significantly informed and shaped by the theoretical frameworks mapped out in Chapter 3. As well, and in keeping with my interpretive analysis, the analytical process has been iterative, with theory shaping my initial research questions and analysis, and my analysis shaping and refining my research questions and the theoretical concepts I drew on as the analysis unfolded. For example, when I began my research, my research questions and analysis sheets were informed by my theoretical focus on biopolitics and neoliberal governance, but I was not yet engaging specifically with healthism as a technology of governance. As I conducted my analysis I identified an emphasis on maternal responsibility for health within the texts, which led me to healthism as a theoretical concept that could help me make sense of this emphasis. My adoption of healthism as a theoretical tool is indicative of the iterative nature of my analysis.

My choice of critical discourse analysis as a methodology is informed by the understanding that discourse has shaped, and continues to shape, the way in which we conceive of underdevelopment as a problem, and of development as a solution to this problem. By enabling and constraining how development is defined, development discourse enables and constrains what kinds of development practices are understood as both necessary and

possible (Cornwall, Harrison and Whitehead, 2008). Similarly, how we understand health, specifically maternal health, will enable and constrain specific ways of responding to problems of health, including health inequities. Critical discourse analysis is an appropriate means by which to elucidate how maternal health has been understood and responded to within Canadian development policy. My research examines how maternal health is discursively constructed as an object of development, and how this construction in turn relies on a particular understanding of 'development' as a sphere in which developing world populations are governed. Alongside this investigation, I have also examined how groups of people are discursively represented, specifically mothers and women in the 'developing world', but also development actors, and 'Canada' itself. Examination of how these actors are discursively constructed within development discourse is crucial to help elucidate how the range of possible actions by and in response to such groups is made intelligible.

Informed by my understanding of and commitment to reproductive justice, I have adopted critical discourse analysis as an appropriate research methodology through which to explore how power relations are (re)produced, sustained, negotiated and/or challenged within Canada's development programming, with specific reference to maternal health. My analysis has been informed by postdevelopment and postcolonial scholars who have demonstrated how the 'west'/developed world has been discursively constructed as a site of enlightenment, while the 'east'/underdeveloped world has been discursively constructed as the site of ignorance, 'savagery', and poverty (Said, 1978; Escobar, 2011). More specifically, my analysis has been informed by the work of Chandra Mohanty (1991), which has shown how the figure of the 'third world woman' has been deployed alongside the image of the 'first world feminist' as a way of maintaining a global hierarchy in which women of the Global South are positioned as vulnerable, passive and in need of salvation. My work has also been informed by the scholarship of Kalpana Wilson in examining how these discursive representations have both adapted and continued into the contemporary neoliberal era, relying on and perpetuating racialized understandings of 'underdeveloped' populations in ways that sustain the authority of the 'western' development apparatus (2012). As such, my project has investigated how the texts analyzed construct not only social problems such as maternal health, but also actors who are constructed as able to act,

or not, in order to successfully address such problems. Furthermore, I have critically examined how the texts discursively shape understandings of gender and specifically motherhood, and how these configurations function to uphold and/or disrupt gendered global power relations among differently positioned speakers/actors. Following the assertion that CDA does not produce critique for critique's sake but rather as having "very practical, concrete effects for political action", my analysis raises questions about how these discursive constructions shape material reality by acting as a form of reproductive governance with specific references to marginalized women in the Global South (Dennhardt, 2013 p. 71).

4.3 Methods

4.3.1 Constructing the Field of Analysis

In keeping with the critical underpinnings of CDA, I acknowledge that data fields are not "out there, waiting to be described", but are rather constructed by the researcher herself (Cheek, 2000, p. 126). This research has therefore been conducted with the view that the selection of texts for analysis is an integral part of the process of research as knowledge production. Given this understanding of research, I follow Laliberte Rudman and Dennhardt in their statement that "the challenge of data collection is not to find all possible texts out there but rather to decide which texts to choose to best trace discourses of interest" (2015, p. 142). My selection of texts has been motivated by a desire to examine texts that can best help me answer my primary research questions.

In order to identify texts that would provide the best avenue through which to examine my research questions, I began to familiarize myself with texts from five websites associated with the government of Canada, which explicitly addressed maternal, newborn and child health programming. These were 'Maternal, Newborn and Child Health' section of the Government of Canada's website; Prime Minister Harper's official website; the DFATD website; the International Development Research Centre (IDRC) website; and the Grand Challenges Canada website. On each of these websites I used the internal search feature to search for 'maternal health', downloading all of the results. This search resulted in the collection of 243 texts, at which point I determined that I would move forward with an

analysis of texts from two of these sources in order to allow for a smaller sample size and hence more focused analysis. I chose to exclude texts from the Grand Challenges and IDRC websites because these organizations, although they are funded by and receive their mandate from the government of Canada, also function as (relatively) independent associations whose definition of and approach to MNCH seemed, from initial reading of the texts, to reflect their individual institutional goals and cultures. Although a comparative analysis of these institutions' engagement with MNCH remains an interesting possibility for future study, I determined that it was not within the scope of this study to include such an analysis.

Despite providing a rich source of texts regarding Canadian engagement with MNCH, I also decided to exclude texts from Prime Minister Harper's website. This decision was in part due to this website already being the subject of an extensive critical discourse analysis as part of an earlier study on the Muskoka Initiative, which was published as I was in the process of making this decision (Tiessen, 2015). Furthermore, the significant number of texts produced by the internal search were diverse as to their focus and form. Many of the texts focused specifically on the role and activities of Prime Minister Harper, and although my analysis does ultimately address the significance of MNCH programming for discursive construction of Harper as a political actor, excluding these texts allowed for a more focused field of analysis centered on the role of the Canadian government itself. A final concern was that, as I was in the process of finalizing which texts to include, Primer Minister Harper's tenure ended, and his website was taken down and replaced with that of Prime Minister Justin Trudeau. Although I had already downloaded all search results prior to the website being retired, I nevertheless had concerns about conducting analysis on a site that I could no longer access in real time, particularly given the volume of pages included.

Ultimately, I decided to analyze the Government of Canada's website on maternal, newborn and child health, itself a subset of the Government's broader webpage, as these pages provided numerous examples of how Canadian engagement with MNCH was presented publicly. As such, they exemplify the way in which maternal health is discursively constructed as a development problem, while also outlining how Canadian activities have and continue to address this problem by funding various programs and

interventions. The decision to focus on these webpages contributed to the shift of my project away from discourses of sexuality and towards a more specific focus on maternal health, a shift which is appropriate given the focus on maternal health by the Canadian government at this time. A list of the webpage analyzed can be found in Appendix A.

I also decided to analyze the project descriptions listed on Department of Foreign Affairs, Trade and Development's (DFATD) page "Projects Funded under the Muskoka Initiative". This page provides a list of programs identified by DFATD as falling under the mandate of the Muskoka Initiative and funded using the resources committed through it. As such, inclusion of project descriptions allowed for analysis of what kinds of interventions were deemed fundable under the umbrella of maternal, newborn and child health, and how these projects were presented in order to access funding. A list of these project descriptions can be found in Appendix B. In total, I analyzed 38 webpages from the Government of Canada website, and 88 project descriptions from the DFATD page. For webpages that included videos, I transcribed the videos and analyzed the transcript. Each webpage was between one to three pages once printed, and each project was between half a page and two pages long once printed.

The webpages analyzed as part of the Government of Canada's MNCH site were all ultimately linked to the maternal health home page. This page was used as a starting point from which to find all other Government of Canada MNCH pages. This homepage could be accessed by searching 'maternal health' from the Government of Canada webpage, or by clicking the "Canada and the World" option from the Government of Canada homepage. Project descriptions were all linked from the DFATD page entitled "Projects Funded under the Muskoka Initiative". All pages were downloaded and stored so as to ensure consistency in the texts analyzed in case of any changes to the webpage during the analysis process. Webpages were imported into the program NVIVO, as well as downloaded as PDF files to a folder on my computer, to act as a backup. NVIVO was used to store and organize documents, but it was not used directly to analyze texts, as this was all done by hand.

4.3.2 Critical Discourse Analysis of the Selected Texts

I conducted my critical discourse analysis through the use of analysis sheets, which I developed to provide me with a set of guiding question that helped direct and focus my analysis of each text. I began with analysis of the texts from the Government of Canada's MNCH website, conducting two rounds of analysis before moving on to analyze the project descriptions. The initial analysis sheet, used to inform the first round of analysis of the MNCH website, was developed in relation to my overarching research questions, as well as my theoretical framework. It can be found in Appendix C. In particular, this initial analysis sheet was designed to help me read the texts closely and critically in order to systematically document answers to questions such as:

- How is the problem of maternal health defined? Where is the problem located?
- What actors are mentioned in the text and how are they portrayed?
- How is the (maternal body) conceptualized and represented in the text?
- What assumptions are made regarding motherhood, femininity and sexuality?
- How is the (maternal) body constructed as an object of development? What sorts of maternal practices of the self are idealized/assumed?
- How is development conceptualized and represented in the text? What is represented as constituting development, and how is it to be pursued? What types of development practices are made possible/not possible within the text?
- How is risk addressed or referred to within the text?

The questions included on this first analysis sheet were somewhat broad, and were intended to help me identify dominant discourses and discursive constructions relevant to my research questions across this initial body of texts. I read each text before beginning my analysis to help familiarize myself with the text. I then analyzed each text using the analysis sheet, answering questions while also making notes about anything interesting that did not fit neatly into any of the categories outlined in my analysis sheet. Once I had analyzed all of the webpages using the first analysis sheet, I typed up my findings and compiled a

provisional list of recurring discursive constructions. This initial list included the following discursive constructions:

- Canada as a global leader
- MNCH as a global problem
- Women and children as populations 'at risk'
- Development as increasing access to services

This list formed the basis of the second analysis sheet, which was aimed at refining my analysis to further unpack how discursive constructions were being deployed by the body of texts. This second analysis sheet, which can be found in Appendix D included more specific guiding questions in order to analyze these emerging discursive constructions in greater depth, including:

- How is Canada positioned as a global leader through its work on MNHC?
- How is MNCH positioned as a global problem/project while simultaneously situated in particular regions/populations?
- How are women and children in the developing world constructed as a vulnerable population?
- How is development configured as increasing access to services?

This analysis sheet was more explicitly informed by my theoretical framework, as well as my emerging interest in Canada's construction as a development actor. Each MNCH webpage was analyzed using this second analysis sheet, and the results were compiled and organized to give an overview of the main discursive constructions that I identified in this body of texts.

Once I had completed two rounds of analysis of this set of texts, I analyzed the project descriptions. I began with a pilot analysis of 15 texts, which were chosen to ensure inclusion of projects receiving various levels of funding. These 15 texts were analyzed using the first analysis sheet from my previous round of analysis, in order to both familiarize myself with the project descriptions as well as to determine similarities and differences between the discursive constructions that emerged in the web pages and the specific project descriptions. In compiling the results of this initial analysis, I found that,

in general, the project descriptions deployed many of the same discourses as did the MNCH webpages. I analyzed the remainder of the project descriptions with the second analysis sheet used in my analysis of the website, in order to focus my analysis on how these shared discourses were being deployed, while continuing to make note of any interesting differences, and of instances where these discourses were contested. The original 15 texts were also re-analyzed using this second-round analysis sheet.

Once I had completed the analysis of both sets of texts, I compiled the answers and examples from my analysis sheets and began to write up my findings. This process was part of the iterative analytical process, as I continued to make connections between different discursive threads, organizing them into categories that best elucidated how they support particular understandings of a) maternal health as a development problem, b) appropriate solutions to this problem and c) the role of different actors. These findings are presented in Chapters 5, 6 and 7. During this process I further interpreted my findings through my theoretical lenses, to draw conclusions as to how these discourses functioned to allow for a particular range of actions by specific development actors, and with what implications. These conclusions are presented in Chapter 8.

4.3.3 Designing, Conducting and Analyzing Interviews

In addition to conducting a discourse analysis of key texts related to MNHC, I also conducted five interviews with key informants. These interviews were intended to strengthen my analysis by allowing me to examine how the discursive constructions analyzed within the texts are taken up, negotiated, advanced and resisted by international development policy makers and practitioners. Interviews can be considered a rich source of discourse, which is understood not as static, but as taken up, reinforced and changed through its use by individuals not only through written texts, but through everyday conversation and practical action (Brinkmann and Kvale, 2014). As Hardin argues:

> The relationships between institutions and individuals is circuitous. Individuals alter and change institutional practice by moving with and between discourse in creative ways that change institutional practice (Hardin, 2001, p. 18).

Of course, institutional texts such as those analyzed from Government of Canada and DFATD websites are also written by individuals, however these texts were necessarily vetted and endorse by government authorities. The interviews provided an opportunity to better understand how those working within the field of MNCH engaged with the discourses that characterized the analyzed texts, and to consider how these discourses are supported, nuanced or even contested.

My initial intention was to conduct ten interviews with individuals who were uniquely engaged in Canadian maternal health programming, including participants who had been actively involved in developing and/or funding projects included under the Muskoka umbrella. To this end, a recruitment e-mail was drafted, along with sample interview questions, and submitted for ethical approval at Western University (see Appendix E and Appendix F). Upon receiving approval, I began recruiting participants. Potential participants were identified based on them having worked within the field of Canadian MNCH, whether as policy makers, advocates, researchers or practitioners. Potential participants could work directly for the government; for an institution associated with/funded by the Canadian government; or for an NGO that had worked on MNCH during the Muskoka era, (2010–2015). E-mails were sent to potential participants whose position (or previous position) and contact information was publicly available, or who had been suggested by previous participants and who had given permission for me to contact them with recruitment materials.

The response to these recruitment efforts was poor, potentially due to the tendency for individuals working in these fields to change positions relatively frequently, particularly given that recruitment was carried out shortly before the 2015 change in government. Another possible explanation might be that individuals working directly on policy might be resistant to speaking openly and publicly about this process. In some instances, a potential participant declined to be interviewed, but offered suggestions for alternative individuals and arranged for those individuals to contact me. In other cases, potential participants agreed to be interviewed, but future attempts to contact these individuals in order to set up an interview were unsuccessful. Respondents were able to ask me questions about the project before agreeing to be interviewed. Due to the small number of

participants, and in the interest of protecting anonymity, which was promised in the interview consent form, I have chosen not to disclose the organizations with which the participants were associated, nor the capacity in which they engaged in MNCH work.

Respondents were given the option of conducting interviews either in person or by phone, depending on availability and other constraints. Two of the interviews were conducted in person, two were conducted over the phone, and one was conducted through video call. All interviews were recorded. Each interview lasted between twenty minutes and an hour.

The interview script was developed based on my initial research questions. Questions remained quite broad so as not to over-determine responses, and to allow participants the opportunity to determine how they would address topics of interest. As I completed each interview I re-evaluated my interview script, with the result that a modified interview script was used for the fifth interview. Although I had intended to use this new script for all subsequent interviews, due to my inability to find additional participants, the fifth interview ended up being my last one.

Once I completed each interview, I transcribed it, which allowed me to familiarize myself with the interview as text. Structured analysis of interviews did not take place until after my textual analysis of the web documents had been completed, which meant that there was a significant time lapse between the time when interviews were conducted and when they were analyzed. Due to the small number of interviews, I did not begin with an open analysis, but rather used an analysis sheet developed in reference to results from my textual analysis. This strategy allowed me to immediately focus on how the interviews supported, nuanced, or contested the discursive constructions identified in my textual analysis. Although my analysis was guided by previous findings, I did make note of new discursive constructions that emerged in the interviews. After the initial analysis, I re-analyzed the interviews in part to further explore these emerging threads.

The interview component of my project did not produce as rich of a data source for analysis as I had planned. Nevertheless, the interviews contributed to my overarching analysis by providing additional examples of how particular discourses have been deployed, particularly in the discursive construction of Canada as a global leader in maternal health

policy. The interviews also revealed additional discursive constructions that point to interesting questions for future research. To these ends, I have presented findings from my analysis of the interviews alongside those form my analysis of the MNCH webpages and DFATD project descriptions in Chapters 5, 6, and 7.

4.4 Ensuring Rigorous Analysis

As stated, CDA does not have a set of standardized methodological steps, an element that can make it difficult to identify universally accepted quality criteria (Cheek, 2004). Quality issues are further complicated by the fact that CDA does not attempt to produce the 'true' or 'accurate' reading, but rather to "produce a reading that draws upon theory to question taken-for-granted assumptions and related practices" (Laliberte Rudman and Dennhardt, 2015). The question is not whether a particular reading or interpretation is 'correct', but rather whether the study is theoretically and methodologically rigorous. To ensure the rigor of this research project, I draw on the four quality considerations outlined by Laliberte Rudman and Dennhardt, adapted from Ballinger's work on quality considerations in qualitative research more broadly (2015). These considerations consist of coherence systematic and careful research conduct, convincing and relevant interpretation, and accounting for the role of the researcher. In this section, I outline how I have ensured the rigor by attending to these four quality considerations.

Coherence refers to the "overall fit between the elements of a study", including the research questions, theoretical frameworks, and methodology (Laliberte Rudman, Dennhardt, 2015). I have ensured the coherence of my research by selecting theoretical frames that compliment and align with one another, as well as with my research objectives. Specifically, as theoretical tools, biopolitics, governmentality and healthism are well suited to examination of how maternal health is discursively constructed, as well as how it operates as a site of reproductive management and as a site of reproductive injustice. The perspectives I have drawn upon from both critical development studies and critical health studies share theoretical underpinnings, specifically, a constructivist approach that also aligns with my research objectives and methodological frameworks. These theoretical frames and their relation to my research project are outlined extensively in Chapter 3,

fulfilling the requirement that theoretical perspectives must be explicitly outlined in order to be assessed (Laliberte Rudman and Dennhardt, 2015).

In keeping with Laliberte Rudman and Dennhardt's assessment that systematic and careful research is "demonstrated through careful documentation", I kept a methodological journal throughout my research project (2015). In this journal, I documented each of my decisions and actions. In addition to documenting my 'decision trail', in keeping this journal I was compelled to reflect on each of my research decisions, ensuring that my rationale was sound and aligned with my methodology and theoretical frames. Where I was uncertain about a decision, I sought guidance from my committee members, who helped point out key considerations in order to further ensure that my decisions were grounded my theoretical and methodological frameworks. Furthermore, using analysis sheets to guide my research helped me ensure that my analysis of each text was deliberate, systematic, thorough and consistent. They also provided me with another form of documentation, allowing me to return to and reflect retrospectively on my analytical process and findings.

My use of analysis sheets also helped me verify that I was producing a convincing and relevant interpretation of the texts. Since these sheets were developed with reference to my research questions and theoretical frameworks, they compelled me to move beyond a surface reading of each text while ensuring my interpretation was grounded in textual evidence. To further assess the relevance and reliability of my readings, I met with my committee members at key points in the analytic process to present my findings and receive feedback. In presenting my findings in Chapters 5, 6 and 7, I have included multiple examples from the texts themselves to support my interpretations and to demonstrate the appropriateness of my analysis. In Chapter 8, I bring these findings into conversation with my theoretical frameworks as well as existing scholarship on the Muskoka Initiative to demonstrate how my interpretations have contributed to new understandings of MNCH programming.

The final quality laid out by Laliberte Rudman and Dennhardt is to account for the role of the researcher, which requires engagement in reflexivity (2015). Throughout the research process I kept reflexivity journals, which allow researchers "reflect on their own

subjectivities and their discursive positioning" while fostering awareness "that their own work is shaped within a specific sociopolitical context" (Laliberte Rudman and Dennhardt, 2015, p. 147). In addition to constituting a key practice in constructivist research, reflexivity is also an integral component of much feminist scholarship (England, 1994; Jorgenson, 2011). Rather than seeking to eliminate the 'bias' of our subjectivities and social positions, feminist and constructivist theory acknowledges that knowledge production is always subjective, and that our unique experiences and positionality can provide important insights that others may miss. Practicing reflexivity helps us understand our subject positions, and how this positionality has shaped the research process. In the following section, I address how practicing reflexivity has helped me understand and account for my social positioning, and its role in my research project.

4.4.1 Accounting for my Positionality as Researcher through Reflexivity

In accounting for my role as researcher, I have been explicit about my motivations for conducting this research, including my political and theoretical commitment to reproductive justice. This commitment is in part the outcome of my experience as a woman who does not desire or intend to have children, and my awareness that my ability to abstain from childbearing is dependent on my reproductive rights. My commitment to reproductive justice is also the outcome of my years as a feminist scholar, through which I have gained an understanding of how infringements on reproductive rights effects the autonomy, health and life trajectories of women and girls, while acting as a means through which women, and racialized and colonized communities are oppressed. I acknowledge that my research questions, theoretical concerns and analytical foci are influenced by my desire to promote reproductive justice for women in the Global South. My research goals are informed by an understanding that everyone has a right to reproductive autonomy, and that infringement on the reproductive autonomy of individuals and communities constitutes a violation of their human and communal rights.

I have provided a more detailed account of my motivations for conducting this research in my introduction. In this account, I have been transparent about how this research has been motivated by both an intellectual curiosity, and by my sense of particular discourses as

oppressive and unjust. Furthermore, in reflecting on my interest in discourses surrounding femininity and maternity, I also recognize that my research has been motivated by my own feelings about mothering and motherhood. When I began this research, I was extremely critical of discourses that equated maternity and femininity, and that situate women's value in their roles as mothers and that reify qualities associated with the maternal. This critical stance was informed by my familiarity with feminist critiques of the 'maternal imperative', as well as constructivist theories that helped demonstrate how maternal expectations both draw on and strengthen dominant understandings of appropriate gender roles. Yet it is also informed by my experience of feeling excluded from these discourses as a woman who is not a mother, does not intend to become a mother, and whose life choices and characteristics have often been read as at odds with the maternal ideal. This affective reaction constituted an important starting point in helping me to identify a problem that was in need of greater examination. That being said, in acknowledging my feelings towards discourses of maternal altruism, as well as those that equate femininity with maternity, I have also become more open to, and less dismissive of other women's positive and affirming reaction to these same discourses, and have become sensitized to women's use of these discourses to achieve important goals. In doing so, I have developed a more nuanced critique of maternal essentialism and of the maternal imperative, which acknowledges how these discourses are wielded against women without devaluing women's desires to become mothers and their positive mothering experiences. For example, in watching my own friends become parents who at times make sacrifices for their children, I have come to understand these sacrifices, and the imperative behind them, as legitimate and agentic, even as I maintain a critical perspective regarding why maternal sacrifice is valued and how its reification acts as a technology of governance.

A significant element of my reflexive process has been to expose myself to alternative perspectives, and to reflect on my response to these perspectives. This practice has helped me to identify my own theoretical convictions and assumptions, and to shift or nuance my understandings if needed. For instance, reading the world of scholars who challenged the critical stance I hold towards medicalization has helped me to examine, clarify and nuance this stance. Notably, Johnson's (2016) work on women's differing relationships to medicalization was important in helping me to evaluate my own understandings, and to

make space for women's desire for medicalized childbirth without interpreting this desire as the product of patriarchal and/or colonial forces. Her engagement with how resistance to, and desire for medicalization is bound up in social positions and identity formation has also helped me to reflect on how my own critical stance is in part afforded to me by my position as a Canadian citizen who has access to universal healthcare, as well as the economic means to seek alternative forms of care if desired. As such, her work has helped me develop a more nuanced and productive understanding of medicalization, while again recognizing how my own perspective has been shaped by my positionality.

Another means by which I have challenged my own perspective is through the interviews I conducted, as well as informal conversations I engaged in with individuals working within the development and non-governmental sector. This includes my attendance at the 2015 Annual Conference of the Canadian Network for Maternal, Newborn and Child Health, where I attended panels that highlighted many of practical considerations of relevance to organizations working in MNCH, including marketing. The exposure these experiences gave me to the practical concerns of MNCH advocacy and programming helped me gain insight into the way in which those who work within development navigate frameworks and discourses that they do not necessarily agree with, and which may be at odds with their own beliefs and values. Through these encounters I gained an appreciation for the difficulties faced by development workers who may share similar critical perspectives, but who must act strategically in balancing the costs of critique with their ability to mobilize resources in order to support their work. This added perspective has helped me better account for the privilege afforded to me as someone researching and writing on maternal health from within academia, while encouraging me to think carefully about the material implications of my analysis for marginalized women, and for those who advocate and work to improve reproductive justice on the ground.

Chapter 5

5 Constructing Maternal Health as a Development Problem

In the next three chapters, I outline the key discursive constructions identified in my analysis. I begin in this chapter by outlining how maternal, newborn and child health is defined through population level statistics: specifically, maternal and infant mortality rates. These mortality rates are used to articulate MNCH as a global development problem, while simultaneously locating it within the 'developing' world. These statistics contribute to the discursive construction of women and children in the developing world as 'at risk', situating them as vulnerable populations in need of intervention. Pregnancy, childbirth and childhood are all constructed as periods of medical risk that are particularly dangerous in 'developing' contexts. Yet the medical risks associated with pregnancy, childbirth and childhood are also constructed as 'preventable' through access to particular forms of medical intervention. Thus, the problem of MNCH is predominantly constructed as medical in origin, and as able to be resolved through increased access to medical services.

In the next section of this chapter, I outline how the texts construct the solution to MNCH as lying in interventions that increase the provision of formal healthcare services. These include training healthcare workers, providing inputs and infrastructure, building managerial capacity and providing data. Furthermore, I outline how family planning is discursively constructed as an element of medical care that plays a key role I mitigating the risks associated with pregnancy and childbirth. My focus throughout the chapter is on demonstrating how the discursive construction of healthcare provision as a solution to MNCH render MNCH a technical problem, with a fairly straightforward, solution.

5.1 Constructing Maternal, Newborn and Child Health through Risk

One of my primary research goals has been to examine how MNHC is constructed as a development problem, and how this construction has informed and allowed for the formulation of particular kinds of interventions as both necessary and appropriate. My analysis demonstrates that the Government of Canada's MNCH webpages draw on

population level data to construct MNCH as a problem that is both global in scale, and which is localized within particular regions. In the following section, I examine how MNCH is constructed as a development problem not only through appeals to statistics such as maternal and infant mortality rates, but also through discourses of risk, and in particular, through the establishment of pregnancy, childbirth and childhood as periods of high risk to both women and children in the 'developing' world. In doing so, I note how the maternal body is itself situated as a site of potential risk to the health of (future) children. I further demonstrate how the construction of maternal and child health as 'preventable' medicalizes the risks associated with pregnancy, childbirth and childhood by positioning these risks as manageable through access to particular kinds of health services. This risk construction situates the root of the problem of MNCH not only in biomedical, medical risks, but in the inability of women within the 'developing' world to adequately manage these risks through access to healthcare services, including attended childbirth, nutritional supplements and immunization.

5.1.1 Constructing and Situating MNCH through Maternal and Child Mortality Rates

One of the central discursive constructions identified through my analysis is the construction of MNCH as a health problem that must be solved. Within the texts analyzed, the establishment of MNHC as a problem was repeatedly achieved through reference to quantitative data, often in the form of maternal, infant and child mortality rates. For example, two MNCH webpages include the following statement:

> 17 000 children younger than five years old still die every day, mostly from preventable causes (MNCH 2).

> 6.6 million children die every year. 2.9 million children die in the 1st month of life. 1 million children die in the first 24 hours of life (MNCH 22).

While such statements identify MNCH as a global problem by referring to high maternal and child mortality levels globally, more commonly, texts refer to the mortality rates in specific countries, or in the general regions of the 'developing world'. For instance, the

following statements reference mortality rates in the 'developing world', a region which is not defined, but which, through these statements, is specified as a generalized site of danger:

> According to the United Nations, a woman dies every two minutes due to pregnancy related complication. Most of these deaths – 99% - occur in developing countries and most could be prevented (MNCH 34).

> It is absolutely unconscionable that 100 times as many women die in pregnancy and childbirth in many parts of the developing world compared to Canada (MNCH 33).

The inclusion of a temporal referent in the first statement (every two minutes) connotes that the danger posed within these countries is imminent. Furthermore, in highlighting the high number of deaths that occur in this region, these statements refer not only to the rates themselves, but specifically to how high these rates are in comparison with either global mortality rates or with those in the 'developed world' country (Canada). At times, both webpages and project descriptions also used regional and country-specific date to demonstrate that pregnancy is much more dangerous within these areas. In this way, particular countries and regions are constructed as risky, and a hierarchy is created in which some countries and regions are riskier than others:

> The risk of dying from complications [during childbirth] is 1 in 3800 for mothers in developed countries. *But it climbs to 1 in 30 for mothers in sub-Saharan Africa or 1 in 44 for mothers in Hait*i (MNCH 23).

> Mozambique, the country with the *31st highest under-five mortality rate* in the world (P4).

> Lacking sufficient health systems and primary health care services, Nigeria lags behind in terms of maternal and child ill health. *Maternal mortality remains high, with 630 deaths per 100 000 live births,* and more than half of expectant mothers deliver outside of health facilities (MNCH 13).

Although only one interview participant spoke explicitly about differences in mortality rates, they similarly identified that a central issue in MNCH is understanding "why some countries have extremely low or virtually no mortality, while others have higher levels of

mortality" (I5). The informant therefore reiterates the discursive construction of MNCH as a problem that is located within particular countries and which is indicated by higher rates of mortality.

5.1.2 Using Mortality Rates to Identify Who is in Need

The use of mortality rates and population level mortality rates are used to construct MNCH as a problem that is both global, and that is situated within the 'developing' world. In doing so, the texts construct the 'developing' world as a place of danger, where pregnant women and children are at risk. The texts explicitly rely on this construction of the 'developing' world as risky to justify interventions, using mortality rates as a means of (seemingly objectively) identifying those countries that are most in need of help. The connection between mortality rates and the need for intervention are highlighted in the following statements, which specifically identify countries where Canadian interventions are operating. These statements also demonstrate how the construction of MNCH as a development problem is interconnected with the construction of necessarily and appropriate solutions:

> Canada focuses its bilateral efforts in *10 countries of focus where maternal and child mortality rates are high.* These countries are Afghanistan, Bangladesh, Ethiopia, Haiti, Malawi, Mozambique, Nigeria, South Sudan and Tanzania (MNCH 7).
>
> This project aims to increase access to, and use of, maternal and child health and disability (MCHD) services and contribute to a reduction in mortality and disability rates in Bangladesh, *where the infant and maternal mortality rates are among the highest in the world* (P48).
>
> Of Canada's $1.1 billion in new funding, 80% flows to sub-Saharan Africa, including Ethiopia, Mozambique, Mali, Malawi, Nigeria, South Sudan, Ethiopia and Tanzania, because *that region faces the greatest challenges in addressing maternal and child mortality* (MNCH 7).

In these examples, mortality rates are deployed to demonstrate that Canadian interventions and hence resources are targeting those areas that are most in need, as defined through mortality statistics. The construction of MNCH as a problem through the use of mortality statistics is tied to the construction of countries that are in need, and the construction of

Canada as a country that "focuses its efforts" on areas where the problem is most pronounced.

The discursive construction of Canadian interventions as targeting 'problem' regions came up in one interview, in response to a question regarding the strengths of the Muskoka Initiative. The participant's answer supports the discursive linking of high mortality rates and the need for targeted interventions:

> It's really trying to focus on comparative countries and geographic areas that *still carry a high burden*. If I even look at the evidence generated from the implementation research that's been taken on through this initiative, *it really focuses on countries that carry probably 23% to 20% of the global burden of maternal and newborn child mortality* (I4).

In this statement, high mortality rates are used to indicate which countries carry a 'high burden' of maternal mortality, and specifically, a high proportion maternal and newborn mortality. This language again reiterates how MNCH is constructed as relational, while also positioning it as a global encumbrance, and an encumbrance to those countries where mortality rates are highest. Although this initial statement situates Canadian interventions as targeting those countries with the highest burden of maternal mortality, the same participant also identified a global failure to support those countries through provision of development assistance:

> If you look at the 75 countdown countries that *carry most of the burden*, a lot of them were not getting heavy amounts of developmental assistance coming their way (I4).

This statement reinforces the assumption that interventions are ideally conducted in countries where mortality rates are highest, as a global failure to do so is explicitly identified as a weakness. As such, the statement supports Canada's use of mortality rates as the basis for providing assistance as appropriate.

Within the analyzed texts, population level data is used to both locate MNCH within the developing world, as well as to define it. Repeated references to mortality rates contribute to the construction of maternal and child health only in terms of mortality and survival. Health is equated with a lack of mortality; with survival. Based on this construction,

success in ensuring maternal health is expressed and measured through changes in mortality and/or survival rates:

> This project helps women of childbearing age maintain better health and helps *to increase survival rates* for children under five in Tanzania (P50).
>
> As part of the Millennium Development Goals (MDGs) agreed to in 2000, the global community made a commitment to *reduce child mortality* by two thirds from 1990 to 2015 (MNCH 2).
>
> This project aims to *reduce maternal and newborn deaths* by increasing women's access to qualified midwives in South Sudan (P15).

The construction of MNCH as survival is addressed in greater detail below, where I further discuss components that are excluded from this definition, and the way in which some interview participants problematize them. Before addresses these exclusions, I outline how mortality rates themselves are constructed as an outcome of the risks associated with pregnancy, childbirth and childhood, and an inability to successfully manage these risks through access to medical services.

5.1.3 Constructing Maternity as a Time of Excessive Risk

In citing high maternal and child mortality rates to both define and locate the problem of MNCH, the texts construct women and children in the developing world as vulnerable populations who face a higher than acceptable risk of death. This process aligns with the rise of risk discourse in neoliberal contexts, and specifically, with the ways in which risk discourse is used to identify populations who are in need of intervention and management, as addressed in Chapters 2 and 3 (Kaufert and O'Neill, 1990). Furthermore, these texts draw on mortality data to construct this vulnerability as arising from medical risks associated with periods of pregnancy, childbirth and childhood. For instance, in reference to childbirth, one webpage opens with the statement; "childbirth…few acts are as anticipated…or as dreaded" (MNCH 8). This quotation immediately positions childbirth as a time of fear and danger. Texts further link this danger to specific medical complications that can occur during pregnancy and childbirth, reinforcing the construction of reproduction in the developing world as 'high risk'.

> Every 2 minutes a woman dies of pregnancy related complications like: bleeding following childbirth; infections; or high blood pressure during pregnancy (MNCH 23).

> Right at the time of birth and the time from onset of labour to 48 hours after birth being a high risk area (I3).

In addition to constructing pregnancy and childbirth as periods of risk, at times the maternal body is itself constructed as a source of risk to both fetal and child health. For instance, multiple texts describe the need to address "mother to child transmission of HIV", while another situates maternal infection (that is, infection of the maternal body) as a major cause of stillbirth:

> The three main causes of death – prematurity, complications, maternal infections and hypertension are among the major causes of stillbirths (MNCH 2).

Similarly, maternal malnutrition is constructed as a risk factor affecting future children, with one website state that "when pregnant women suffer from undernutrition, they and their babies are at higher risk of complications and death" (MNCH 4). As such, some project descriptions identify improving pregnant women's nutrition as a means through which to address child mortality. Such statements not only implicitly support the construction of maternal malnutrition as a risk to future children, they exemplify how the specification of the maternal body as a source of risk justified interventions that specifically target maternal health. This construction of the maternal body as a site of intervention in turn rationalizes the need for reproductive governance in order to ensure the well-being of the population, both in the present and in the future. For instance, one project states that:

> The project aims to reduce infant mortality in three districts of the Kayes region by improving the nutritional status of children under the age of five and pregnant and nursing women, and reducing the malnutrition rate (P11).

By constructing maternal disease and malnutrition as not only a source of risk to mothers, but also to their children, the analyzed texts strengthen the construction of pregnancy and childbirth as a period of risk for both mothers and children. They also contribute to the construction of maternal, newborn and child health as one cohesive project, and of interventions as able to address the risks posed to both women and children simultaneously by targeting the maternal/pregnant body. This construction positions maternal health as a

site of governance that targets women's maternal health as a means of improving the well-being of children, and as such, of future populations. Maternal health is constituted as a key site of biopower, as well as a means by which women are instrumentalized. I will return to these constructions in Chapters 6 and 8.

5.1.4 Constructing Childhood as a Time of Excessive Risk

In addition to constructing pregnancy and childbirth as periods during which mothers and newborns are at an elevated risk of death, childhood is also constructed as a period of risk. This construction relies on indicators such as infant and child mortality, the latter of which refers to the death of children under five years of age. These indicators are used to highlight the risk of death experience by children within developing countries, with a particular focus on the first month after birth:

> 6.6 million children die every year. 2.9 million children in the first month of life. 1 million children die in the first 24 hours of life (MNCH 22).
>
> Of the 6.3 million child deaths each year, more than 40 percent or 2.8 million occur within the first month of life. One million of these deaths occur within the first 24 hours, making the first day of a baby's life the most critical to her or his survival (MNCH 2).
>
> Those hundred days [after birth] are really critical. That's when most infant mortality actually happens (I1).

Within the project descriptions, the risk of death during childhood is primarily attributed to malnutrition, disease, or a combination of the two. While these issues are largely situated as medical issues, in some instances the texts do draw a connection between these issues and social determinants such as access to water and sanitation:

> Undernutrition – including fetal grown restriction, suboptimum breastfeeding, stunting, wasting, and vitamin A and zinc deficiencies- *is responsible for 45 % of deaths of children under five, amounting to almost three million deaths per year*. (MNCH4).
>
> Without safe drinking water and access to proper sanitation, people who live in remote areas of northern Ghana are *more susceptible to waterborne diseases* such as diarrhea and other infections, and the *health of children younger than five years old is particularly at risk* (MNCH 9).

> Pneumonia, diarrhea, malaria, measles, HIV/AIDS and undernutrition are the *primary killers of children* in developing countries (MNCH 3).
>
> Undernutrition causes the deaths of 3 million children every year. That's 3 million children who die because they are not well nourished enough to fight off disease (MNCH 24).

One of these quotations references a lack of access to clean water and sanitation as increasing susceptibility to disease, suggesting some engagement with social determinants as increasingly risk of death. However, in the remaining examples, malnutrition and disease are positioned not only as factors that increase risk, but that cause the death of children. While there exists some instances where social determinants are identified as risk factors, it is disease and the bodily symptoms they cause (rather than the conditions that cause them) that are identified as "killers of children", and positioned as directly responsible for child death.

By situating childhood as a time during which risk of death from disease and malnutrition is elevated within the developing world, these texts construct children as a vulnerable population that is need of assistance. In particular, children in the developing world are constructed as in need of interventions that will prevent and treat disease and malnutrition. These areas of intervention align with two of the Muskoka Initiative's areas of focus: improving nutrition and reducing the burden of disease. This alignment demonstrates how the construction of risk is used to legitimize particular fields of action.

5.2 Preventable Death: Managing Risk through Health Care

So far, I have demonstrated how pregnancy, childbirth and childhood are constructed as periods of extreme vulnerability, which are attributed to risks associated with 'complications' during pregnancy and childbirth, as well as with disease and malnutrition. Consequently, women and children in the developing world are constructed as vulnerable populations in need of intervention in order to manage these particular medical risks. Significantly, even as these risks are identified as the primary cause of maternal, infant and child death, they are nevertheless presented as manageable. In this way, the risk framework is tied to a discourse of 'preventability' which situates negative outcomes as avoidable through particular approaches to risk management. This discourse of preventability is

important as it situates maternal, newborn and child death as a problem that can be solved, specifically through the provision of particular kinds of medical services. Thus, the discourse of preventability is key to constructing maternal, newborn and child health as a site for development intervention:

> Every year, millions of mothers and children in developing countries die from *preventable causes* (MNCH 39).

> Together, we can stop *the preventable deaths of women, children and newborns* and save the millions of lives that hang in the balance (MNCH 26).

> What we know is that most maternal and child deaths and morbidities are related to specific diseases that are *completely preventable* (I2).

The construction of maternal and child death as preventable is also demonstrated through the slogan and the name of the 2014 summit, which followed up on the commitments made under the Muskoka Initiative: "*Saving* Every Woman and Every Child within Arm's Reach". In addition to situating conference participants and interveners as saviours (a construction I will return to in Chapter 7), this phrase constructs the eradication of maternal and child death as an achievable goal.

As such, MNCH is constructed as a problem that is situated as an outcome not only of risks themselves, but also of the failure to adequately manage these risks by providing access to medical services. This discursive framing further constructs childbirth that is unattended by medical professionals as inherently dangerous, and promotes attended and hospital birth as a key means of mitigating risks to women and newborns. Conversely, home births are explicitly identified as putting women and newborns at risk:

> Mothers need skilled health workers like midwives during childbirth. This alone could prevent 42% of newborn deaths. Yet, *more than 40 million women give birth without a skilled health worker every year* (MNCH 22).

> In Ethiopia, many women give birth in their homes, especially in rural areas. With some of the highest rates of maternal and child mortality in the world, these home *births can put both the mother and the baby at risk* (MNCH 11).

These quotations explicitly situate risk as able to be mitigated through access to medical care, and uses this framework to construct home births as inherently dangerous and hospital births as objectively safer. This construction contributes to the medicalization of childbirth as a time of risk that can only be managed by specific kinds of medical professionals, in specific places, such as hospitals and clinics. Furthermore, "Canadian supported" prenatal care is identified as key to safe delivery, specifically situating Canadian interventions as providing life-saving care.

> This woman received quality prenatal care from a Canadian supported clinic in Tanzania. She got tablets to prevent anemia and was treated when she became ill. She delivered her baby safely (MNCH 22).

The notion of preventable deaths is linked discursively to the construction of medical intervention as 'live-saving'. Healthcare service such as immunization and treatment of disease are specifically situated as means of 'saving lives':

> The GAVI Alliance uses the funds, along with funding from other donors to achieve its mandate to *save children's lives* and protect people's health by increasing access to immunization in poor countries (P19).

> 88% of infants received three doses of the PENTA vaccine, a combination vaccine designed to *protect children from five deadly diseases* (MNCH 39).

> Improve access to basic primary health care services to *reduce the number of women and children dying* of common diseases as such as malaria and HIV/AIDS (P32).

The risks associated with malnutrition are similarly constructed as preventable through access to medical care, with access to nutritional supplements positioned as a means of protecting both mothers and children:

> More than 180 million children reached with two doses of vitamin A each year: a key nutritional element important for healthy development, immunity and eyesight (MNCH 39).

> This project aims to *reduce the number of children who are sick and dying* by improving the access of 2.2 million Ethiopian children to highly effective care to prevent and treat malnutrition (P77).

As these examples illustrate, healthcare in the form of immunization, nutritional supplements and disease treatment are situated as able to save lives. As with access to

healthcare during pregnancy, healthcare during childhood is situated as the means by which to prevent preventable deaths. When read in relation to the discursive constructions of pregnancy, childbirth and childhood as periods of medical risk, the discursive construction of healthcare as saving lives positions risk as medical, and as manageable at the level of the individual. These constructions in turn legitimize the emphasis on addressing MNCH by increasing access to medical care.

5.3 Managing Risk Through Contraception and Family Planning

In conducting my analysis, I was particularly interested in how texts constructed the role of family planning and contraceptive services both within the broad agenda of the Muskoka Initiative, and within the individual projects funded through the Initiative. This specific interest in family planning is linked to my research questions and theoretical frameworks, which include an understanding of both contraception and abortion as key components of reproductive justice, and an awareness of the significant criticism the Muskoka Initiative faced for failing to include funding for abortion. Given the significance of family planning to my research questions, this section is devoted to how family planning is constructed within the analyzed texts, and specifically, how it is incorporated into the framework of service provision and risk prevention. Although references to family planning and contraception were limited, in this section, I demonstrate how its inclusion contributed to the construction of MNCH as a problem that can be addressed by increasing access to medical services, while also implicitly aligning with the strategy of limiting fertility as a development strategy, as discussed in my literature review.

5.3.1 Family Planning as Pregnancy Prevention

Family planning was identified as a core component of the International Muskoka Initiative signed in 2010, and is addressed in six of the thirty-six government webpages and 11 of the 88 project descriptions. When referenced, family planning services are rarely described in detail, but in every case are included as a means of preventing, rather than ending, a pregnancy; that is, family planning is situated as contraception but not abortion. This configuration aligns with the overarching omission of abortion from the Muskoka

Initiative. For example, in addressing the role of family planning within MNCH one text refers only to "averting" pregnancies, stating that "family planning support funded by Canada has contributed to averting 220 000 unintended pregnancies" (MNCH 13), while Project 5 speaks of the "mobilizing of additional funds of US$11 million to procure contraceptive commodities" (P5). A telling quote from MNCH 34 states that "an estimated 220 million women would like to delay or avoid pregnancy, but are not using contraception" (MNCH 34). By speaking only to delaying and/or avoiding pregnancy through use of contraception, any desire to terminate existing pregnancies is rendered absent in the texts, as is the actual use of abortion as a healthcare service. None of the analyzed texts mention abortion as a health care service that women needed or gained access to through project activities. As such, although none of the texts include an explicit and comprehensive definition of what family planning constitutes, it is discursively constructed as a form of pregnancy prevention, and not as including any form of pregnancy termination.

5.3.2 Family Planning as Medical Intervention and Risk Management

Inclusion of family planning in the analyzed texts maps onto the broader focus on risk management through increasing access to medical services. In project descriptions that include family planning in their project activities, family planning is described as a health service, provided alongside other forms of medical care. Family planning is therefore medicalized, presented as an issue of providing medical services rather than being explicitly positioned as a component of reproductive autonomy, rights or justice. For instance, in the following quotations, contraception is listed alongside other medical supplies, while family planning is listed alongside forms of medical care, including antenatal and postnatal care:

> The project also aims to connect at least 40% of districts to electronic stock management systems that enable them to monitor their supply of essential *medicines, vaccines, contraceptives*, and other supplies (P40).
>
> 11 health centres offered immunization, family planning, antenatal and postnatal care (P25).

By presenting family planning as a component of health care, provided and accessed alongside other forms of medication and health services, the texts situate family planning within the medical sphere. In doing so, the texts both medicalize and depoliticize family planning, a framework which is at times used strategically to avoid ideological resistance to contraception (Johnstone, 2017), and which I will address in greater detail in Chapter 8.

As a medical intervention, family planning is also explicitly positioned as a life-saving intervention that reduces maternal mortality, diminishing the risks associated with pregnancy and childbirth by preventing pregnancy in the first place. For instance, one webpage explicitly links the prevention of pregnancy through Canadian supported family planning activities to the prevention of maternal mortality, stating that:

> Family planning support funded by Canada has contributed to *averting 220 000 unintended pregnancies* and *prevented an estimated 1350 women from dying* during childbirth (MNCH 13).

Similarly, webpage 39 states that "family planning support contributed to averting over 236 196 unintended pregnancies and 1443 maternal deaths" (MNCH 39). Project 5 explicitly utilizes a risk-management framework, stating that:

> More than one million couples were provided with protection against unwanted pregnancies that contributed to averting over two hundred thousand pregnancies and over 1000 pregnant women from dying during childbirth (P5).

In these examples, family planning is situated as a medical intervention that prevents both pregnancy and maternal death, acting as a solution to MNCH as a development problem constituted through high maternal and child mortality rates. This construction relies on and reiterates the discursive construction of pregnancy and childbirth as inherently risky, and as especially risky for women and children in the 'developing' world. In turn, prevention of pregnancy and childbirth through contraception is constructed as a self-evident strategy for reducing maternal mortality. Significantly, this construction relies upon statistics, albeit estimated, regarding the number of deaths that can be prevented through increased use of contraception.

5.3.3 Family Planning, Reproductive Preferences and Empowerment

Although family planning is primarily presented as a medical service, there are a few implicit references to family planning as a means through which women can make decisions about their fertility. Within the Government of Canada webpages, although the language of reproductive choice and/or justice is not explicitly used, there are references to reproductive planning and preferences. For instance, the previous quotation from webpage 13 references "unintended pregnancies", indicating a distinction between planned and unplanned pregnancies, even though it does not explicitly acknowledge whether unplanned pregnancies are desired once they occur. Additionally, webpage 34 states that "an estimated 220 million women would like to delay or avoid pregnancy, but are not using contraception" (MNCH 34), constituting the only explicit reference within the Government of Canada webpages to not only reproductive planning, but to the relationships between planning and reproductive desires.

Implicit references to reproductive preferences are found within three of the eleven project descriptions that discuss family planning, and are similarly vague. Returning again to a previously discussed quotation, Project 5 does reference protection against "unwanted" pregnancies, acknowledging that people do have reproductive desires, and that family planning has a role in allowing individuals to fulfill these desires by preventing unwanted pregnancies. The description of Project 24 states that:

> Haitian midwives receive quality training, equally accessible to women and men, aligned with the expectations/needs in obstetric/neonatal care and in family planning, taking into consideration the rights of women and girls (P24).

Although this quotation includes an acknowledgement of the rights of women and girls, it does not explicitly identify reproductive rights as part of these rights, nor does it explain what role family planning plays in ensuring these rights, including them alongside obstetric and neonatal care services more broadly. Similarly, Project 13 states that:

> 28 adolescent girls' and boys' groups are now working to empower 602 youth and have held a total of 721 health educations sessions on issues such as health, nutrition, early marriage, family planning, and pregnancy (P13).

In this quotation, education about family planning, alongside education on other health issues, is situated as part of a process of empowerment. Yet, the project description does not explicate how education about family planning (or other topics) actually works to empower youth, specifically girls and women, in terms of allowing for reproductive choice. Although there are some implicit acknowledgements of the role of family planning as part of reproductive rights and/or empowerment, these links are never explicitly drawn out, and texts do not highlight this role in justifying their inclusion of family planning services in their activities. Furthermore, access to contraception and the ability to have non-reproductive sex is never mentioned, nor is the connection between contraception and sexual agency, health or rights.

5.3.4 Increasing Use of Family Planning as Development Goal/Outcome

As described, within the field of analysis, family planning is explicitly constructed as a means of reducing risk of maternal mortality, and implicitly connected to ideas of reproductive planning and/or preferences. However, in some of the texts that discuss family planning, little to no justification is given for its inclusion. Rather, in three of the project descriptions, increased use of family planning is listed as a project outcome, with no explanation given as to why this increase is significant or desirable:

> The percentage of women between 15 to 49 years of age using family planning increased from 15.4% to 19.5%. (P75).
>
> The percentage for the use of modern family planning methods, increased from 11% at the database to 19.72 in September 2014, from 20 869 users to 39 964 (P46).
>
> The total number of acceptors of new modern contraception methods has almost doubled from 122 817 users in 2011 to 231 627 in 2013 (P26).

In addition to operating on an assumption that family planning use is a worthy development goal, by listing increased use/acceptance of family planning services as part of their project outcomes, these texts construct family planning use itself as a positive/desired outcome, rather than positioning the choice of if/how to use family planning as the desired goal. Such positionings both draw upon and reinforce assumptions regarding the desirability of lowering individual and aggregate fertility rates within the developing world, without

addressing implications for women's reproductive rights and autonomy. Indeed, the way in which these outcomes are both measured and worded indicate that it is not only the provision and availability of family planning services that is desirable, but actual use and 'acceptance' of family planning services, further demonstrating how lower fertility is implicitly constructed as a development goal, rather than the improved reproductive autonomy of women and/or couples. These outcomes point to the way in which family planning is situated as a service to be provided, but also a particular behaviour to be encouraged in order to lower rates of maternal death. In one case, the text specifically identifies reproduction among young or adolescent women as being vulnerable to unplanned pregnancy, stating that:

> Reproductive health services can be difficult to access and expensive for young women. This can put them more at risk than adult women for unplanned pregnancies and sexually transmitted diseases. Early or forced marriage (before the age of 18) is also closely associated with adolescent childbearing (MNCH 34).

This quotation situates adolescents as in particular in need of contraception, drawing on understandings of adolescent pregnancy and childbearing as an inherently negative outcome. In addition, given the straightforward tabulation of contraception use within project descriptions, use lower fertility is in general, constructed as desirable.

Family planning is constructed only in terms of contraception, and is constructed as a means of preventing 'unwanted' pregnancy, and as a way of decreasing maternal mortality rates by preventing pregnancy and childbirth in the first place. Within this construction, abortion is excluded, even though it may too serve as a means through which to improve maternal mortality rates. Improved access to family planning as a medical service is emphasized, as is the adoption of family planning, itself situated as an outcome of development programming. The significance of the discursive construction and inclusion of family planning will be outlined in Chapter 7, with particular references to how this medicalization of contraception, while seemingly depoliticizing the issue of contraception, implicitly aligns with ideologies of population control and eugenics.

5.4 Constructing MNCH as a Problem of Healthcare Access

In the previous section, I outlined how the texts analyzed situate medical risk as both inherent to pregnancy, childbirth and childhood, and as manageable through access to formal medical services. This discourse of preventable medical risk is central to the construction of MNCH as a development problem that is both terrible, and that can be solved. Furthermore, this discursive construction specifically locates the 'problem' of MNHC in the capacity of 'developing countries' (where maternal and child mortality is high) to provide women and children with adequate access to medical care. Statements such as "women and children in developing countries are significantly more likely to die from simple, preventable causes" (MNCH 7) both construct maternal and child death as a problem with a solution, and as a problem that exists specifically in the failure of prevention within the 'developing' world. For instance, webpage 11 links Nigeria's insufficient health system to poor maternal and child health, stating that:

> *Lacking sufficient health systems and primary health care services*, Nigeria lags behind in terms of maternal and child ill health (MNCH 11).

Similarly, project description 53 highlights the poor quality and availability of healthcare services in South Sudan, while identifying additional factors associated with the 'developing world', such as poor nutrition and sanitations, as compounding this deficiency:

> Maternal, Newborn and Child Health (MNCH) *services in South Sudan are either weak or completely lacking*, and this is compounded by inadequate nutrition and sanitation (safe disposal of waste water), and a lack of preventative health care practices (P53).

Additional examples point explicitly to the unavailability of vaccines:

> *Vaccines are unavailable, health services are poorly provided or inaccessible,* and families are uninformed or misinformed about when and why to bring their children for immunization (MNCH 3).
>
> As recently as 1985 only about 2% of Bangladeshi children were vaccinated against preventable diseases" (MNCH14).

These statements again contribute to the construction of MNCH as a problem not only of risk, but of risk management, and as primarily linked to inadequate access to poor quality

medical services and technologies, such as vaccination. MNCH is constructed as a problem that can best be solved by improving the capacity of developing countries to provide adequate, effective medical services to its population, and specifically to women and children.

The focus on improving access to healthcare is demonstrated by the use of quantitative data outlining how many individuals have been able to access medical services as a result of interventions. For instance, MNCH webpage 3 states that:

> The World Health Organization estimates that, in high risk countries, more than one billion children were vaccinated against the disease through mass vaccination campaigns, resulting in a 78% drop in deaths as a result of measles, from 562 000 deaths in 2000 to 122 000 in 2012 (MNCH 3).

This statement uses quantitative data regarding the number of children who access healthcare, correlating it to the number of measles-related deaths to demonstrate the effectiveness of immunization interventions. Quantitative data is hence deployed to justify interventions by demonstrating effectiveness, while reiterating the discursive construction of access to health services such as vaccination as an effective way of addressing child and maternal mortality. Given this construction, many projects also list quantitative measurements of how many individuals have accessed medical care as a way of demonstrating the effectiveness of their programming. In these cases, access is itself presented as an outcome, a configuration that both relies on and reiterates the understanding that increasing access to healthcare improves health. For instance, in describing one of the funded projects, website 17 states that: “as a result, some 452 people were able to consult a health professional, most of them for the first time in their lives” (MNCH 17). Similarly, website 14 states that “As recently as 1985, only about 2% of Bangladeshi children were vaccinated against preventable diseases. Today, that percentage has reached 82.5% - and is still rising.” (MNCH 14). The presentation of quantitative data demonstrating increased access is used to reinforce the understanding of increased access as a desired outcome in and of itself while also contributing the reification of quantitative data as a means of measuring development/project success.

In this section, I outline how the interventions prioritized within the texts are positioned as improving the quantity and quality of medical care. In addition to relying on the construction of MNCH as a problem that can be addressed through increased provision of medical services, the focus on interventions that aim to increase the capacity of governments, hospitals and clinics to deliver adequate healthcare implicitly situate the problem of MNCH in the inadequacy of developing world health workers, infrastructure and governments. By focusing on interventions such as training healthcare workers, providing supplies and infrastructure, improving managerial capacity and data collection, these interventions render maternal, newborn and child health a technical problem that can be solved through provision of relatively straightforward interventions that build capacity rather than engendering systemic change within or between countries.

5.4.1 Rendering MNCH Technical by Training Health Care Workers

In both the Government of Canada's webpages and the project descriptions, training local health workers is presented as key to improving both the quantity and quality of health services available to mothers and children. In these texts, the training received by healthcare workers, including nurses and doctors, is directly correlated with the quality of care provided, and in turn, is framed as necessarily leading to improvements in maternal and child health. Because many projects list the number of individuals trained as part of their outcomes, it is not always clear whether it is existing health workers who are receiving additional training, or if these roles are being created through the training itself. Nevertheless, in at least some cases, training is presented as means by which to increase the number of individuals who are able to access healthcare. For instance, one project states that by receiving training through their programs:

> 576 clinical officers, 576 administrative medical officers, 40 obstetrics professionals and 96 midwives are expected to have increased skills in emergency surgical and obstetrical care contributing directly to reducing illness and death in mothers and newborns in rural Tanzania (P69).

While this quotation links increased training to a reduction in maternal and infant illness and death, such links are not always made. Rather, the focus is on training as an output that is presumed or estimated to provide care to women and children. For example:

> Since 2010 the project has achieved impressive results, such as *training 248 nurse-midwives to provide life-saving care to an estimated 100 000 pregnant women*. Two hundred and eighty community health extensions workers have been trained and equipped to provide community-based newborn care (MNCH 13).

> We are strengthening health care systems for women and children by *increasing the number of health care workers* (MNCH 8).

In the first quotation, health care workers, specifically nurse-midwives, are described as providing 'life-saving care' after receiving training. Because trained health workers are situated as providing healthcare that saves lives, increasing the number of healthcare workers through training is constituted as a key development outcome. Similarly, in the second quotation, increasing the number of health care workers is presented as strengthening health care systems, similarly positioning this increase in workers as a key component of MNCH interventions. Additionally, training not only increases the quantity of health care workers, but also the quality of the medical care they provide. For example, one project description states that it seeks to:

> Improve the health of mothers and newborns by assisting Tanzania's Ministry of Health in training 1300 non-physician health professionals to improve their ability to provide quality obstetrical care (P69).

This goal is to be achieve by "reviewing curricula at medical training schools owned by the ministry of health". In a similarly vein, Project 84 states that:

> 132 health workers, including 96 midwives, have graduated from four Global Affairs Canada (GAC) – supported Health Sciences Institutes and are now contributing to meeting the vast needs for maternal and newborn health services across South Sudan (P84).

These quotations demonstrate that improving the delivery of health services is understood as pursuable not only by providing additional training, but by improving the curriculum through which health professionals receive their education. Although the details of who is responsible for improving curriculum, or what exactly these improvements entail are not provided, these interventions raise questions as to what constitutes 'good' training, as well as 'high quality' care. Furthermore, by constructing healthcare as strengthened through the training of healthcare workers, and the improvement of curriculums, training itself is

constructed as a key output of development. This construction contributes to the ways in which MNCH is positioned as a problem of technical improvements.

5.4.2 Constructing Hierarchies of Care through the Training of Traditional Birth Attendants

Texts that describe training as a key output of development vary in the level of detail they provide regarding who has, or will receive this training. For instance, Project 5 refers to health workers in a broad sense, and describes "training 1611 health workers to provide maternal and child health service and information" (P5). In contrast, Project 33 states that its activities are designed to "train 200 doctors, nurses and midwives in reproductive health, and the management of health and nutrition services" (P33), specifically identifying doctors, nurses and midwives as the recipients of training. The latter quotation constructs particular kinds of healthcare workers (doctors, nurses and midwives) as both in need of training, and as capable of using this training in the provision and management of health services.

In addition to healthcare professionals such as doctors, nurses and midwives, other projects describe the training of traditional birth attendants, community health workers, and volunteers. At times, training descriptions acknowledge the role of traditional birth attendants in providing maternal health care, as with the project 32, which describes "training 170 traditional birth attendants (75 women and 95 men) in maternal health services" (P32). An additional project similarly describes training traditional birth attendants on "safe, clean delivery, nutrition and improved child-feeding practices, and emergency obstetric care" (P34). While these projects acknowledge and include traditional birth attendants as healthcare providers, they also identify this group as in need of additional medical training. Furthermore, their inclusion is at times paired with a configuration of their role as helping patients to access more formal, medicalized forms of care. Tellingly, one project states that "1150 traditional birth attendants were trained to recognize signs of labour distress and learn when to refer patients to health facilities" (P1). One webpage highlights how traditional birth attendants are constructed as important, yet limited in their role, and as most useful in directing women towards appropriate forms of healthcare rather than providing it themselves. This webpage is entitled "Canada Helps

Deliver Childbirth Education in Ethiopia", identifying Canada as providing key assistance in the delineation of appropriate roles for traditional birth attendants. The webpage states:

> [Traditional birth attendants] know the families they work with and they are a valued part of the community. Yet, they do not have the training or equipment to assist when there are complications. To improve the health and chances of survival for these mothers and babies, traditional birth attendants play an important role. They provide advice to mothers about their pre-natal care and speak of the benefits of delivering babies in an equipped government health centre or hospital where trained staff take care of the mothers and newborn babies".

In this example, there is an attempt to recognize the value of traditional birth attendants, while shifting their role to one of advisor. Yet even as traditional birth attendants are acknowledged, the webpage constructs a hierarchy between traditional and 'modern' forms of healthcare, drawing on language that evokes risk (survival, complications) to delineate who is able to manage childbirth effectively. Significantly, training birth attendants is situated not only as a means of improving the quality of care provided by birth attendants, but as helping them to recognize when they are unable to provide adequate care so that they can direct women to seek this care elsewhere.

This same webpage includes a testimonial from a birth attendant, as well as an explicit description of how training is used to promote particular forms of healthcare:

> "*Birth attendants like me cannot help when complications occur*" admits Genet Briso, 60, a traditional birth attendant in the Arsi Negele district. *Her inability to assist during a childbirth complications* does not stem from an unwillingness to help, but rather from a lack of knowledge and resources (MNCH 11).
>
> Thanks to the training she received, Genet Briso, along with her cohort, *now understand the importance of assisted delivery methods* that promote a safe and healthy environment for both mother and newborn: "From the training, I have come to understand that mothers can *get all the help they need from health professionals*" says Briso (MNCH 11).

In these quotations, training is explicitly identified as changing Briso's understanding of her own role, based on her inability to provide the care necessary to manage the medical risks associated with childbirth.

The role outlined and promoted through training for traditional birth attendants contrasts the role outlined for midwives, and the way in which training is positioned as helping them to achieve this role. The same webpage quoted above describe "training provided to the health workers on safe, clean delivery and emergency obstetric care as well as the establishment of equipped neonatal care units and health centres" (MNCH 11). By including a testimonial from a midwife whose training has helped her handle complicated cases deemed outside the purview of traditional birth attendants, training is positioned not only as helping health workers to provide care, but as a means through which to communicate values and to delineate roles appropriately:

> "I wanted to be a midwife to help women and children in my community, but before the training, I did not have the confidence to handle birth complications" says Dirbe Feyissa, a midwife working in the Kelo Health Centre. "*After taking the basic obstetric care training, I and my colleagues are now able to manage even breach cases, which in the past we would not have been able to manage",* she adds.

This paragraph is telling, in that it constructs training as allowing midwives to provide the healthcare needed to manage the risks associated with childbirth. Training continues to be constructed as input, and trained health care workers with a clear understanding of their roles as a key output of development programs. Significantly, midwives are situated as capable of being trained to deal with birth complications, and hence to provide care during birth, while traditional birth attendants are not.

5.4.3 Rendering MNCH Technical by Providing Infrastructure and Supplies:

In addition to delineating roles for different forms of healthcare workers, the provision of training is constructed as a relatively straightforward way of improving the quantity and quality of healthcare available to women and children in the developing world. Similarly, the provision of physical inputs, such as building and medications, are also described as a key form of improving country capacity to deliver healthcare to its population. In this regard, texts specifically describe how programs work to improve the provision of healthcare services by contributing to infrastructure and supplying resources. Provision of infrastructure and supplies are listed as easily measurable and tangible outcomes of

Canadian investments. Notably, while these provisions are credited as directly enabling more people to access healthcare, as with training, the focus is often on measuring the resources supplied, rather than the on measurable changes in health outcomes.

The construction of building is one form of infrastructure provision highlighted in the texts with one project stating that their work "contributes to the construction of a new 200-bed provincial hospital in Gonaïves" (P14). Another project describes "constructing eight health facilities" (P78). The constructing of physical buildings are credited with enabling the provision of increased services, at times to a quantifiable number of individuals:

> "Through a project that began in Bangladesh in 2011, 13 village maternal and child health centres have been built in five districts, including 13 tricycle ambulances and three boat ambulances." (P34).

> "Each Family Health House provides services for as many of 1500 to 4000 people in a building with a delivery room, examination room, and waiting room, where women and children can receive around the clock ante-natal, delivery and post-natal care as well as immunization services seven days a week." (MNCH15).

Texts also highlight the provision of supplies and equipment as a key outputs of their projects, stating that they are "providing healthcare supplies and medicines" (P78), "distributing neonatal care kits" (P83) and "equipping 63 health facilities and 30 maternity wards" (P88). The provision of equipment is again identified as improving the recipient state's capacity to provide healthcare, as in one project's claim that their work:

> supports the procurement and distribution of equipment such as newborn resuscitation devices, HIV testing kits, communication equipment, and reproductive health supplies to cover 60% of the annual requirements of these states (P5).

Similarly, one website describes the provision of a solar suitcase as "an economical, easy-to-use portable power unit that gives health workers medical lightning and power, including during obstetric emergencies" (MNCH 22), while another states that "providing refrigerators to community health centres for vaccine storage, ensuring timely supply of

medicines for essential care at the community level" (P6). In each of these examples, the provision of a particular piece of equipment is presented as allowing for improved delivery of healthcare services. Given the construction of healthcare services as directly preventing maternal and child death, these activities are depicted as relatively simple, straightforward ways of impacting maternal and child health in the developing world.

Within the texts analyzed, the provision of training and physical resources are often grouped together, presented as inputs that can be delivered fairly straightforwardly, and as a way to improve individual and systemic capacity to deliver healthcare services. As such, the emphasis on providing training, infrastructure and resources renders MNCH a technical problem, consisting of providing appropriate inputs, which in turn will improve the provision of medical care needed This provision is demonstrated in the following examples:

> 2357 female and 2766 male community health workers were trained on maternal, newborn and child health guidelines and equipped with bicycles, umbrellas, bags and all the paperwork they need to *do their job effectively* (MNCH 10).

> "This project has assisted fifteen Nigerian states and the Federal Capital Territory to strengthen the *delivery of key maternal, newborn and child health services*, as well as to ensure that health workers have the skills, equipment, supplies and medicines *to provide care*" (MNCH 13).

In both examples, training and equipment are situated as allowing individual health workers to provide healthcare, with website 13 directly linking this improved ability to an overall strengthening of state capacity to delivery health care services. These statements encapsulate an overall focus on providing training and resources as inputs that, once provided, are assumed to improve the delivery of healthcare services in developing countries. This discursive framing contributes to the construction of maternal, newborn and child health as a technical problem that can be solved by providing healthcare practitioners with the necessary tools, in turn responsibilizing them for addressing maternal health without necessarily engaging with the social, political and economic factors that affect health and contribute to health disparities.

5.4.4 Rendering MNCH Technical by Building Managerial Capacity

In addition to constructing training, infrastructure and equipment provision as means through which to improve the capacity of health workers to deliver medical services, improved institutional management is constructed as an additional site through which 'developing' countries can improve their ability to provide healthcare access. Projects describe helping health care facilities improve their management, with one project stating that through its activities it "strengthens the management and supervision practices in health care facilities" (P10) and another that it is "improving procedures and communication across all levels of community health facilities" (P63). These statements indicate that these projects situate at least part of the solution to the problem of MNCH in improving institutional capacity through improved management and communication, implicitly constructing part of the problem of inadequate healthcare provision in poor management of healthcare institutions. In doing so, the texts contribute further to the technocratization of MNCH, while situating the problem of MNCH in the limited capacity of developing countries to adequately manage health care systems.

In addition to targeting the management of healthcare facilities, some projects also include descriptions of how their projects are improving the managerial capacity of developing world governments, either at the state or the community level. The strengthening of governments' management is again described as corresponding to increased capacity to deliver health services. For instance, Project 23 states that their project has "strengthened government management of health services that are more responsive to the health needs of South Sudanese, particularly in the area of maternal and child health" (P23). Similarly, project 46 states that establishing "departmental coordination mechanism facilitates the delivery of more effective treatments by health institutions" (P46), again directly linking managerial improvements with an improved delivery of medical care. Project 31 links improved managerial capacity to efficiency, effectiveness and sustainability of health systems, stating that "the project also seeks to improve the management capacity of the Provincial Directorate so that it functions more efficiently, effectively and sustainably over the long term" (P31). These examples illustrate the way in which projects seek to improve management of health systems both at the level of hospitals and clinics, as well as at

country and state level government. Although they target health systems, these interventions nevertheless continue to put forward technical interventions that focus on the provision of healthcare as the primary means by which to improve maternal health. Implicitly, these interventions situate the problem of maternal health in country capacity to deliver healthcare services, without engaging with the systemic factors that affect maternal health, or that might affect a country's ability to provide adequate healthcare services to its citizens.

5.4.5 Building Capacity Through Gender Sensitive Delivery

In seeking to improve institutional capacity, some projects specifically seek to improve the ability governments and health institutions to deliver services that are "gender-sensitive" or "gender-equitable". For instance, Project 30 states that:

> The Red Cross Mali improved its ability to coordinate and collaborate with the Ministry of Health in the delivery of maternal, newborn and child health services in a gender-sensitive manner (P30).

Similarly, Project 15 claims to have:

> strengthened capacity of graduate midwives, midwifery students and health workers to deliver gender-responsive reproductive health and midwifery services (P15).

Although project descriptions such as these indicate that they either seek to or have successfully increased the provision of gender-sensitive health services, they do not explain or unpack exactly what these service improvements entail. Therefore, while these examples imply that gender is a factor that influences people's experiences of and access to healthcare, they lack a detailed account of what these effects might be and how they are being addressed through service delivery. Furthermore, while such inclusions appear to acknowledge gender as a social determinant that affects health, they do so only in reference to the effect on access to, and delivery of healthcare services.

The importance of gender-sensitive delivery was also addressed by one interview participant, in response to a question regarding the role of gender in Canadian MNCH policy. When asked what role the participant saw gender play in Canadian MNCH policy,

part of the participant's response identified gender sensitive training and service delivery as aspects that were being incorporated into some of the programs funded through Muskoka, but which were not explicitly required or even addressed by the Government of Canada itself. In speaking to this issue, the participant made a distinction between "the medical way of treating" health issues, and "the whole health package", stating:

> There's the medical way of treating it, but what's the impact? What's the gender impact on the wife? So there's all these kinds of things that you know you can teach the basic medical stuff, health medical or you can introduce these other elements that are very critical to the whole health package (I5).

This response supports the inclusion of gender sensitive delivery within maternal health programming, and draws attention to the importance of consider not only whether medical care is provided, but also how it is provided. Gender is acknowledged as a factor that intersects with and impacts the effect of medical treatment.

5.4.6 Building Capacity to Overcome Contextual Barriers to Healthcare Delivery

In addition to addressing gender sensitive delivery as a component of healthcare delivery, the texts construct additional contextual factors that health providers must overcome in order to ensure adequate delivery of healthcare services. For instance, those who live in rural locations are constructed as less able to access healthcare, and projects describe efforts to overcome geographic barriers in order to increase healthcare delivery and accessibility. For instance, Project 34 states that their project aims to improve maternal, newborn and child health in "three remote and undeserved districts in Ethiopia" (P34), while Project 36 claims that:

> The goal of this project is to strengthen Ethiopia's health systems in order to deliver effective maternal, newborn and child health services to nomadic communities in the Omo Valley (P36).

In both cases, nomadic and remote communities are specifically targeted as populations in need of increased access to medical care. These increases are pursued through the same strategies outlined above, including training and equipping community health workers to deliver services and refer patients. Project 10 states that their program is "equipping

community health workers to provide services in remote areas and to refer patients to health centres when necessary", again situating community health workers as able to increase access to healthcare, and to overcome the barrier represented by living in a remote area. Increased provision within these communities is also correlated with improved health, with Project 45 stating that their activities have:

> Contributed to reducing morbidity due to malaria, pneumonia and diarrhea among children under the age of five in South Sudan, especially in targeted communities which did not have a health facility within walking distance (P45).

Additional factors that are identified as needing to be acknowledged and integrated into healthcare delivery are conflicts and natural disaster, with Project 15 describing one of their goals as "increased availability of midwifery and reproductive health services for women and girls across South Sudan, including those displaced by conflict" (P15), and Project 24 stating that their project:

> Aims to offer some 230 000 women and girls who were victims of the earthquake, including 250 000 pregnant women, greater access to neonatal and obstetric preventive and emergency services (P24).

As with the inclusion of gender sensitive delivery, the inclusion of contextual factors such as conflict, natural disaster, and geographical location do indicate some acknowledgement of environmental factors as social determinants of health. However, the focus remains on how these factors influence access to medical services, and how they can be overcome in order to increase access to health services, maintaining the overall focus on delivery of medical services as the overarching goal of the projects as a whole.

5.4.7 Building Capacity to Monitor the Health of the Population

In addition to describing capacity building activities that provide resources and training, the texts analyzed also describe activities aimed at building developing countries' capacity to monitor the health of their populations through data collection. The lack of population level data is often cited in the documents as limiting a 'developing' country's ability to ensure the health and rights of its women and children. There are several references within both sets of texts to the importance of Civil Registration and Vital Statistics (CRVS); that is, the collection of data on births, deaths, adoption and marriage, and the provision of birth

certificates. Limited data collection is presented as limiting the ability of governments to adequately provide services, while also making it more difficult for individuals to access health care and legal protections associated with citizenship. For instance, webpage 12 states that:

> Without a birth certificate these children could be *denied basic rights and protection*. In terms of everyday life in Tanzania, without proof of their birth, a child *might not have access to education, health care or important legal rights*. These children are also at *greater risk* of abuse, childhood marriage, working at a very young age, or being prosecuted as an adult if accused of a crime (MNCH 12).

Webpage 20 also states that "Because they are not registered, those 40 million children might lose out on opportunities and benefits like immunization and education", and that CRVS "helps promote the rights and equality of women. For example, by making sure no girl is forced into early marriage" (MNCH 20). These examples demonstrate how institutional knowledge and recognition is constructed as a key requirement for accessing of legal rights and health and social services. Furthermore, knowledge of CRVS, and of population level data more broadly is constructed as allowing governments to monitor the health of the population and to successfully plan and implement health services, and by extension, to govern its citizens and manage its population. The following examples illustrate this construction:

> Being able to better track civil registration and vital statistics is another way to improve health. $100 million of Canada's support will let the Global Financing Facility set up ways to track civil registration and vital statistics in countries where no such systems exist (MNCH 18).
>
> CRVS give governments the information they need to create policies and programs that meet the needs of their people (MNCH 20).
>
> We are strengthening health care systems for women and children by increasing the number of health care workers as well as the government's ability to plan for and monitor progress by improving civil registration and vital statistics (MNCH 8).

These quotations emphasize the importance of CRVS in building countries' capacity to monitor the health of the population and to provide adequate health services, emphasizing the link between knowledge of, and governance of the population and the maximization of wellbeing. Three of the analyzed projects explicitly identify data collection, including

registering births and issuing birth certificates, as key activities that they are engaging in in order to address the problem of poor CRVS:

> This project aims to register and issue birth certificates to 3.5 million girls and boys under the age of five (including 90% of newborns and 70% of previously unregistered children in ten regions of mainland Tanzania (P72).
>
> At the country-level, implementation efforts include: Strengthening civil registration and vital statistics systems (e.g. births and deaths) (P27).
>
> Birth registration, referrals to India's national maternity health benefit scheme, and the tracking of the number of children immunized at the village level were facilitated (P66).

Furthermore, some texts explicitly construct such data collection as allowing countries to improve their healthcare policies, allowing them to evaluate what programs and services are lacking, and which ones are needed. From a biopolitical perspective, these projects can be understood as building country capacity to monitor and hence govern their population. For example, referencing an assessment they facilitated, Project 12 states that:

> With this assessment, Tanzanian officials can identify more easily the essential life-saving services needed for children and can monitor progress toward the Millennium Development goals (P12).

Further, Project 51 states that

> The Maternal and Perinatal Death Review was scaled up to cover three new districts, which means that seven districts can use this review to collect and analyze information on the cause, place and time of maternal deaths, still births and newborn death in order to inform future policies and programming (P51).

This quotation demonstrates how the ability to collect and analyze population level mortality data is constructed as an important source of governance, informing and facilitating the creation of policies and programmes. Similarly, Project 57 states that "the information collected through this project helps the national and state-level ministries of health develop five-year plans for making emergency obstetric and newborn care more available" (P57), further establishing data collection as a key component of health-care planning and management, which in turn is situated as increasing access to medical services.

In addition to collecting data regarding births and deaths, program descriptions also reference the ability of governments to collect data regarding other health indicators, such as malnutrition and immunization rates. Again, these measurements are situated as enabling the government to more effectively manage healthcare services, and by extension the health of the population. For example, Project 71 states that **"**a nutrition analysis was completed in all eight countries to increase awareness of the nutrition situation and allow for the development of the best strategies and priorities for improvement"**.** Again, population level data is situated as a key component of health governance, constructing health monitoring and data collection as a crucial health activity.

5.4.8 Data, Monitoring and Accountability

Throughout the texts, collection of data regarding the population, including civil registration and vital statistics, is situated as a key component of effective health governance and provision of appropriate health services. This emphasis on data collection is reflective of the biopolitical use of statistics to monitor and govern the population. Furthermore, the ability to measure data is linked to an ability to measure the results of interventions, and in turn, to ensure accountability. The relationship between statistics and accountability is exemplified in one project, "Implementing the Recommendations of the UN Accountability Commission", which focuses on implementing indicators, strengthening civil registration systems, and "analysis and reporting of country specific information on results and resources" (P27). This project explicitly links the ability to gather data through indicators and civil registration with the ability to hold those implementing interventions accountable.

The importance of data collection was also highlighted by interview participants, both in terms of how it can enable countries to better serve their populations, as well as in terms of how it can ensure that Canadian interventions are having the desired impact. One participant also spoke to the strategic importance of data in terms of allowing countries to mobilize support, describing how, in a meeting, an official from a 'developing' country stated that:

> Sometimes we just need that information at a very timely place to help advocate for a decision. So I think it's really looking at the relevance and timeliness of what we're doing and always making sure that there's a way to feed that back into national decision making and subnational decision making (I4).

This statement aligns with the construction of statistical data as an important factor informing decision making, facilitating advocacy, and enabling governments to take particular kinds of actions. This participant further articulated the importance of helping governments to gain access to such data, highlighting the necessity of:

> really making sure that we're getting good information and that it gets fed into the hands of decision makers and policy makers so that it informs what they do at the country levels (I4).

In addition to supporting the need for data for governments, participants also identified the need for Canadian interventions to be backed by population level data, with one participant emphasizing the importance of being able to demonstrate impact by asking "What are the indicators that we can be using to show that we are on the right path? Making sure we keep our eye on the ultimate impact of saving and improving lives?" (I3). Similarly, another interviewee stated that "there still needs to be very strong evidence that needs to be generated to demonstrate how that commitment has impacted; and created a positive impact" (I4). Here again, measurable data in the form of indicators is identified as a means of making sure that Canadian interventions are having the desired effect on the health and lives of recipients.

The emphasis on measurements as a key tool in mobilizing resources and measuring impacts points to the political work that seemingly 'neutral' statistics do. Although quantitative data is often presented as objective, participant comments implicitly and explicitly acknowledge that measuring and monitoring is a political process, and that the tools used to monitor the population have an impact on policy formation. One interviewee summed up the importance of measuring by stating "you care about what you measure, and you measure what you care about" (I3). This comment both emphasizes the importance of having measurable data in order to justify action, while also pointing to the ways in which measurements may be bound up in pre-existing understandings of what is important.

As suggested by the above quotations, interviewees both supported the construction of population level data as a central component of policy formation, and as a tool for leveraging support. Yet data collection was also identified as an area where Canada could improve, both in generally, and in specific relation to how it measures inputs. One participant identified measurement as a central limitation of Canadian policy, simply stating that "we could do a better job measuring" and that "we could do a better job of sharing resources around evaluation and monitoring" (I2). Another participant specifically problematized the way in which Canada has measured the impact of interventions, acknowledging and resisting the ways in which statistics can be used to homogenize populations and as such, obscure the ways in which particular members are marginalized:

> I want to see disaggregated numbers. I don't want to see averages. I want to see numbers coming from women of different socioeconomic groups…for example looking at outcomes for the poorest, which are always the worst (I1).

In addition to commenting on the need for data to be disaggregated, this participant also critiqued the way in which measures of inputs were being used rather than measures of outcomes, stating that:

> All the indicators were on the input sides. So, they would talk about how many mothers were now being seen prenatally, had the three prenatal visits; that were birthing in the presence of a skilled birth attendant, had post-natal follow up. It was those kinds of statistics (I1).

These statements challenge how Canada has measured its impact, while reiterating the need for measurements of some kind. In this sense, the interviews both support collection of population level data as an important element of health policy and governance, while also challenging how this data has been used and mobilized in ways that are seen as limiting.

5.5 Exclusions

In this section, I outline the exclusions from the Muskoka Initiative that I noted through my analysis, as well as those identified by interview participants in response to a question explicitly asking them to address the limitations of the Muskoka Initiative as they understood it. In addition to being asked to identify limitations, participants were also asked to speak to the role of sexuality and sexual health in Canada's MNCH program, as this was

originally a more central interest of my research questions and an exclusion I had made note of in my own (ongoing) analysis. In addition to the absence of sexual health in the Muskoka Initiative, the issues of family planning, abortion, life-stages beyond pregnancy and childbirth, the need to move beyond survival, and social determinants of health were brought up by participants themselves without explicit prompting. Although unprompted, these issues align with exclusion that I had noted in my own analysis. In this section, I address each of these exclusion in turn, acknowledging how, in their responses, participants challenge a specific construction of MNCH as articulated through the Muskoka Initiative while often reiterating key discursive constructions.

5.5.1 The Exclusion of Sexuality

Sexual health outside of the realm of reproduction was not explicitly included in the analyzed texts. As with any of the exclusions noted in my own discourse analysis, this absence can in part be explained by my own construction of the field of analysis. As my analysis specifically focused on the maternal health section of the Government of Canada website, as well as projects funded specifically within the Muskoka Initiative, it is possible that development interventions that target sexuality have been included within development policy, albeit in different projects. Nevertheless, the exclusion of sexuality within the texts analyzed does indicate that maternal health and sexual health were treated as separate concerns within Canadian development policy during this period, and that sexual health was not included as part of the Muskoka Initiative itself. This exclusion is significant given that a key critique of emergence of maternal health as a dominant development framework has been its use as a means of replacing and marginalizing more comprehensive approaches to health and to sexual and reproductive rights.

When asked directly about how the Muskoka Initiative contended with issues of sexuality, participants addressed how they understood sexuality as being included and/or excluded. Their answers speak to how sexuality is understood when included in definitions of maternal health, or of development more broadly. For instance, in discussing sexuality, two participants brought up HIV; one in terms of a key concern, and another as an alternative space through which non-reproductive sexuality was being address. Thus, in discussion sexuality, the dominant framework continued to be risk management and prevention of (a

potentially deadly) disease. For instance, one participant state that the programs their organization works with:

> necessarily include components of sexual health and sexual rights. I mean, HIV/AIDS is major if you're looking at reducing the burden of disease; HIV/AIDS is right up there as one of the major concerns. So sexual education program, access to protection, so that's contraception, also contraception in terms of preventing sexually transmitted disease but also family planning services (I2).

Another participant stated in reference to the Initiative that:

> It's almost like, completely stripped of this, the fact that there's this whole part of sex and reproduction, or sorry part of sex that has nothing to do with reproduction. I think that comes into play a little more in the HIV space (I3).

In linking sex and sexuality to the transmission of disease, these participants draw on and reiterate risk-based understandings of sex, that situate sex as something to be managed. This negative framing of sex, critiqued by the 'sex-for pleasure' perspective was also addressed by one of these same participants, who stated that:

> There's a lot more conversation around some of the negatives around sexuality and why some people would, what would drive people to be essentially being sex workers at very young ages (I3).

> The negative impacts of sexual abuse and such that happens in early childhood, and this links back to the adverse child events scale study that was done really linking those kind of early abuse to later stage kind of illness, chronic disease, mental health issues and such (I3).

Although identifying the inclusion of sexuality as often focusing on the negative, these statements nevertheless reiterate the discursive construction as sexuality as a site of risk, and specifically, biomedical risk. Thus, although the exclusion of sexuality from maternal health programming is being challenged, the inclusion of sexuality reiterates dominant risk-based frameworks that characterize the Muskoka Initiative's approach to health.

In one participant's response, sexuality was configured as a space through which to address social determinants of health. In speaking to the exclusion of sexuality in terms of sexual rights for the LGBT community, states that the 'issues' related to LGBT rights were related to both clinical and social determinants of health:

> LGBT rights were completely not even on the books… even though we knew there were huge issues around that, that has as much to do with social determinants of health as they did with the clinical determinants of health, but both were issues for that community, for those communities (I1).

Including one of the only explicit references to social determinants within my analysis, this statement thus points both to the exclusion of LGBT rights within Muskoka programming, as well as to the initiative's limited engagement with social determinants.

5.5.2 The Exclusion of Family Planning, and Abortion

As outlined in greater detail below, family planning was referred to in some of the analyzed texts, albeit fairly minimally. However, participants nevertheless identified family planning as a key exclusion of the Muskoka Initiative. Two participants spoke specifically about the exclusion of funding for abortion services, both in terms of its relationship to maternal mortality, and, in one case, in terms of reproductive choices. The first participant specifically referenced the relationship between illegal abortion and mortality rates, stating:

> We knew because we had seen it on the ground, the impact of legislated restriction of access to safe and legal abortion, and women were dying; the number of – the morbidity and mortality associated with illegal abortion is huge, and we were allowing that to continue. And Canada said oh, it's somebody else's business, we'll let the Swedes look after that…clearly it was offensive, and unacceptable to Harper's ideology, and that's when it became very clear that the MNCH focus was driven largely by ideology (I1).

In this quotation, the participant explicitly contexts the exclusion of abortion in Canadian MNCH policy both by associating it with former Prime Minister Harper's conservative ideology, and by situating its exclusion as contributing to high maternal mortality rates. As such, legal abortion is constructed as a key component of maternal health, due to its ability to save lives and impact the overall mortality rate. As such, the participant draws on dominant frameworks to challenge the exclusion of abortion within Muskoka programming. A second participant spoke to their own personal involvement in MNCH programming in terms of improving women's empowerment, including their ability to make reproductive choices. This same participant voiced their negative feelings regarding the exclusion of abortion, and their personal belief that abortion has a place in maternal health programming:

> It has a lot to do with dealing with issues of women's empowerment and the ability of women to actually make choices a) to get pregnant in the first place and b) when she's pregnant to actually seek – be exposed to and seek healthcare when and where she needs it (I3).

> I fully believe that there's a role for safe abortions – this is me speaking personally – and I think it's appalling here in Canada that that's been clawed back, the access that's been clawed back and I think it's really tragic in other countries where that's not even a possibility (I3).

Although this participant does challenge the exclusion of legal abortion by expressing their own belief in the importance of reproductive choice, they also articulate a rationale for why it may not have been appropriate to include abortion in Canadian development policy. Specifically, the participants state that in countries where abortion is not legal, it would not be appropriate for Canadian policy to challenge this legal standing:

> I think the reality is though, there are a lot of countries that it's not legal – and so then when you're talking about that it's kind of like, playing a role to change another country's legal framework, I think is a bit outside the bounds of what international development should do (I3).

Through this discursive move, the participant is able to both express a personal support for safe and legal abortion, and to rationalize why it might be excluded from Canada's global development agenda. This articulation draws on an understanding of development as somewhat apolitical, which itself can be understood as a response to critiques that development has historically been a site through which developed countries have exercised their power.

5.5.3 Beyond Maternal and Child Survival

As outlined above, the texts analyzed rely on a definition of maternal and child health that conflates health with mere survival, measured through maternal and child mortality rates. This definition was challenged by two participants, one of whom brought up the need to look at women's health from a more holistic lens. The following statement, which acted as a lead into a statement on the exclusion of contraception and abortion, speaks to a range of issues that were excluded through Muskoka's specific focus on maternity:

> There are a whole range of MNCH issues that were emphasized – perhaps over-emphasized to the exclusion of other and it was the exclusion of other issues,

> particularly around women's health that was a huge…the emphasis was half way I would say, instead of being holistic and inclusive of all issues under women's health (I1).

In addition, one participant specifically contested the Muskoka Initiative's focus on maternal and child, identifying this focus as a key limitation of Canadian policy, and articulating a belief that development policy should focus more on overall well-being, including mental health:

> We've been very short-sighted and really only looking at child survival for the last little while and I think the exciting thing about where that's headed is that total intertwining of how mum is, not only physically but also mentally, and the outcomes that happen with the babies (I3).

In pointing to the need to focus on overall well-being, the participant explicitly contrasts the standards of health that are upheld for women in the developing world, and those that are upheld for women within Canada:

> It starts to really link this survival to thriving agenda; um, which is so critical, again, not enough for us to be focusing just on children living, and mums living, like we have to really start pushing the bounds and saying come one, for our own population we really care about well-being, so why wouldn't we have that as part of our development agenda too? (I3).

In articulating an understanding of health that moves beyond survival, the interviewee contests the dominant framework of the Muskoka Initiative in which maternal and child health are equated with maternal and child survival – i.e., with not dying. This framework is further contested by participants' claims that the maternal health agenda must be linked to healthcare agendas beyond periods of reproduction. Yet in challenging Muskoka's narrow focus on pregnancy and childbirth, the participant continues to link maternal and child health. Her statements justify inclusion of women's health over the life-course by appealing to the affects that this inclusion will have on the health of children. The focus thus remains on the maternal body as a vehicle for the child, and for the future health of the population:

> Focusing on maternal, newborn and child health pulls us into a more life course approach thing, where it's not just one generation you're dealing with, it's not just one point in time you're dealing with, it's actually quite a complex problem that is

> over a period of time, over several generations, and can have a massive impact on populations (I3).
>
> We keep saying like "ok, we need mums to be healthy in order for them to deliver a healthy baby, and yet, and then we started saying ok well need the antenatal care to be there because that's going to make them healthy. And then we realized, actually we need them to be healthy before they even conceive an, um, so it's this circular thing, because we're recognising like ok, we really just need people to be healthy for everyone to be healthy (I3).

In pointing to these exclusions, interviewees to some degree challenge the construction of maternal, newborn and child health within the Muskoka Initiative. In doing so, they do draw on alternative discursive constructions to challenge what they identify as limitations of the programming. Yet, in bringing up various additional elements such as sexuality, abortion, and non-reproductive health, these participants simultaneously draw on discursive constructions to justify and support their contestations. Thus, ultimately, their responses end up reiterating the construction of maternal health as a problem of development.

5.6 Summary

In constructing maternal, newborn and child mortality as preventable, the texts analyzed situate the solution to MNCH in managing the medical risks associated with pregnancy, childbirth, disease and malnutrition. By constructing formal medical care as the best way to mitigate these risks, the texts in turn construct increasing access to attended childbirth, prenatal care, immunization, and treatment for disease and malnutrition as the primary means through which development interventions can solve the problem of maternal, newborn and child health. This increased access is pursued through interventions that are seen as improving the capacity of developing countries to deliver healthcare services, such as by providing resources in the form of training and infrastructure, as well as by increasing managerial capacity at various institutional levels. Data collection is also identified as an important component of capacity building, as well as a key tool in measuring the effectiveness of programs and hence of justifying the interventions funded through the initiative. Significantly, this combined emphasis on increasing access to healthcare and measuring progress through quantitative data can result in a preoccupation with outputs,

such as the number of health-workers trained. As I discuss in Chapter 8, this overarching construction of maternal health contributes to the depoliticization of development, and the construction of maternal health as an issue of straightforward technical interventions.

Chapter 6:

6 Responsibilizing 'Developing' World Communities and Women

As I have shown in the previous chapter, maternal, newborn and child health is primarily constructed as a problem that can be addressed by building the capacity of developing world countries to provide quality medical care to their populations. In this sense, responsibility for improving maternal, newborn and child health is situated within 'developing' countries, and assigned to developing country governments, medical systems, and healthcare workers. Yet in constructing solutions to MNCH, the texts focus not only on building the capacity of governments and institutions, but also of communities and of individual women. Specifically, programs seek to improve maternal health by encouraging individuals to seek medical care at appropriate times. Accessing medical care is identified as a healthy practice that should be encouraged alongside other 'healthy' everyday behaviours such as child feeding and hand-washing. As such, programs seek to build the capacity of individuals and local communities to overcome barriers to healthcare access, including a lack of awareness and understanding of why this medical care is important. In this section, I address how interventions aim to promote 'healthy' individual and community practices, and in doing so, govern women's health behaviours. These include awareness raising activities that seek to overcome resistance or ambivalence to western medical care among 'developing' world women, as well as within their families and communities. In seeking to promote particular behaviours as 'healthy' these interventions act as a form of governance that responsibilize women for their maternal health, as well as for the health of their children.

6.1 Responsibilizing Communities

The discursive construction of improved managerial capacity as a means of increasing the accessibility and quality of medical services is applied not only to governments and health

facilities, but also to communities. The goal of implementing and/or improving community management of MNCH situates the community as an appropriate site of intervention through which to improve health systems management, simultaneously identifying communities as prime sites through which health systems can and should be managed. In doing so, the texts construct the management of health systems as at least in part the responsibility of individuals within these communities. For instance, on project description states that:

> The project is designed to strengthen existing health systems and to empower community members, especially women, to demand the health services they require, to make choices that support good health, and to get involved in managing local health care services (P1).

Notably, in specifically seeking to empower women to advocate for health services, these programs treat women's time as though it is elastic, while potentially adding to their burden of unpaid labour. Another project describes its activities as:

> Enhancing the participation of communities in decision making processes within the health sector, including the management and distribution of health services, holding the government to account, and raising awareness of better health practices (P36).

Together, these statements responsibilize individuals by situating the solution to MNCH, conceived of as resulting from inadequate health services, in the ability of communities to manage their local health care services. Furthermore, the statements presume that community members have the power to demand healthcare services and to hold the government accountable, as well as the capacity to manage local health care services. Given the lack of explicit details regarding how these activities are being supported, these projects contribute to the responsibilization of individuals for ensuring adequate healthcare is provided within their own communities.

Improved community-based management of health care services is presented, along with the training of community healthcare workers, as a means of improving the availability of quality healthcare services. One project states that their interventions aim to:

> Improve the ability of health care systems, including community-based health systems, to deliver quality health care that meets the needs of people (P32).

Another project states that through its activities:

> 224 community health workers (CHW (80 men and 144 women) were trained on Integrated Community Case Management (iCCM) (an approach to prevent and treat childhood illness beyond health facilities so that more children can access life-saving treatment), pharmaceutical management, and maternal, newborn and child health services" (P30).

Similarly, project list implementation of community health management systems as both goals and outcomes of their activities, further situating responsibility for healthcare within communities themselves. For example, one project stats that "the project supports the scale-up of Community-based Management of Acute Malnutrition (CMAM) services in Malawi" (P42). These interventions contribute to the construction of improved managerialism as a key strategy for enhancing the provision of healthcare services, while also contributing to the construction of communities as responsible for ensuring this provision, including by providing certain services themselves.

6.1.1 Training Community Health Workers and Volunteers

In addition to 'empowering' community members to advocate for improved access to health services, programs also provide training to community health workers and volunteers so they can provide these services directly. Just as the training of healthcare workers is presented as improving the provision of healthcare on a broad level, training 'community health workers and volunteers, is also presented as a key strategy for improving access to medical care. Because many projects list this training as part of their project outcomes, it is not always clear whether these are existing health workers and volunteers who are receiving additional training, or if these roles are being created through the training itself. The role of these community health workers and volunteers is presented as providing basic healthcare services, monitoring health, and encouraging healthy behaviours including the utilization of healthcare when needed.

> *2465 community health care workers were trained* to provide nutritional counselling, growth monitoring, prenatal check-ups, safe pregnancy and delivery, postnatal and newborn care and infectious disease prevention and treatment (P66).
>
> *3736 community health volunteers and women groups members* were trained to identify children suffering from acute malnutrition in order to teach families to

> incorporate nutritious foods into their diet and to show them healthy hygiene practices (P11).
>
> A total number of 330 823 children under the age of five received treatment for malaria (129 008 children), pneumonia (91 315 children), and diarrhea (110 500 children) from over *7200 community-based volunteers* at an *average cost of $8.51 per treatment* (P45).

Significantly, training volunteers is specifically identified as a means through which to improve access to medical care at a relatively low cost. As such, this reliance on (presumably) unpaid volunteers raises questions as to how these programs contribute to the burden of labour of community members, and specifically of women.

Although there is generally not a great amount of detail indicating who community health volunteers and/or workers are, one project states that their activities include "training community-based volunteers, most of whom are illiterate women, to provide simple treatment in their communities" (P45). This statement indicates that community volunteers do not necessarily have a great deal of education, and yet are nevertheless positioned as able to be trained to provide particular kinds of health education services. Through this process, community members, and especially women, are constructed as having the capacity to become responsible for managing and improving the health of their communities.

6.1.2 Responsibilizing Communities through Awareness Raising Activities

In addition to training community health workers and volunteers to provide health services, programs describe education activities aimed at raising awareness of the importance of particular healthcare practices and services among community members more broadly. As indicated in some of the quotes outlined in section 6.1.1, some of these activities include training community workers and volunteers to provide education to community members themselves. For example, one project states that "244 men were trained to raise the awareness of other men on the importance of maternal health" (P58) while another claims that "9500 educational leaflets were distributed and 407 street theatre events were organized to raise awareness and improve knowledge of maternal, newborn and child health" (P66). Significantly, within the first quote men are specifically identified as key

actors whose awareness of maternal health is in need of improvement in order to improve maternal health. Additional project descriptions contribute to the discursive construction of community education as a key site of awareness raising interventions:

> The project includes: organizing community events and mass media campaigns, training community theatre groups, and selecting peer youth educators and male champions to raise awareness about potential health issues (P10).
>
> 85% of women and 76% of men in these villages improved their knowledge of sexual and reproductive health (P58).
>
> 23 935 people, including more than 10 000 men, attended awareness raising sessions on how to prevent illnesses impacting mothers and children under five (P73).

In addition to raising awareness regarding the importance of accessing healthcare, projects also seek to make community members aware of cultural elements that are understood as posing barriers to women's healthcare access. Notably, while reference is made to harmful practices and cultural views, the texts do not explicitly identify which practices and views are specifically targeted. For instance, Project 9 states that "106 informal service providers have been trained to *reduce harmful practices* and to increase appropriate referrals for mothers and newborns" (P9), while Project 88 states that it is "helping communities address *traditional cultural views impeding the use of health services*" (P88). These statements indicate that there is an explicit attempt to improve access to services by changing cultural understandings that have been identified as 'harmful', implicitly constructing developing world cultures themselves as barrier to healthcare and hence, a legitimate site of interventions.

Awareness raising is also used as a strategy for addressing the way in which gender is understood as a potential barrier to healthcare access, albeit implicitly. Texts identify gender and gender equality as issues taken up within awareness raising activities, implicitly identifying it as a potential barrier in need of being addressed to ensure access. For instance, Project 30 states that "21 health messages relating to maternal, newborn and child health, cultural barriers, environmental health and gender were designed and recorded" (P30), while Project 1 describes how the project "supports community engagement activities that help local communities become more aware of issues relating to the health of women and

children and to gender equality" (P1). In both of these quotations, gender is named and linked to the health of both women and children – yet the specificity of how gender acts as a potential barrier that must be overcome through such awareness raising activities is absent. Additional examples support this construction by similarly identify the need to raise awareness of gender equality as part of their project activities:

> Providing information about gender barriers to maternal, newborn and child health services to about 3.5 million women and men (P5).
>
> In Mali, over 3 300 community groups attended maternal and child health and gender equality sessions (P88).

These examples suggest that, while the language of gender was largely removed from the language of development within CIDA and later DFATD under the Harper Government, and specifically within the purview of the Muskoka Initiative, some programs nevertheless continued to include gender as a key component of their project descriptions. Although often vague, these projects do identify gender as a potential barrier hindering women's access to health services by identifying a need to raise awareness of gender quality and barriers as part of their overall strategies to improve access to health services for women and children. Interestingly, for the most part, these strategies continue to rely on measurable data in the form of inputs, exemplified in the quotes from both Project 5 and Project 88 included above. Progress towards gender equality is measured through the number of participants in education sessions, with little information about what these sessions entailed, and/or what their impact has been on communities, or on women specifically.

Some projects implicitly address how gender norms and relations might prevent women from accessing healthcare through their project goals and outcomes. For instance, Project 66 states that it is "promoting *shared decision making* on maternal, newborn and child health at the household level" (P66), while Project 58 states as part of their impact that "98% of women *were allowed by their spouse* to access maternal health care services (an increase of 27% since the beginning of the project)" and that "74% of women in the project area now have *the support of their spouse* to seek maternal care (an increase of 49% since the beginning of the project in 2011)" (P58). These statements construct women's lack of

decision-making power within partnerships and households, specifically as a barrier that should be overcome inn order to increase women's access to healthcare services. Such statements rely on implicit understandings of 'developing' world cultures are patriarchal, and of 'developing' world men as oppressors of 'developing' world women.

Significantly, while Project 66 promotes a model of shared decision making, Project 58 measures its impact through the number of women who were supported or "allowed" to access medical care. This phrasing suggests the implementation of a strategic solution that accomplishes the overarching goal of increasing access to medical services, overcoming gendered power relations as a barrier without necessarily dismantling them. Rather than addressing gender inequality directly, the project seeks to increase awareness among male partners of the importance of health services so that women are able to access them. Significantly, both strategies nevertheless target individual behaviour, not only of women, but of their partners as a key strategy for increasing women's access to healthcare services.

Certain projects identify the empowerment of women themselves as a key project activity that increases women's ability to access healthcare. For instance, Project 13 states that "1792 (51% of women living in target areas) report *feeling more empowered* to make financial decisions about their own healthcare needs" (P13). This statement implicitly identifies how gender might act as a barrier if women are not able to make financial decisions about healthcare needs. Similarly, Project 73 states that "mothers' *levels of confidence* regarding consulting their partners on reproductive health and childhood illness issues increased from 69.6% to 90/2%, which is above the target of 90%" (73). This statement, while vague, implicitly situates a lack of confidence as a problem that programs can help address. These projects situate women's ability to make healthcare decisions about themselves and their children in women's own understanding of their ability to do so. How these understandings relate to those of their partners and households is left unaddressed.

The discursive construction of gender and cultural factors as potential barriers to women's healthcare access was also addressed by interview participants, and by one interview participant in particular. This interviewee's comments aligned with the treatment of social factors as a potential barrier to healthcare but differs in the sense that they specifically

address how these factors affect women's agency to seek healthcare, rather than the outcome of accessing healthcare itself. This interviewee identified one of their own goals as understanding:

> What is the average day of a pregnant woman in a low-resource setting and trying to understand what are the more social factors that would lead her to maybe not having as much agency to kind of seek health in the same way that we certainly can (I3).

In this quotation, social factors are identified, broadly, as factors that influence women's agency and hence ability to access healthcare services. The participant returned to this idea several times, speaking specifically to women's agency and ability to make decisions about their health:

> I think that people have identified the issues of being a woman and kind of the disenfranchisement that happens in a lot of societies as a result of that, as a major problem for, leading to healthcare seeking behaviours (I3).

> Dealing with issues of women's empowerment and the ability for women to actually make choices a) to get pregnant in the first place and b) when she's pregnant to actually seek, be exposed to and seek healthcare when and where she needs it (I3).

> Its not just a problem of men keeping women down in these different areas, I think the set ups in South East Asia, or South Asia, with the mothers in law being kind of present, and really dictating a lot of what happens with women who are pregnant (I3).

In all three of these comments, the participant identifies gender as constraining women's decision-making ability, and their ability to access healthcare services. As such, the participant draws on a discourse of agency and empowerment that both highlights structural constraint while potentially aligning with neoliberal 'choice' frameworks that situate health as the outcome of one's ability to make good decisions for one's self.

Another interview participant similarly pointed to a lack of support for particular medical care as a potential barrier for women stating that: "it's not just knowledge, it's not just equipment, it's sometimes…there might be a *lack of support at home*, you know for the women to get the prenatal appointments they need" (I5). Another participant described a program they were aware of which worked with and educated conservative imams in order

to change beliefs surrounding vaccinations and family planning. As with the comments above, the contributions of these two participants identify familial support and religious beliefs as key barriers to healthcare services, supporting the broader identification of familial and community awareness raising as a legitimate strategy for improving women's access to maternal healthcare.

6.2 Responsibilizing Mothers by Governing Health Behaviour

One of the key strategies the texts identify for increasing women's access to healthcare is increasing women's ability and willingness to access healthcare services when they are available. Women are presented as facing barriers to healthcare services, including, but not limited to, their own resistance or ambivalence to seeking care. For instance, one project states that "the project targets current challenges such as inconsistent quality of services and the fact that mothers, for a variety of reasons, hesitate to use such services even when they do exist" (P51). Several additional examples illustrate how the problem of maternal health is situated, as least in part, in women's failure or inability to access medical care:

> The goal of this project is to improve women's and children's health by strengthening the use, quality and availability of health services for women, newborns and children, and addressing the social factors that prevent women from using these services (P58).
>
> The project is designed to respond to the needs of mothers and children by promoting better use of community health services, better household nutrition practices, and improved diseases prevention and treatment measures with a focus on malaria, diarrhea, pneumonia, and mother-to-child transmission of HIV/AIDS (P81).
>
> To make sure they [women] are seeking care at appropriate times (I3).

These examples implicitly situate women's failure or inability to access healthcare as part of the problem of maternal health by identifying it as a site of intervention. The targeting of women's healthcare seeking practices is part of a broader focus on women's health practices, as indicated by the quote above that groups promoting use of community health services with other everyday health practices such as household nutrition factors. Similarly, Project 73 states that their project results "are contributing to improving health facilities

and capacities, improving the quality of health are, and improving women's *healthcare practices*" (P73). Project 13 is slightly more explicit in identifying health behaviours as directly linked to maternal and child mortality, stating that:

> The project is designed to strengthen health systems for improved service delivery and to facilitate the creation of over 100 health focused community groups in order to support improved behaviours in health areas identified as major causes of mother and child mortality (P13).

Again, this broad focus on women's healthcare practices, even when these practices are specifically identified, locates women's own behaviour and choices as part of the problem of maternal health, and hence as a site of intervention. In attempting to change practices, these projects seek to govern women's behaviour, including when and how they access medical services. In the following sections I will outline more clearly which health practices are targeted and through what means, starting with the focus on encouraging women to access healthcare, and the moving on to everyday childcare practices. Significantly, these interventions demonstrate that although solutions to MNHC are largely situated in delivery of healthcare services, governing individual women's behaviour is also constructed as a key component of MNCH programming.

6.2.1 Constructing Women's Lack of Knowledge through Awareness Raising Activities

One of the primary ways in which increased use of healthcare services is pursued is through educating women and 'raising awareness' of the benefits these healthcare services provide. Specifically, projects focus on promoting the benefits of pre-natal care, as well as attended childbirth. In doing so, these project implicitly construct women in the developing world as ignorant of the benefits of medicalized birth practices, and thus only in need of enlightenment to change their behaviour. For instance, MNCH website 11 describes how program implementers:

> provide advice to mothers about their pre-natal care and speak of the benefits of delivering babies in an equipped government health centre or hospital where trained staff take care of the mothers and newborn babies (MNCH 11).

Similarly, Project 9 states that:

> In Bangladesh 53 community health volunteers and 53 female traditional birth attendants have been trained on maternal and newborn are and are doing home visits to pregnant women to educate them on eating nutritious foods, going for antenatal care visits, making birth preparedness plans and watching for dangers signs that indicate a need to go to the health facility (P9).

Again, by situating the solution to MNCH (at least partially) in increasing awareness and education about the (assumed) benefits of formal health services in turn relies upon the construction of women in developing countries as ignorant of these benefits, and as in need of education on order to not only understand but embrace these presumed benefits and seek care. Furthermore, awareness raising activities are positioned as helping women understand not only that they should seek medical care, but when to do so. As such, one website states that:

> Thanks to awareness raising campaign, 30 percent more mothers are now aware of potential signs of complications during pregnancy and *can seek care,* if needed, in a timely manner (34).

This quotation further illustrates how education campaigns are used to construct women as responsible for monitoring their pregnancies and seeking appropriate healthcare if and when complications should arise. As such, women are taught to self-govern in accordance with dominant expectations of when medical interventions are appropriate. In constructing women as in need of this education and awareness raising so that they can identify when to seek medical care, the texts identify lack of appropriate medical knowledge as a key barrier that prevents women from accessing health services while also discounting women's existing knowledge of their own bodies.

6.2.2 Governing Women's Everyday Health Practices through Individualized Behaviour Change

Through various awareness raising activities, the project descriptions outline activities that claim to help women monitor their pregnancies so that they can recognize and act on signs of potential medical complications by seeking medical care. Beyond simply increasing understanding, the purpose of these activities is presented as changing women's behaviours, and in doing so, improving the health not only of women, but of also their

children, both current and future. These efforts align with neoliberal configurations of health as the outcome of individual choices and actions, and with the responsibilization of women not only for their own health, but for the health of their children. Interventions that target communities, cultural attitudes and gender roles are positioned as helping women access healthcare, facilitating their ability to engage in appropriate health behaviours. Although improving access to healthcare is the primary means through which the texts aim to prevent death and solve the problem of MNCH, they also describe attempts to improve health by encouraging particular everyday practices, with a specific focus on child care practices such as feeding and sanitation. These interventions further situate health as the outcome of individual behaviour, contributing to the overall responsibilization of mothers, and to some extent, communities.

Interventions aimed at improving feeding practices similarly situate the solution to child malnutrition in improving women's ability to care for children. For instance, website 37 describes programming that promotes both medical treatment for malnutrition, and improved feeding practices stating that "to reduce the likelihood of relapses, trained volunteers also *conduct follow-up visits* to the homes of children discharged from the clinics, where they *reinforce best practices* in nutrition and health care, and *distribute information cards*" (MNCH 37). Similarly, Project 8 states that "Activities include *training women and community health workers* on infant feeding practices; training on food diversity and nutrition to improve backyard and community gardens;" (P8). In this quotation, women are positioned alongside community health workers as in need of training in order that they might engage in appropriate feeding practices, demonstrating the way in which education is used to construct women as responsible for children's health through their roles as mothers and caregivers. Furthermore, by being positioned as in need for education and training, these women are constructed as having insufficient knowledge, not only of the importance of healthcare, but also of childcare practices, including nutrition. Project 33 specifically identifies change in feeding practices as a goal of project activities, listing "significant *change in nutritional behaviour* among members (m/f) in particular communities" (P33) as part of their project outcomes. The following examples further exemplify how feeding practices are targeted as a site of intervention:

> 25 000 households received *information on good nutrition practices*, such as appropriate child feeding and food preparation (P39).
>
> Support mothers and new babies when they come home, *offering advice* about nutrition, child-feeding practices and basic infant care (P11).
>
> 948 871 children under two participates in the growth monitoring and promotion activities, while *mothers received counselling* on infant and young feeding best practices" (P28).
>
> The project seeks to improve nutrition by *providing training* in home-based agricultural production, education on nutrition, and raising awareness of behaviour change, such as promoting good breast-feeding practices (P41).

The inclusion of training and counselling of feeding practices in both program goals, and in project outcomes illustrate the way in which individualized solutions to health problems through the promotion of particular behavioral norms, described as 'best practice', are included within the overall construction of MNCH as a development problem.

In promoting 'best practices' in feeding and nutrition, breastfeeding, including exclusive breastfeeding is often situated as a best practice, and as a desired outcome. For example, Project 8 states that they are "supporting nutrition by encouraging breastfeeding and ensuring essential micronutrients are available" (P8). While Project 8 directly links breastfeeding to good nutrition, the texts analyzed rarely explicate what it is about breastfeeding that makes it an ideal practice. Rather, certain projects situate breastfeeding as a desired outcome, even as they report increases in the number of children who are breastfed as part of their project outcomes. For example:

> Breastfeeding at birth practices improved significantly in the four health districts of intervention. An average of 83% of children of the four health districts received colostrum in 2012 against 95% in late 2013 (P33).
>
> Proportion of children under six months that are exclusively breastfed increased from 72% to 92% (P81).
>
> 3245 children under the age of one received newborn services such as preventing hypothermia, initiate exclusive breastfeeding, and umbilical cord care (P50).
>
> Approximately 6500 infants' lives saved through breast feeding practices (P41).

As these examples demonstrate, breastfeeding is presented within the texts as a positive, even life-saving behaviour. Interestingly, all of these examples position breastfeeding as

an activity that is engaged in by children, with mothers discursively absent from each statement. Further, references to increases in breastfeeding are not contextualized within the texts, nor combined with a discussion of when breastfeeding might not be ideal, nor of the potential effect it might have on the health and/or lifestyle of the mother. Maternal preference for breastfeeding is not taken into account, and indeed mothers are made absent by the discursive positioning of breastfeeding as a best practice for child nutrition, with success measured solely on the number or proportion of children who receive it. In these ways, mothers' the texts obscure any reasons why breastfeeding may not be adopted. Rather, it is constructed as an ideal and uncontested feeding choice.

Although the discursive construction of breastfeeding as a child nutrition intervention obscures the role of mothers, and the impact breastfeeding may have on them, some projects explicitly address the impact of maternal nutrition during pregnancy and breastfeeding as a key means by which to improve the overall health of mothers and of children. Maternal nutrition during the pregnancy and breastfeeding is construction as a key site through which awareness raising and behavioural change can improve overall health. For instance, Project 9 states that:

> In Bangladesh 53 community health volunteers and 53 female traditional birth attendants have been trained on maternal and newborn are and are doing home visits to pregnant women to educate them on eating nutritious foods, going for antenatal care visits, making birth preparedness plans and watching for dangers signs that indicate a need to go to the health facility (P9).

In this quotation, eating nutritious food is situated alongside other forms of medical care such as antenatal visits, and seeking health care in the case of potential complications. As such, it is situated specifically as a health intervention and exemplifies the way in which every day behaviours such as food are brought into the sphere of health. This medicalization of nutrition further situates it as an appropriate site of intervention, targeted primarily through awareness raising activities that again promote 'best practices'. Additional projects identify improved maternal nutrition as an important outcome of program activities, with project 40 stating that "7200 infants aged less than two years and 9800 pregnant and lactating women received food and general nutrition education in 40 health facilities across three rural districts" (P40). Project 12 describes "handling cases of moderate acute malnutrition that are detected among pregnant and nursing women"

resulting in "reduced malnutrition in pregnant and nursing women in the regions of Kayes, Koulikoro, Segou, Sikasso and the district of Bamako" (P12). Such statements construct maternal nutrition as an important intervention, which makes sense given the way in which both pregnancy and malnutrition are constructed throughout the project as sources of risk. Yet significantly, projects that aim to raise awareness in order to improve maternal nutrition largely situate such interventions as way through which to mitigate risks specifically to future children. For instance, Project 11 states that:

> The project aims to *reduce infant mortality* in three districts of the Kayes region by Improving the nutritional status of children under that age of five *and pregnant and nursing women*, and reducing the malnutrition rate" (P11).

The main goal is identified as reducing infant mortality, and project activities include addressing the nutrition of "pregnant and nursing women" (P11). As such, the project discursively identifies improving the nutritional status of pregnant and breastfeeding women as a means through which to improve infant health and survival. Similarly, Project 37 states that their activities "reduce nutritional deficiencies that affect safe childbirth and development" (P37), again positioning improved maternal health as a means of improving child development. Such statements indicate the way in which the maternal health interventions are situated not only as means of improving maternal health per se, but also as means of intervening in the health of children and potential future children. Such construction is made more explicit in Project 64's description of the "1000 days" period from conception to two years of age as a key site of intervention. The project description states that:

> Focusing on the "1000 days" window of opportunity, from the day of conception to the age of two years, the project supports Malawi's national efforts to prevent anaemia in pregnant and lactating women (at 38% in 2010) and stunting among children under two years of age (at 47% in 2010) (P64).

By identifying the period of crucial intervention as beginning from the day of conception, the project necessarily situates the maternal body as implicated in this intervention as the fetus at this stage exists only within said body. This statement helps illuminate why the maternal body becomes a site of intervention in child health both within the project, and in other projects, if more implicitly in the latter. The implications of this positioning will be

explored in greater detail in the discussion chapter, including how, in focusing specifically on maternal health, women's need for nutritious food outside of periods of reproduction are ignored. For now, it is worth noting that this positioning is significant in part because it highlights how mothers are responsibilized for the health of their children not only through care practices such as child feeding, but also through care of their own bodies during childbirth and lactation. Much in the same way as health interventions during pregnancy are situated as in the best interest of both mothers and their children, maternal nutrition is situated as a site of intervention in the health of children.

In addition to encouraging 'good' feeding and nutrition practices, project descriptions also promote behaviours understood as preventing and treating disease. These interventions further individualize responsibility for disease prevention and treatment, particularly through women's roles as caregivers. Promoted practices include being able to recognize signs of disease and to seek treatment when disease may be present. For instance, Project 29 describes "educating families about health behaviours, signs of illness and seeking care" (P29), while Project 30 helped produce "radio broadcasts on illness symptoms and treatment" (P30). Similarly, Project 34 states that project activities have led to "increased practice of appropriate gender-sensitive, home-based management of childhood illness and prevention of common diseases among parents (mothers/fathers)" (P34). This goal of increasing awareness of, and practice of actions that treat and prevent diseases is pursued not only through increasing families' willingness to access health services, but also by encouraging everyday practices that are constructed as helping to prevent illness in the first place. For example, Project 5 states that their program is:

> Reaching over three million caregivers with training on the prevention of leading diseases affecting mothers and children (sleeping inside insecticide treated bednets, using oral rehydration solutions to treat diarrhea, completing immunizations, hand washing, antenatal care and preventing mother to child transmission of HIV) (P5).

In this statement, the practices in which caregivers are trained, and which are situated as disease prevention measures include both formal medical care in the form of diarrhea treatment, immunization and antenatal care, as well as everyday care practices in the form of sleeping and hand washing practices. As such, everyday care practices are identified as ways of promoting health through the prevention of diseases, reinforcing the construction

of disease as something that is preventable, while at the same time situating responsibility for this prevention not only in healthcare systems that provide healthcare services, but in the everyday practices of caregivers. Project 34 describes "reaching 45903 people with information on the proper and consistent use of long lasting insecticide-treated nets" (P34), and website 11 states that, through their program:

> Traditional birth attendants have worked to educate mothers on proper and consistent use of the 42 120 long-lasting insecticide nets distributed by the IMPACT project, helping protect 14 151 pregnant women, 38, 055 children and 25 752 other family members from malaria (MNCH 11).

Again, such projects explicitly seek to change sleeping behaviour, encouraging the use of mosquito nets both by improving access to mosquito nets by distributing them to families, as well as educating and raising awareness regarding how and why to use mosquito nets as a form of disease prevention. Similarly, sanitation practices are references by several projects, with Project 73 stating that they are "promoting vaccination, appropriate care during illness, and better household sanitation and hygiene" (P73), and Project 8 stating that their project has resulted in "improved household hygiene practices and diarrhoea prevention among children under two and pregnant women" (P8).

Attempts to change behaviour are targeted not only at mothers and caregivers, but also at children themselves, particularly when it comes to sanitation practices. In this way, children too are identified as populations in need of governance, who must learn how to adequately conduct themselves in order to protect their health. For instance, Project 36 extends its education beyond mothers and caregivers stating that *"*at the community level, the project provides training for men, women and children under five in hygiene, nutrition, and sanitation, in addition to undertaking community awareness activities" (P36). The project further claims that "More than 193 801 men, women, and school children have received training on themes related to water, hygiene sanitation and nutrition" (P36). As with provision of healthcare services, communities are also targeted, as exemplified by Project 28's attempt to end open defecation within entire villages, listing in their results that "6122 villages achieved open defecation-free status" (P28). Additionally, Project 87 states that they are "promoting and supporting community-led awareness and education campaigns that aim to change the way people approach hygiene and sanitation" (P87).

Schools and school aged children are in particular targeted for changed sanitation and hygiene behaviour, with Project 87 further stating that "the project aims to improve water, sanitation and hygiene facilities and practices in 300 schools and 650 surrounding communities" and that "hygiene promotion campaigns to promote hand-washing and healthy hygiene practices have been launched in 343 schools, benefitting 57 249 girls and boys" (P87). Similarly, Project 9 states that "encouraging this practice (hand-washing with soap) in schools helps prevent diseases such as diarrhea and infections" (P9). Again, individual hygiene practices such as hand washing are situated as able to prevent disease, and as such, to mitigate a key factor in child mortality, further individualizing the responsibility for child health.

6.3 Building Individual Capacity by Removing Cost as a Barrier to Medical Care

The texts analyzed position interventions as helping women to overcome the barriers that keep them from accessing medical services when required. These barriers are addressed explicitly, as well as implicitly, through descriptions of what actions are taken to help improve individuals' capacity to access services. For example, MNCH website 35 illustrates this strategy describing how one program:

> aims to reduce the barriers that prevent women in rural areas from getting access to the health services they require, to provide better-quality health services for mothers and children in rural areas, and to improve the ability of community health management teams to deliver quality health services (MNCH 35).

This quotation demonstrates how programs increase access to healthcare not only by improving the delivery of services (as addressed in Chapter 5), but also by removing barriers that prevent individuals from accessing healthcare once available. As I have outlined above, these activities include removing the barriers posed by women's ignorance of or ambivalence to the benefits of medical care through awareness building. They also include removing the barriers posed by the resistance of male partners, and 'traditional' practice, again, through education. Additionally, the texts address the potential barrier posed by poverty, and with the cost of healthcare services. This barrier is addressed both on in terms of how healthcare is delivered, and by improving individual women's ability

to pay for services. For instance, one website explicitly identifies cost as a barrier to access, stating that: "this initiative was essentially aimed at making health services accessible to women and children *by removing financial barriers* and improving the quality of the service" (MNCH 10). More commonly, this barrier is identified implicitly through reference to the need to lower costs and/or make services free, as in the following examples:

> A set of health promotion, prevention and curative intervention is delivered, free-of-charge to the targeted population through a network of 17 hospitals in all 10 departments (P43).
>
> The project works to bring affordable and quality health services for women and children to front-line health facilities in under-served communities…This make it easier for low-income and poorer communities to use these services (P50).
>
> Satisfaction regarding the project demonstrated an overall satisfaction rate of 83.2%, mainly associated with the fact that the services were free (P43).

A few projects address the barrier of cost not only through reducing the price of services, but also through income generating or transfer programs that seek to give economically vulnerable women the resources to pay for healthcare services and their associated costs. Project 79 does this through a voucher scheme "which *offsets transportation and other costs*, to provide *incentive to encourage pregnant women to seek health care* attention during pregnancy and childbirth as well as for their newborns" (P79). Project 35 simply states that their project "enhances women's *ability to pay* for health services" (P35).

The strategies above exemplify the implicit construction of poverty and economic vulnerability as a barrier to healthcare access. Poverty is also identified as a key factor in determining one's access to nutritionally and/or calorically adequate food, although again, this is usually done implicitly through descriptions of how programs have sought to increase available resources. For instance, Project description 8 states that "The project has created 95 village savings and loans groups that are designed to provide financial support for dietary diversity and food security involving a total of 459 women" (P8). Similarly, project description 11 states that:

> 95.46% of children suffering from severe acute malnutrition have completed their treatment and were cured, while their mothers (or the person who was accompanying them) received vouchers to purchase food (P11).

By describing increased access to resources as part of the solution to MNCH, these projects implicitly construct lack of income as contributing to poor nutrition and as a barrier to health. These texts therefore acknowledge the economic poverty as a social determinant of health, although it continues to be addressed at the individual rather than the systemic level. Solutions therefore address individual inability to pay for particular types of healthcare and or/food, but not necessarily the broader factors that contribute to economic marginalization.

6.4 Summary

The texts analyzed construct awareness raising activities as a key site through which to improve access to health services and as such, to improve the overall health of the population. Awareness raising and education are situated as strategies through which to encourage particular kinds of everyday healthy behaviour, particularly for pregnant women, mothers and children. The promotion of these practices draws upon and promotes understandings of health as the outcome of individual behaviour, responsibilizing individual women for their own health, and the health of their children. Despite the overarching focus on access to medical care, everyday health activities, including, but not limited to accessing healthcare, are constructed as means by which individual women can tailor their behaviour to manage their own health and the health of their children. Furthermore, though traditional cultures, gender norms and poverty are all positioned as potential barriers that keep individuals from accessing health services, they are presented as surmountable through straightforward transfer programs, as well as through continued awareness raising among communities and their leaders in ways consistent with a western biomedical health framework. These interventions also situate community members as capable of improving health outcomes through the direct provision of services, as well as through encouraging specific health behaviours.

Chapter 7:

7 Constructing Development Actors

In the previous chapters, I outlined how the analyzed texts construct MNHC as a problem of preventable deaths that can be solved by increasing access to healthcare services. In turn,

MNCH programming that enhances access to health care services by educating services providers, optimizing management and educating women are presented as effective solutions to high maternal and child mortality. I have also demonstrated how these solutions responsibilize developing world governments, communities and women, situating the solution to maternal, newborn and child health in capacity building interventions that improve not only that ability of developing countries to provide medical services, but the ability and willingness of developing world women to access them. In this chapter, I consider how these discursive constructions presume and enable the construction Canada itself as capable, yet benevolent development actor and as a global leader in maternal, newborn and child health. I also examine how Canada is constructed as part of a global community working to address MNCH, and as a 'partner' to 'developing countries' as well as NGOs. This emphasis on community and partnership contributes to the construction of Canada as a benevolent nation, providing much needed aid to the 'developing' countries while respecting their sovereignty and autonomy. This construction obscures Canada's economic and political, inoculating Canadian interventions against accusations of neocolonialism, working to legitimize Canadian funded development interventions.

7.1 Constructing Canada as a Global Leader with the Capacity to Address MNCH

The establishment of Canada as a global leader in MNCH is one of the strongest discourses to emerge from my analysis of the government of Canada webpages. Throughout the website, Canada is explicitly identified as taking a leadership role on a global scale both generally, and with specific reference to the Muskoka Initiative. In particular, Canada is positioned as an advocate for MNCH, and as responsible for putting MNCH on the global development agenda. For example, Canada is credited for having "taken a leadership role on improving global, newborn and child health" (MNCH 4), and for having "brought international attention to the issues of undernutrition" (MNCH 4). Canada's leadership is articulated in reference to the development and implementation of the International

Muskoka Initiative, in addition to its leadership on the issue of MNCH within the United Nations:

> Because of *Canada's leadership through the Muskoka Initiative*, maternal, newborn and child health has become a global priority (MNCH 26).

> In May 2014, as the Muskoka Initiative was nearing its end, *Canada once again mobilized the global community* and reinvigorated the discussion and commitment on maternal, newborn and child health at the global Saving Every Woman, Every Child: Within Arm's Reach summit in Toronto (MNCH 8).

> At the 69th Session of the United Nations General Assembly where *Canada continued to advocate to ensure that maternal, newborn and child health remains a top priority* in the post-2015 development agenda (MNCH 34).

These quotations contribute to the discursive construction of Canada as a leader within the global community, whose advocacy is responsible for putting and keeping MNCH on the global agenda. This discursive construction was also supported by participant interviews, with informants identifying Canadas a global leader, and as being recognized as a leader by the global community. For instance, one participant stated:

> Focus on women and children's health is something that Canada kind of put a flag in and that we've actually made progress, and we should keep going on it (I3).

Another participant spoke of being at an event where:

> One person after another would get up and speak and every single one of them directly attributed that *Canada had made the effort to take the lead and bring the world together* on what is known as a solvable problem" (I5).

One participant also identified Canadian leadership in terms of its ability to influence other countries, stating that:

> We've been able to *influence other countries' investment* in maternal, newborn and child health, so that's one of the key areas where I think the Muskoka Initiative has shown or *resulted in tremendous leadership* (I2).

These excerpts demonstrate that informants not only identified Canada's leadership on MNCH, but also understood this leadership to be recognized on the global stage.

7.1.1 Constructing Canada as a Life Saver

The construction of Canada as a global leader on MNCH is also achieved through the representation of Canadian funded initiatives as saving the lives of women and children within the 'developing' world. As I have shown, 'developing' world women are presented as both vulnerable populations in need of intervention, and as (potentially) active agents capable of becoming responsible for their own health, and the health of their children. In Chapter 5, I outlined how discourses of risk are used to construct women and children in the developing world vulnerable populations, while maternal and child mortality rates are used to construct the 'developing' world itself as a place of danger and unnecessary death. Yet, as I have also demonstrated, while 'developing world' women and children are presented as at risk of dying, their deaths are constructed as 'preventable'. Women and children are thus situated as lives who can be saved through Canadian funded interventions. This construction is illustrated through the repeated use of the slogan "Saving Every Woman and Every Child is within Arm's Reach" (MNCH 20; 21; 22; 23; 24 25). This slogan situates Canadian interventions as capable of saving women and children within the 'developing world'. Other examples strengthen this construction, situating Canadian activities as actively preventing death and saving lives:

> Together, *we can stop the preventable death* of women, children and newborns, and *save the millions of lives* that hang in the balance" (MNCH 26).

> The Micronutrient initiative is *saving and improving the lives* of 500 million people every year in 70 countries with its child survival, child health, growth and development, and women's and newborn survival and health programs (MNCH 8).

> I feel proud to be Canadian, to see…*the lives that are being saved of women and children through Canadian efforts and Canadian innovations* (MNCH 33).

These examples not only construct developing world populations as lives to be saved, but specifically situate Canada and its partner organizations as their saviours. Significantly, although the language of saving lives contributes to the construction of developing world populations as passive objects of development intervention, this construction exists alongside the positioning of developing world women as capable of becoming responsible health-seeking subjects. I will address the tension between these discourses in Chapter 8.

7.1.2 Constructing Canada as a Healthy Nation and as a Capable and Committed Development Actor

While developing countries are constructed as sites of poor maternal, newborn and child health due to this limited capacity to provide services, Canada, in contrast, is discursively constructed as a site of good health, where mothers and children are health and are able to access adequate medical care. For instance, one webpage states that "Every child has the right to basic health. And in Canada, most do". The text then goes on to describe the lack of immunization available to children in the 'developing' world (MNCH 19). The contrast this webpage presents between the availability of healthcare in Canada versus the 'developing' world sets up a hierarchy wherein Canada is positioned as a country who is able to provide adequate healthcare to its population, and 'developing' countries are not. Similarly, webpage 22 states that "in Canada, most babies are fortunate enough to get the care they need to get a good start" (MNCH 22). In addition to obscuring disparities in healthcare that exits within Canada, this quotation situates access to healthcare as the result of good fortune, obscuring the structural factors that shape disparities in access both within and between countries. Disparities between Canada and developing countries are also highlighted by the statement that "it is absolutely unconscionable that 100 times as many women die in pregnancy and childbirth in many parts of the developing world compared to Canada" (MNCH 33). Although this statement highlights the inequity that exists between Canada and 'developing' world countries, as well as the injustice of these inequities, this statement similarly fails to grapple with the reasons that might explain these discrepancies. Again, but contrasting Canada with the 'developing' world, the statement also fails to acknowledge or account for inequality in health access and outcomes that exist within Canada, as well as within developing countries themselves. Instead, Canada is constructed monolithically, as a place where good health just so happens to be available to all.

In addition to being constructed as a site of good health, Canada is also positioned as a site of resources, which are deployed in order to solve the problem of MNCH on a global scale. For example, Canada's funding activities and commitments are highlighted on several of the government of Canada pages:

> Under the Muskoka Initiative, Canada provided $1.1 billion in new funding and made a commitment to maintain $1.75 billion for existing maternal, newborn and child health programming, for a total contribution of $2.85 billion over five years (2010–2015) (MNCH 7).
>
> At the summit, Canada pledged an additional 3.5 billion over five years (2015–2020) to improve the health of mothers, newborns and children around the world, building on Canada's initial investment of $2.85 billion form 2010–2015 (MNCH 8).
>
> Canada is a long-standing donor to Gavi, the vaccine Alliance, which improves access to new and underused vaccines for children living in the world's poorest countries (MNCH 38).

In these examples, Canada's ability and willingness to provide money is used to demonstrate Canada's commitment to MNCH. As such, it contributes to the construction of Canada as a country that is capable of taking meaningful action on MNCH, and that is generous enough to act on this capacity.

Canada is further identified as a source of funding in project descriptions, as each description includes the amount of funding provided by the Canadian government. Furthermore, many of the descriptions include the statements: "This project is part of Canada's Maternal, Newborn and Child Health Commitment". Although Canada funds programs implemented by actors and organization that are not necessarily Canadian, by contributing funds, Canada is able to take ownership of a broad array of development interventions. Again, Canada's financial contributions are also taken as evidence of its 'commitment' to MNCH. By allotting funds, Canada is able to decide which programs receive financial support, and how much. The positioning of Canada as a source of financial resources builds upon and reiterates Canada's construction as a source of expertise and authority to direct MNCH programming, not only through involvement in international agreements, but also through the allocation of resources.

In addition to providing funds, Canada is positioned as holding and sharing expertise, as are the organizations that Canada supports through the Muskoka Initiative. For instance, one webpage describes how:

> In the summer of 2014, Canadians, civil society, academia and private sector organizations were consulted to ensure that *Canadians' wealth of expertise* continues to shape Canada's top development priority; maternal, newborn and child health (MNCH 8).

Situating Canada as a site of both funding and expertise further positions Canada as an actor that has not only succeeded in providing healthcare to its own population, but which is also capable of supporting developing world countries that, in contrast, are positioned as lacking the resources and expertise to do the same. Again, Canada is positioned not only as an advocate and leader who is committed to solving MCH, but also a country who has the capability and authority to act on this commitment. For example, webpage 4 describes how Canada is "helping countries prepare sound national plans and programs to improve nutrition by supporting government ministries in developing countries working with donors, civil society organizations and other key partner" (MNCH 4) Page 17 claims that:

> Canadian grassroots action, from elementary and high school club projects to college and university support to *Canadian expertise* in non-profits, civil society, private industry and large organizations shows that, together, Canadians are making a difference (MNCH 17).

Project descriptions also rely on the construction of Canada or implementing partners as experts by describing how their programs are able to provide technical assistance and consultations in order to build the capacity of recipients. One project states that they are "*providing technical assistance* and support to improve local level planning by the government" (P51); and "*increasing community and Ministry of Health capacity* to manage and support effective and nutrition programs" (P29). These quotations situate not just Canada, but Canada's implementing partners, in a support role, whereby they are able to build the capacity of recipients by sharing their expertise.

Canadian expertise, indicated, for example, by existing involvement in nutritional programming, was also highlighted in interviews, with participants speaking to Canada's capacity to engage in MNCH programming. For instance, one participant stated that "we have some amazing players in Canada: NGOs that do phenomenal work abroad" (I3). Another participant stated that:

> Canada is one of the few countries that has our own multilateral [organization] that focuses on nutrition, through the Micronutrient Initiative, that probably (I'm speculating here) but that probably influenced the decision to focus on nutrition. Because we're a major player on the world stage (I2).

This quotation highlights how Canada's existing work on nutrition positions it to address the problem of nutrition, one of the Muskoka's areas of focus. In addition to position Canada as holding expert knowledge in this area, this quotation also suggests that Canada's existing expertise played a role in determining what kinds of interventions Canada would support.

The construction of Canada as a country with the capacity to address MNCH is also supported by interview participants' references to Canada's principles and overall approach to development. These principles, which include a commitment to gender equality, are drawn upon to position Canada as able to succeed in implementing its MNCH programming:

> These have been very successful programs, and again it's partly because of *the way Canada does development*. You know, there's a lot of experience, there's a *lot of good principles*" (I5).

> Other critical principles that we apply that are really Canadian are *gender equality,* which really makes a big difference (I5).

> Canada isn't necessarily bigger always on the financial investment, but I think where it does play a very strong role is *its normative approach* to its investment. Is to keep the underpinnings of *human rights, of gender, of reproductive and sexual health, as, you know, and the progressive thinking that goes behind that at a policy level* (I4).

Canada's principles, and overarching approach to development work to further legitimize Canada as a development actor who is well positioned to take on the issue of MNCH.

7.1.3 Measuring and Demonstrating Canadian Success:

Canada's capacity as a development actor is further supported by references to the successes of Canadian funded MNCH interventions. Through references to measurable outputs and outcome, Canadian funded interventions are presented as having made progress on improving MNCH in the 'developing world'. Canada is presented not only as

a global leader whose advocacy helped put MNCH on the global agenda, but also as a competent development actor whose interventions have effected significant change within the 'developing' world.

Canada's success is presented through various means, including broad statements regarding the difference Canada has made through its interventions. For instance, webpage 17 states that "we are *making a difference* for healthy mothers and children" (MNCH 17), while webpage 19 states "through these efforts, Canada and key partners are *taking huge strides* to end preventable maternal and child deaths within a generation" (MNCH 19). Aligned with the construction of the problem of MNCH as one of high mortality, success is also communicated through quantified, population level data, such as those found within the following statements:

> Through concerted efforts coordinated by the Global Polio Eradication Initiative, since 1988, new cases of polio have decreased by more than 99% and at least 2.5 billion children around the world have been immunized against polio (MNCH 3).
>
> With the support of donors like Canada, the EPI is credited with preventing approximately 200 000 deaths a year in Bangladesh. Its success in achieving and maintaining polio-eradication status, and in staying on course to eliminate measles by 2016 is widely acknowledge – even in rural areas (MNCH 14).
>
> The number of children who die before their firth birthday has dropped by 45%, from more than 12 million in 1990 to 6.3 million in 2013. The number of women who die each year during pregnancy or childbirth has dropped by 45% from 523 000 deaths in 1990 to 289 000 in 2013 (MNCH 39).

In addition to supporting the construction of Canadian interventions as successful, these examples illustrate how 'development' is constructed as something that can be quantifiably measured. Most project descriptions include a section outlining the results of their project, listing measurable outputs, either in terms of services provided, or changes in the health of the population. For example:

> *Maternal deaths dropped from 306 in 2011 to 153 in 2013* in four districts (as per preliminary analysis of the Maternal and Perinatal Death Review, which is examining deaths in the two months before expected birth and up to one month after delivery)" (P51).
>
> Approximately *85% of the population* living in the targeted districts *have now access* to the basic package of health services (P75).

> These results have contributed to improving the health of women and children demonstrated by the fact that *neonatal mortality rate in the project area was reduced from 44 per 1000 live births* in 2011 to two at the end of the project (P58).

These statements identify increased access to healthcare as evidence of project success, as well as changes in maternal and neonatal mortality rates. These measurements are used to demonstrate the impacts of project activities, and to demonstrate that projects are indeed leading to positive outcomes, as intended.

Although success is primarily communicated through measurable outputs and outcomes, some webpages also construct interventions through inclusion of testimonials from local individuals within recipient countries, including health workers, local leaders, and women themselves. Although rare, these testimonials work to further establish the success of interventions, highlighting the impact these interventions have had on both individuals and communities. As such, they represent an alternative means through which to demonstrate success. For example, website 9 states: "In the words of Nicholas Wake, *a local leader* in the Tatale district, NORST "has *brought joy and relief for the people in the area*" (MNCH 9). This statement draws on the authority of a local leader to demonstrate that the described project has had an impact, bringing 'joy and relief'. Similarly, webpage 10 claims:

> In 2014 at the commissioning of a water system in Bunkpurugu, *Canada received high praise from Ghana's President, John Mahama*, who said, "By providing water, Canada is saving lives in Ghana" (MNCH 10).

By providing direct quotations from local and national leaders, these quotations draw upon the authority of their voices, as those whose communities are impacted by interventions, to report on the positive outcomes that have arisen from each project. Further, these quotations provide evidence that the funded projects, at least once they are completed, are approved of by leaders within 'developing' countries, to a certain extent inoculating projects against critiques that they have been imposed without local support.

Testimony from locals also 'humanize' results that are primarily reported through quantitative data, emphasizing the impact of interventions on individual lives:

> "I wanted to be a midwife to help women and children in my community, but before training, I did not have the confidence to handle birth complications" *says Dirbe Feyissa, a midwife working in the Kelo Health Centre*. "After taking the basic

> obstetric care training, *I and my colleagues are now able to manage even breach cases*, which in the past we would not have been able to manage" (MNCH 11).
>
> "EPI is doing good things in our country" says Syeda. "*Everyone is quite pleased with this program* because, so far, in the rural areas everyone is complete these free vaccinations. We rarely see someone suffering from polio or tuberculosis, so we are doing well" (MNCH 14).

These quotations again support the construction of Canadian funded intervention as appropriate and successful. They also situate Canadian interventions as having been supported by local actors, who, if not directly impacted by interventions, are able to closely observe their results. These testimonies also implicitly construct the relationship between project implementers and recipients as one of satisfaction and gratitude. Interestingly, women themselves are rarely quoted. Nevertheless, these testimonials support the discursive construction of Canadian success, and the overarching construction of Canada itself as a development actors whose intervention in MNHC are successful and appropriate, bringing about positive change and saving lives.

7.1.4 Constructing the Need for Continued Intervention

Despite the discursive construction of Canadian interventions as successful, the texts also emphasize the need for ongoing interventions. The texts present this ongoing need not as in evidence of any failure on the part of Canadian interventions, but rather, as indicative of the need to provide more of the same. The phrase "Saving Every Woman and Every Child: Within Arm's Reach", discussed above, clearly situates the issue of MNCH as one that can be solved, but has yet to be. Similarly, the oft-repeated phrase "we need to deliver more results like these" (MNCH 20; 22; 23; 24) highlights the need for continued action, while explicitly linking this needed action to the success of previous interventions. Thus, Canadian success are not constructed as having resolved the problem, but as effective interventions that need to be ramped up. In the same vein, website 27 states that:

> Worldwide the health of women has improved and the number of maternal mortalities has dropped from close half a million to about 280 000. That is 280 000 too many. So, it is important that we need to continue to make further progress (MNCH 27).

This quotation sends the message that while good progress has been made, there is still work to do, and Canada must maintain its commitment and resolve. Indeed, the risk of interpreting success as an indication that the problem of MNCH has been solved is specifically highlighted by an interview included via video on webpage 32, wherein the CEO of the Society of Obstetricians and Gynaecologists of Canada stated:

> Probably the most dangerous thing we could have done is said, ok we're going to do this and then abandon ship and say ok, we're onto the next task. It's really important that once we take something one we see the job through (MNCH 32).

Canadian success is therefore mobilized to justify continued action in the face of ongoing need, further legitimizing Canada's work on MNCH.

7.2 Canada as a Leader and Partner in a Global Community

The discursive construction of Canada as a global leader in MNCH is tied to the construction of MNCH as a global problem requiring a global solution. As outlined in Chapter 5, MNCH is a problem that is constructed as both global in nature, and as located within particular regions and countries. As a global problem, MNCH is identified as a shared responsibility, requiring global solutions through international cooperation and collaboration. Many of the Government of Canada webpages describe action that is being taken, or that needs to be taken, by this global community. For instance, webpage 35 states that:

> As part of the Millennium Development goals (MDGs) agreed to in 2000, the global community made a commitment to reduce maternal mortality by three quarters from 1990 to 2015 (MNCH 35).

Webpage 25 states that "now we need to do more than ever as a global community" (MNCH 25), while several pages repeat an appeal that "we need to do more together globally" (MNCH 20, 21, 22, 23, 24). This use of the word 'we' situates Canada as part of this community, which is being called on to continue action on the problem of MNCH. These examples also demonstrate how Canada, situated as part of the global community, is legitimized in taking an active role in MNCH programming.

Within the texts, the UN and G8 are explicitly identified as institutions through which the global community is working to address MNCH. For example, webpage 35 states that:

> In September 2010 the *United Nations Secretary-General* announced a $40 billion Global Strategy for Women's and Children's health, aimed at *helping the world* meet millennium development goals to reduce child mortality and improve maternal health (MNCH 35).
>
> In June 2010, through the Muskoka Initiative, *Canada led G8 and nonG8 leaders* to commit $7.3 billion to *mobilize global action* to reduce maternal and child mortality and improve the health of mothers and children in the world's poorest countries (MNCH 35).

These statements further strengthen the construction of Canada as part of a formalized global community, and the construction of MNCH as an issue that is recognized within this community.

Interview participants also specifically identified Canada's prioritization of maternal health as aligned with global goals. For instance, one informant stated that "the efforts in Canada were very much *aligned with the efforts globally through WHO*" (I2). Participants also explicitly referenced global development initiatives such as the Millennium Development Goals as part of their explanation for why Canada chose to focus on maternal health. For instance, one participant stated that Canada's prioritization of MNCH "was very *consistent with the Millennium Development Goals* at the time" (I3). Another stated that:

> The world had set 8 development goals, *the Millennium Development Goals* in the year 2000. And in 2008–2009 it became clear that we were going to meet most of the goals, but *we were not going to meet MDGs three and four,* which pertain to maternal, newborn and child health – we weren't on track at all. It was really*, that was the rallying point* around which the effort was pushed (I2).

A similar explanation was provided by another participant, who stated that:

> The fact is that that these are areas that, of the original Millennium Development Goals, were showing the least amount of progress, that *needed more attention* and actually a platform and a focused initiative on these areas (I3).

These quotations situate Canada's focus on MNCH as a response, not only to the agreement made by the global community to address MNCH as part of the MDGS, but also a responding to the failure on the part of the global community to achieve these goals. By

taking on a leadership role in this area, and by establishing MNCH as a top development goa, Canada is positioned as stepping up to a solve a problem that the global community as tried, but so far failed to resolve. Interestingly, one participant also noted that global priorities could also be limiting factors, stating that "I think it's really hard for a government international agency to really go outside the box of what a global framework looks like" (I3). This quotation points to the way alignment with a global framework may have limited Canada's development action.

7.3 Constructing Canada as a Development Partner that Provides 'Support'

While on a global scale, Canada is constructed as a leader, the relationship between Canada and 'developing' countries themselves is positioned as one of partnership and support. Rather than taking a leadership role, Canada is described as a 'partner' who is working with recipient countries and organizations towards common goals, as determined not only by the international community, but also by recipient countries themselves. For example, webpage 39 states that "Canada *supports country-led efforts* to improve access to essential health services by training health workers and ensuring that health facilities are adequately equipped" (MNCH 39). Webpage 13 claims that "Canada is among the countries that *supports Haiti* in the pursuit of this objective" (MNCH 13). These quotations situate Canadian interventions as a form of support offered to 'developing' countries, who are pursuing development objectives that they themselves have established.

Project descriptions also deploy the discourse of country-led development and Canadian partnership, with statements such as "The project is implemented in alignment with the *Government of Nigeria's* Integrated Maternal, Newborn and Child Health Strategy" (P5) and "[the project] supports Tanzania in *achieving national targets* for reducing child mortality and improving maternal health (Millennium Development Goals 4 and 5)" (P10). Again, in these examples, developing countries are constructed as defining their own development goals, with projects helping them to achieve these goals rather than imposing particular development frameworks or objectives. In this configuration, Canada is also positioned as helping developing countries to take responsibility for the health of their population. The framing therefore (to a certain extent) inoculates Canada against

accusations of colonial imposition of development goals and programs, while resisting the construction of developing countries as taking a hand-out, instead of a hand-up.

Just as Canadian relationships with 'developing' countries are characterized as ones of partnership and support, so too are relationships between 'developing' countries and other global development actors. Global actors, institutions and organizations, particularly those implementing Canadian funded interventions, are situated as providing support to 'developing; countries, allowing these countries to achieve their goals:

> The Global Fund's model is based on the *concepts of country ownership and performance based funding,* which means that people in the countries *implement their own programs* based on *their priorities* and the Global Fund provides financing on the condition that verifiable results are achieved (P21).
>
> This project expands Canada's support to Renewed Efforts Against Child Hunger and Undernutrition (REACH) *in order to support country-led efforts* to effectively scale up-nutrition activities to improve the health and reduce death in the most vulnerable mothers and children (P70).
>
> This project supports the United Nations Children Fund (UNICEF) *in partnership with* the Mozambique Ministry of Health, to undertake a nationwide measles vaccination campaign for children under five (P85).

Within these examples, global actors and campaigns are constructed as working in partnership with developing countries themselves, supporting them in achieving their own 'country-led' efforts. The global development sector itself is explicitly positioned as a sphere of international and cross-sectoral cooperation, obscuring the power dynamics that exist between various countries, organizations and institutions.

As part of the construction of Canada's role as one of support and partnership, 'developing' country governments, like developing world women, are constructing both as in need of support, and as active participants in their own development. Despite previously discussed constructions of developing world countries as unable to successfully provide health services and ensure the health of their populations, they are nevertheless constructed as actively involved in development initiatives that seek to address this insufficiency. This construction is in part achieved through the acknowledgement and support of country-led

initiatives described above, as well as through explicit reference to the active role that developing world governments play in defining and implementing programs:

> The Government of Kenya has always played a crucial role in the program's success. In 2009 the government launched the Home-Grown School Meals Program (HGSMP) (MNCH 16).
>
> *Canada's support has further helped the government of Nigeria to roll out its own programs* (MNCH 13).
>
> Programming priorities in fact were determined by developing countries themselves (I1).

While the active role of developing countries is not emphasized to the same extent as is Canada's leadership and support, its description nevertheless contributes to a construction of developing countries as in need of support, and yet as active development agents. Furthermore, Canada is situated as able to provide the support these countries need, and to do so in way that respects the agency and sovereignty of 'developing' countries. Thus, Canada is situated as a global leader and source of important resources, and as working in partnerships that allow 'developing' countries to establish and pursue their own development goals. This construction of Canada as a development 'partner' who not only helps 'developing' country governments, but does so in a way that respects their autonomy, adds a level of legitimacy to Canadian interventions, inoculating Canada against critiques of (neo)colonialism.

In addition to situating Canada as supporting developing world governments in achieving their MNCH goals, Canada is also positioned as supporting and partnering with various NGOs. In describing Canada's support of, and partnership with, international NGOs and multilateral institutions, Canada is again situated as part of a global community working together to address MNCH. This discourse further positions Canada as taking a role of support, rather than imposing its own agenda, even though partner NGOs and particular initiatives are chosen in alignment with Canadian definitions of MNCH, as well as established areas of focus. The following examples demonstrate how Canada is constructed as partnering with and supporting organizations actively working to address MNCH:

> Canada supports UNICEF and Helen Keller International in delivering essential health and nutrition services that are saving the lives of children under five in Africa, through Child Health Days (MNCH 4).
>
> Canada and the Aga Khan Development network, the AKDN, are collaborating today in many countries in Africa and Asia, to reach out to some of the most vulnerable communities, to help both mothers, children and their families and communities improve their chances of surviving and thriving as active citizens in their communities (MNCH 30).

Within the project descriptions themselves, partnership is also emphasized, with each project description listing the "implementing partner"; that is, the organization that is receiving funding and carrying out the project. That organizations receiving funding are situated as partners suggest an equal relationship in carrying out a common goal, again eliding power differential at work in the process by which the Canadian government decides which programs and 'partners' to fund.

In project descriptions, implementing organizations are often identified as partnering with local organizations to carry out their project. Again, this discourse of partnership suggests equitable working relationships, situating the projects as having the support of local groups:

> International Child Care Canada is working with International Child Care Haiti to implement this project (P31).
>
> Partner organizations include: Seeds of Hope International Partnership (Zambia), Danish Committee for Aid to Afghan Refugees (Afghanistan), Church World Service (Cambodia), Ethiopian Kale Heywett Church (Ethiopia), Environment and Public Health Organization (Nepal), National Centre of Environmental Health and Water Supply (Laos) and Pure Water for the World (Haiti) (P86).
>
> To implement this project, the Christian Children's Fund of Canada is working in partnership with: Bole Bible Baptist Church Child Care and Community Development, Ratson-Women, the Youth and Children Development Program, and the Wolaitta Kaele Heywot Church Terepeza Development Association (P34).

Although these statements provide little detail as to what these working relationships encompass, that they are situated as 'working with' and 'partnering' with additional NGOs, including local organizations, further positioned development as a collaborative process.

7.3.1 Private Partnerships

In addition to partnering with local governments and organizations, Canada and Canadian funded organizations are also constructed as partnering with actors within the private sector. For instance, Project 76 includes "promoting public-private partnerships" (P76) as one their project activities, while Project 72 specifically references its partnership with mobile service provide Tigo:

> The project supports the scaling up of an innovative birth registration system, which was developed by Tanzania's birth registration agency in partnership with Tigo (a mobile service provider (P72).

Other private partnerships that are constructed as effective in addressing MNCH include:

> Canada's support for the zinc Alliance for Child Health, a partnership among the micronutrient initiative, the government of Canada, and Teck resources, a Canadian mining company, has made it possible to treat 5.6 million children (MNCH 6).

> The Global Fund to Fight AIDS, Tuberculosis and Malaria is a unique, public-private partnership and international financing institution dedicated to attracting and disbursing additional funds to prevent and treat HIV and AIDS, tuberculosis (TB) and malaria (P21).

By identifying partnerships between governments, NGOS, and private entities, Canada implicitly supports such partnerships as legitimate ways through which to pursue development goals. Interestingly whereas in partnerships with developing world governments and NGOs Canada is situated as supporting these partner organizations, in partnerships with private entities, Canada is positioned or utilized as "leveraging" the resources these organizations have to offer:

> Canada is *leveraging private-sector expertise* and supporting partners who are finding innovative solutions to these problems (MNCH 6).

> We need *to leverage* the capital, innovation and technical know-how of the private sector to accelerate efforts (MNCH 21).

> For example in Mozambique, Canada is supporting a public-private partnership with Coca-Cola, *using its refrigerated trucks* to deliver vaccines when they are not delivering soft drinks (MNCH 6).

The language of 'leveraging' and 'using' resources suggests that while in partnerships with NGOs and developing countries Canada supports their partners without implementing their own agenda or pursuing their own interests, in partnerships with private companies, Canada makes use of the resources these companies can offer in pursuing established goals. The language subverts a reading of public-private partnerships as providing an opportunity for private companies to dictate development programming or to use development interventions as an opportunity to support their own interests. This language appears to alleviate anxieties around public-private partnerships as potentially compromising development interventions. Instead, partnerships are presented as providing access and use of resources, while allowing Canada to remain in control of how and for what purpose they get used.

7.3.2 Canadian Partnerships in Tension

Throughout the texts analyze, Canada is situated as a unified actor, with references to 'Canada' usually indicating the Canadian government. When references are made to Canadian partners, these partners are constructed as sharing a unified goal of addressing maternal, newborn and child health. This treatment of Canada as a unified set of actors sharing a common agenda is made visible through statements made by participants addressing the way in which the MNCH agenda was constructed and adopted by the Canadian government. For instance, one participant highlighted the role of 'sector leaders' who engaged in advocacy in order to put MNCH on Canada's development agenda prior to the G8 summit, stating:

> A number of *sector leaders* convened to explore how they could *encourage Canada to take up the banner of maternal, newborn and child health* as part of their Chair of the G8 summit that was being held in Canada in 2010. So, following that meeting in 2008, a group of sector leaders convened quite regularly and *they worked to influence leaders* and to provide information and to *recommend that Canada invest in Maternal, newborn and child health through* the G8 summit in 2010 and they were successful (I2).

This statement makes visible the 'behind the scenes' work that was done before Canada became a leader on the global stages. The statement continues to draw on a discourse of partnership, positioning the Canadian agenda as having been established by advocates and

experts working collaboratively. While the statement reinforces a discourse of partnership, to a certain extent it also disrupts the construction of Canada as a unified actor, with leaders needing to be convinced and encouraged to take on MNCH as a development goal.

Comments from another participant highlights how the construction of Canada as a unified actor can obscure the power dynamics at work in the process of agenda setting. Specifically, decisions to fund MNCH itself directed the efforts of other actors and partner, encouraging them to pursue MNCH focused projects in order to access funding. The participant spoke specifically to the way in which their own activities (and framing of these activities) were influenced by the Canadian government's prioritization of maternal health, stating that:

> The commitment by the Harper government was backed up by a great deal of money. And money can shape pretty well anything, and it does shape people's opinions, and it does shape their attitudes as well…so I think the money helped a lot to push the concept (I1).

This quotation illustrates how discourses of partnerships, described above, hides the extent partnerships are nevertheless imbued with power differentials including the power of the funding actor (the Canadian government) to set development agendas and priorities. This aspect will be analyzed further in Chapter 8.

7.4 Summary

Throughout the texts analyzed, Canada is situated as global leader and advocate for maternal health, as well as a development actor who has the resources, expertise and commitment to address MNCH as a development problem. Canada is constructed as a country which has succeeded in ensuring the health of its own population, and is positioned as capable of providing resources and expertise needed by 'developing' countries who have been unable to do the same. This positioning of a Canada as a country where maternal, newborn and child health is strong, and which has the financial resources and expertise needed to help others, helps to strengthen the discursive construction of Canada as a global MNCH leader, and in turn, to legitimize Canada's development actions. The construction of Canada as a capable development actor who can, and should, engage in the problem of

MNCH is further bolstered by the discourse of Canadian success, constructed through references to quantifiable outputs, as well as testimonial from local recipients.

Through discourses of Canadian success, Canada is constructed as a country with the motivation, values and authority to take on MNCH, and in doing so, to respond to a problem that has been identified by the global community, and by 'developing' countries themselves. Descriptions of Canadian funded interventions situate Canada's response as one of providing support for local partners and governments and contributing to 'country-led' initiatives that are both welcome, and implemented through equitable relationships of partnership. This discursive construction of Canada as both a leader, and a supportive partner, is central to the positioning of Canadian interventions as an appropriate means of addressing the problem of MNCH.

Chapter 8

8 Discussion and Conclusion

The goal of this research project has been to determine how maternal health is discursively constructed as a development problem within Canada's Muskoka Initiative, and to examine how this discursive construction has shaped how maternal health has been governed within Canadian development programming. In addressing these questions, I have also considered how the discursive construction of maternal health draws on and reinforces dominant norms of motherhood, and how it aligns with neoliberal development frameworks. Furthermore, I have interrogated how Canadian development programming situates the bodies and reproductive lives of women in the Global South as sites of development intervention, asking how maternal health programming thus acts as a sphere of biopolitics through which women's reproduction is governed. In pursuing this research, I have sought not only to contribute to theoretical understandings of how biopolitics functions within the sphere of global development, but also to contribute to understandings of how maternal health programming can contribute to, and/or undermine reproductive justice.

To answer my research questions, I conducted a critical discourse analysis of texts associated with Canada's Muskoka Initiative. Specifically, I analyzed documents from the

Government of Canada's MNCH website, as well as project descriptions for programs funded through the Muskoka Initiative. My findings show that these texts construct maternal health primarily as a problem of unmanaged risk, with maternal and child mortality positioned as 'preventable' through increased access to medical care. Based on this dominant framing, interventions are constructed as able to address MNCH by providing the inputs necessary to improve the availability of medical care; providing infrastructure, resources and training; enhancing the management of health systems; encouraging women to seek medical care through 'awareness raising' activities; and removing cultural 'barriers' to healthcare through community education. Furthermore, my analysis demonstrates that central to the discursive construction of development programming is the configuration of Canada as a global leader in maternal, newborn and child health, providing resources and expertise to 'developing' countries, while ostensibly allowing these countries to take the lead in establishing their own health goals. In this chapter, I address each of these discursive constructions through the lens of my theoretical frameworks. In doing so, I draw connections between the construction of maternal health within the Muskoka texts and neoliberal development frameworks, with particular attention to the depoliticization of health in development. I argue that the particular iteration of maternal health programming put forward within the Muskoka Initiative also contributes to the instrumentalization of women within development, as well as the entrenchment of patriarchal gender norms and expectations. I argue that the maternal health programs funded through the Muskoka Initiative seek to 'empower' women by assigning individual responsibility for their reproductive health, while also governing them through the promotion of particular reproductive, health and care practices.

8.1 Maternal Health as a Biopolitical Project

As I outline in section 5.1 maternal and child mortality statistics are used to define and locate the problem of maternal and child health within the 'developing' world, as well as to demonstrate the improvements attributed to MNCH interventions. This use of demographic statistics is indicative of the configuration of MNCH as a biopolitical problem. Foucault (2003) states that biopolitics is concerned with, and seeks to affect, vital phenomenon at the level of the population. By measuring and seeking to improve global

and national maternal and child mortality rates, the Muskoka Initiative can be understood as a biopolitical project that takes as its object 'the population'. Furthermore, as I discuss in greater detail below, these population level changes are sought through attempts to govern the reproductive behaviour of individual women, exemplifying how reproduction, and specifically maternal health, is situated at the axes between the biopolitics of the population and the anatamopolitics of the body.

Understanding the Muskoka Initiative as a biopolitical project helps elucidate how programs are designed not only to benefit individual women's wellbeing, but also to compel them into particular ways of being. The use of statistics in the Muskoka Initiative not only helps to locate and define the problem of maternal health, it is also used to legitimize interventions based on the understanding that these interventions will produce particular, measurable changes at the level of the population. Women are thus not only targeted as individual recipients of services and resources, but are also impelled to be healthy, responsible, reproductive citizens who will contribute to the project of development, as measured through the health of the population. Within this biopolitical logic, wherein maternal health is considered not only as a project of saving individual lives, but of managing populations, the imperative to govern women's reproduction appears logical. I argue, therefore, that the configuration of maternal health as a biopolitical project aligns with and reinforces the broader instrumentalization of women within global development discourse.

Understanding maternal health as a biopolitical project can help illuminate how development programming acts as a site through which women's bodies, and particularly their reproductive lives, are governed. It also raises questions as to how biopolitics operates at the global level. When Foucault originally developed his theories of biopower and biopolitics, he did so with a focus on European nation-states. Nevertheless, scholars have adapted his theories to the contemporary, globalized context, finding his ideas useful in explaining how populations are governed across national borders (Elbe, 2005 Bashford, 2006; Sanford, 2013). As Bashford argues, considerations of global biopolitics involve both an international lens, which considers how populations are governed within and across borders, as well as a global lens, which takes as its focus the human population across the

world. Furthermore, examinations of global biopolitics have demonstrated the need to consider the role of multilateral institutions, such as the World Health Organization, whose role is understood as managing the health of the world's population (Bashford, 2006; Sanford, 2013). As Li (2007) argues, in considering the role of such institutions, as well as NGOs that operate transnationally, the relationship between biopower and governance becomes extremely important. This is because these global and/or international actors cannot rely on the sovereign power of the state to achieve their aims, and must rely instead on less direct forms of governance. Similarly, my dissertation demonstrates how a country like Canada can deploy biopolitical technologies of governance in order to manage populations in 'developing' countries without directly challenging these countries' sovereignty or rights. As such, my dissertation contributes to understandings of global biopolitics as it operates between countries, as well as to critical development studies concerned with how 'development' programs act as a site through which relations of power are enacted and reinforced.

8.2 Medicalization, Technocratization and Depoliticization through Risk

Before turning to the specific ways in which women are governed through maternal health programming, I examine how this governance is made possible through the construction of maternal health as a problem of risk management. Specifically, I argue that discourses of risk are used to construct MNCH as a problem that is 'preventable' through technocratic, depoliticized interventions that seek to increase access to healthcare. I argue that this technocratic approach to maternal health aligns with neoliberal frameworks of development that focus on delivering resources and changing individual behaviour, rather than advocating for systemic change.

8.2.1 Locating MNCH through Risk

Within the Muskoka texts, population level data is used not only to define maternal health, but also to identify certain populations as especially at risk of maternal mortality. As outlined in section 5.1, while maternal health is constructed as a global problem, it is also specifically located within the 'developing' world, where maternal and child mortality rates

are highest. By situating the problem of MNCH within the ‘developing’ world, the texts contribute to the construction of ‘developing’ countries as places of poor health, and of ‘developing’ world populations as in need of aid. This construction presents the ‘developing’ world as places of homogeneity, obscuring the social, political and economic inequality that exists within ‘developing’ countries and failing to differentiate between health outcomes and/or access to healthcare within their populations. Furthermore, the use of maternal and child mortality statistics draws on medicalized understandings of pregnancy and childbirth as periods of heightened risk in order to construct mothers and children as in danger, and hence, as in need of being saved. The use of statistics to situate mothers and children as at risk is thus used to justify the need for Canadian interventions that can provide the resources required to manage the medical risks associated with pregnancy and childbirth, and by doing so, save the lives of women and children within the ‘developing’ world.

By locating populations ‘at risk’ of maternal and child mortality within the ‘developing’ world, the Muskoka texts situate the factors that put populations at risk within the ‘developing’ world as well. Situating risk within the developing world acts as a means of bounding the field of action within which MNCH can be addressed. For instance, the apparent lack of trained medical professionals within ‘developing’ countries is addressed through training programs within these countries, but not through examination of the policies and conditions that incentivize the immigration of skilled health medical professionals from ‘developing’ countries to donor countries (Naicker, et al, 2009; Castro-Palaganas et al, 2017). By containing the problem of MNCH within the ‘developing’ world, solutions and interventions, though implemented by global ‘partners’, seek only to transform the ‘developing’ countries. Furthermore, this configuration draws on and reiterates dominant understandings of ‘developing’ countries as incapable of successful governance.

8.2.2 Medicalizing Reproduction through Risk

Central to this construction of MNCH as a problem that is contained within the ‘developing’ world, is the construction of maternal mortality as ‘preventable’ through access to formal medical care. Specifically, the problem of maternal health is located both

in the inherent risks associated with pregnancy, childbirth and childhood and, more importantly, in the inability of 'developing' world countries to manage these risks through effective healthcare systems. As such, the texts rely on and perpetuate medicalized approaches to pregnancy and childbirth, situating it as a process that requires the supervision and management of medical professionals.

The medicalization of pregnancy and childbirth within the Muskoka Initiative is discernible in the construction of pregnancy and childbirth as periods of inherent bodily risk. As I outlined in section 5.1.3, the texts contain multiple references to complications that can arise from pregnancy and childbirth, putting the lives of women and newborns at risk. As such, pregnancy and childbirth are situated as periods of danger, with childbirth itself described as "dreaded". Notably, although potentially deadly, these risks are constructed as able to be mitigated through treatment from appropriately trained medical professionals, such as doctors and at times, midwives. Furthermore, as I describe in section 5.4.2 traditional birth attendants are explicitly presented as lacking the skills and expertise needed to deal with complications. Instead, their value is identified as providing support to women by referring them to more appropriate, that is medical, forms of birth care.

The construction of pregnancy and childbirth as periods of risk contribute to the medicalized framework that has been critiqued by feminist scholars and midwifery advocates in both the Global North and the Global South (Cheyney, 2008; Cosminsky, 2012; Parry, 2008). Specifically, discourses of risk are used to situate medical supervision and management as the only means by which to make pregnancy and childbirth 'safe'. As such, medicalized pregnancy is constructed as the only 'rational' response to the dangers posed by pregnancy and childbirth. As Barker (1998) has argued in relation to the medicalization of pregnancy in North America, it was largely through the blurring and eventually dismantling of any distinction between 'normal' and 'pathologized' childbirth that helped move reproduction so squarely into the medical domain. Within the Muskoka texts, this process is discernible, as any pregnancy or birth is positioned as having the potential to become dangerous. By extension, one of the programs' main goals is to increase the number of pregnant women who access prenatal care, and to ensure that every birth is attended by a 'skilled medical professional'.

One of the central critiques of medicalized pregnancy and childbirth is that it situates authority over reproduction in the hands of medical professionals, as opposed to women themselves (Parry, 2008). As such, women's knowledge of their own bodies is devalued, and their birthing preferences dismissed. Similarly, with the extension of medical authority over human reproduction, the knowledge of midwives and birth attendants in various contexts has been devalued and even pathologized (MacDonald, 2006; Cosminsky, 2012). In the context of the Muskoka Initiative, interventions aimed at educating women and raising their awareness of the importance of medically supervised birth similarly construct women as, to a certain extent, ignorant of pregnancy and childbirth. Rather than representing women as knowledgeable about their bodies, and their experiences of pregnancy and childbirth, women are situated as in need of education that will help them understand the need to entrust the management of their pregnancies and births to medical professionals.

As stated, within the Muskoka Initiative, traditional birth attendants are explicitly positioned as lacking the skills and knowledge necessary to oversee childbirth. Furthermore, rather than seeking to provide traditional birth attendants with training that would help them provide improved care during pregnancy and childbirth, interventions instead train birth attendants to refer women to 'skilled' health professionals. Significantly, this strategy aligns with what was then the WHO recommendation, which stipulated that maternal health interventions should not seek to train skilled birth attendants, as previous attempts to do so had failed to make significant differences in maternal mortality rates (Cosminsky, 2012). Observing the consequences of this policy in rural Guatemala, Cosminsky argues that this stance on traditional midwives[4] is ultimately harmful, given how many women continue to turn to traditional midwives for care. Her study demonstrates that some of these women chose care from traditional midwives in part because they understand these midwives as able to help with birth in ways that align with their cultural beliefs and values. The decision to hire a midwife may also be influenced by the continued

[4] Cosminsky specifically uses the term midwife in recognition of their skill set, and to avoid the colonial implications of the term 'traditional birth attendant'.

barriers women face in accessing more formalized medical care (Cosminsky, 2012). While it is not within the scope of this study to address how pregnant women and local birth attendants have reacted to or negotiated the training and education programs described within the Muskoka texts, it is nevertheless important to highlight how this process has been contested in other contexts. Acknowledging this contestation problematizes the straightforward narrative of traditional birth attendants as happily accepting their role of providing referrals, rather than continuing to provide culturally meaningful care during birth. It is also worth noting that since the conclusion of the research conducted by Cosminsky in Guatemala, and of the Muskoka Initiative, the WHO has modified its recommendations, emphasizing the potential harm that can be caused through over-medicalization of pregnancy and childbirth and the need to provide care while honouring and respecting women's birthing preferences (WHO, 2018a).

Following Gary's (2002) proposal that feminist engagements with medicalization should interrogate the ways is which medicalization has been used to control and further oppress marginalized groups, my analysis of the medicalization of reproduction within the Muskoka Initiative seeks to illuminate how this medicalization contributes to the depoliticization of maternal health and the governing of 'developing' world women's reproduction. That is to say, I do not seek to critique the provision of medical care itself, but rather to ask specifically what work the medicalization of reproduction does in the broader context of the Muskoka Initiative. In promoting particular forms of medical care as the only means by which to make pregnancy and childbirth safe, the Muskoka Initiative contributes to the reification of western medicine and expertise over other forms of knowledge and practice. In doing so, the texts put forward a straightforward narrative in which women and traditional birth attendants will recognize the desirability and superiority of medical care such as attended childbirth once they have been appropriately enlightened. This narrative obscures the various factors that inform women's reproductive decision making, which have been highlighted in ethnographic studies of women's healthcare and birthing decisions (Cosminsky, 2012; Smith-Oka, 2012; Allen, 2002). Furthermore, by obscuring the ways in which women embrace, negotiate, and resist medicalization, these narratives obscure how the construction of medicalized reproduction as a 'rational' response to risk establishes and encourages particular reproductive norms, including

hospital births. This governing of women's reproduction through discourses of medicalized risk is examined in more detail in section 8.4.

8.2.3 Medicalization as Technocratization

The medicalization of reproduction within the Muskoka Initiative is also significant because it contributes to the depoliticization and technocratization of maternal health, and by extension, of development. Technocratization refers to the ways in which development is positioned as a series of technical problems, which can be resolved through straightforward, technical interventions (Li, 2007). Technocratization has been understood as a key form of depoliticization, as it negates the need to examine and address economic, social and political systems, and specifically, the role that these systems play in perpetuating poverty and/or inequality (Li, 2007). Technocratization thus renders development a question of technical improvements, implemented by development 'experts', rather than a question of social justice and/or systemic change. Significantly, technocratization has been linked to neoliberal development frameworks that prioritize efficiency and measurable outcomes (Li, 2007; Cornwall, Gideon and Wilson, 2008). Within neoliberal frameworks, there is an emphasis on maximizing the efficiency of economic systems and building individual capacity to overcome poverty and social marginalization through increased participation in the existing market system (Cornwall, Gideon and Wilson, 2008). These goals are positioned as achievable through straightforward interventions, including 'empowerment' initiatives that leave existing relations of power within and between countries intact (Li, 2007; Shani, 2012).

The medicalization of reproduction within the Muskoka texts constructs MNCH as a problem of technical intervention by positioning improvements in healthcare delivery as the central means by which to improve maternal and child mortality. While the Muskoka texts construct pregnancy and childbirth as inherently risky, they also identify women and newborns in the 'developing' world as being at heightened risk of mortality during these periods. This heightened vulnerability to the risks associated with pregnancy and childbirth is positioned as the outcome of a lack of access to appropriate medical care, rather than the social, economic or political factors that may affect maternal and child health. In other words, the problem of MNCH as measured through maternal and child mortality is

positioned as the result of a failure to manage the medical risks associated with pregnancy and reproduction. Therefore, by constructing pregnancy and childbirth as events that are inherently risky, the texts position increased access to healthcare as the key, if not only, means by which to prevent maternal and child death. The medicalization of pregnancy and childbirth is hence a central component of the Muskoka Initiative's overarching focus on increasing the provision of medical services, rather than on addressing systemic factors that contribute to maternal and child mortality. Social determinants of health that might contribute to complications are not significantly identified as potential sites of intervention, except in terms of how they might prevent women from accessing medical care. For example, while economic poverty is implicitly situated as a barrier to healthcare by interventions that seek to improve access to services by removing or mitigating the cost of services, systemic and political drivers of poverty are left unexamined, as are the myriad of other ways in which poverty might affect maternal and child health outcomes beyond reducing access to services. The exceptions are brief references to the importance of water and sanitation services and/or the need to improve household capacity to meet nutritional needs. Nevertheless, the overwhelming focus of the texts is the provision of inputs such as equipment, infrastructure, and training, and on improving the managerial capacity of countries and communities to provide healthcare to their populations. As such, the texts avoid engaging with the systemic roots of poverty and inequality within and between countries, including inequitable health outcomes.

To some degree, it might appear that the emphasis on improving the provision of medical care within the Muskoka Initiative offers a less individualized approach than is generally associated with neoliberal frameworks of health and of development. The emphasis on the need for Canada, as part of a global community, to support improvements in state provided healthcare in order to address global health inequities may at first seem indicative of a model of shared social responsibility for managing the risks facing women in the 'developing' world. Likewise, the use of a risk framework that acknowledges, albeit in a limited way, the role that economic and social barriers might play in limiting an individual's ability to access medical care seems to challenge, to a certain extent, a purely individualized model of risk that situates risk management and health outcomes as the sole responsibility of individuals themselves. Nevertheless, the model of risk being deployed in

the Muskoka texts still situates risk in the individual maternal body, and emphasizes how this risk can be mitigated by increasing individual access to resources, and through individualized models of care between women as patients and medical professionals. As such, in seeking to increase access to medical care, the Muskoka Initiative seeks to create circumstances through which women can manage risks at the individual level of the body through access to resources, rather than through addressing social, economic and political risk produced at the collective level. In doing so, it aligns with neoliberal models of health as an individual project of risk management, as well as neoliberal frameworks of development concerned with building individual capacity to improve one's situation and become a responsible, productive and healthy citizen.

As I outlined in section 5.4 interventions funded through the Muskoka Initiative largely focus on increasing access to medical care by providing resources such as medication, equipment, infrastructure and training for medical staff. These interventions are presented as relatively straightforward processes of delivering resources to those in need, rather than as engaging in the restructuring of economic or political systems, or the redistribution of economic and/or political power. This includes a lack of transformative engagement with gender inequality, as interventions that address gender do so by treating it as a barrier to healthcare access that can be overcome by convincing men to allow their female partners to access healthcare. Gender is also addressed as a technocratic issue of healthcare management and delivery in programs that seeks to improve 'gender sensitive' delivery of health services. While there exists limited reference to increasing women's confidence and/or ability to engage their male partners in decisions regarding health, there is no explicit engagement with how these projects target gender inequality as a systemic issue. Thus, the overarching focus remains on technocratic interventions that seek to deliver resources and increase access to medical services.

It is worth noting that access to medical care is an incredibly important component of maternal and child health, as well as reproductive justice. In examining discourses of medicalization, it is not my goal to critique or undermine the need for improved access to medical care for those who need it. Rather, my aim is to demonstrate how the medicalization of maternal health allows for the exclusion of social determinants of health,

as well as their systemic origins. By addressing health disparities only through increased treatment of biomedical risk and their effects, the Muskoka Initiative perpetuates a biomedical model of maternal health that renders the field of development action much narrower than if it included engagement with social determinants as the outcome of economic injustice, gender inequality or environmental degradation. By constructing maternal health as an issue of access to medical care, the texts negate the need to engage in potentially contentious issues of power, and can focus instead on technocratic interventions that increase the availability and accessibility of medical services. As such, I argue that the Muskoka Initiative's medicalization of maternal health draws on and perpetuates a depoliticized and technocratic model of development.

The Muskoka Initiative's technocratic approach is further exemplified by the focus on measurements within the texts, and particularly, within project descriptions. That each project description includes a section outlining what their projects have accomplished indicates that these projects are required to account for their activities, as well as their impact. That this accounting is communicated through quantitative data indicates a broader understanding of impact as something which can be objectively measured. As Keast (2017) has argued in her own analysis of the Muskoka Initiative, this focus on measurement is associated with a depoliticized approach to development and to health, which reduces both to a series of measurable outputs rather than to systemic change.

Some project descriptions draw a direct link between their activities and the number of women and/or children who have either been able to access medical care, or whose lives have been saved because of their intervention. In addition to using quantitative data to demonstrate the impact of their interventions, these projects deploy a linear, cause-effect model of risk that situates poor health outcomes as directly preventable through particular actions. Furthermore, by situating interventions as successfully saving lives, these texts further obscure the need for interventions that address additional systemic factors.

The medicalized model of risk deployed within the Muskoka Initiative effectively constructs the problem of MNCH as one of risk management through access to medical care. By focusing on the management of risks presumed to be inherent to pregnancy and

childbirth, the texts are able to position increased healthcare as the means by which women and children's lives can be saved, and maternal mortality rates decreased. Maternal and child mortality thus becomes a problem that is easily 'preventable', requiring only the political will to mobilize and deliver necessary resources. From a reproductive justice standpoint, this provision of healthcare is extremely important, but nevertheless inadequate. Indeed, the critique that healthcare alone is an inadequate response to maternal mortality, and to disparities in maternal health, has been at the center of analyses of maternal health programs since the early 1990s. As Petchesky (2000) has argued, maternal and reproductive health cannot be separated out from issues of either gender equality or economic justice. Furthermore, sustained and effective intervention into social determinants of health have been identified as requiring not only engagement with the effects of these determinants, but with the social, economic and political systems that shape vulnerability to them (Raphael, 2016). As Harcourt (2009) and other women's healthcare advocates in the 1990s have argued, promoting maternal health alongside macroeconomic policies that perpetuate inequality and poverty at the individual, as well as the national level, will thus always prove insufficient. This is in part why the Cairo Programme of Action was heavily critiqued by feminists and women's health advocates, as endeavours to increase women's access to healthcare were undermined by the popularity of structural adjustment programs (SAPs) that required states to cut funding to public health services such as healthcare, while promoting economic policies that diminished economic capabilities (Harcourt, 2009). Studies on the effects of structural adjustment programs have demonstrated their negative effects on the health of women and of children, due in part to cuts to public spending on health systems, the introduction of user fees, and limited availability of healthcare in rural areas (Jacobson, 1993). The economic impact of these SAPs also affected women's health through decreases in real wages, which led to increased economic vulnerability, longer work hours, and increased participation in unregulated and hazardous workplaces (Jacobson, 1993). Furthermore, while low wages increased the need for women to work outside of the home, they remained responsible for domestic duties, with overwork, stress and exhaustion aggravating negative health outcomes (Lugalla, 1995). Furthermore, Lugalla (1995) argues that in the Tanzanian context, increased economic vulnerability exacerbated gender inequality, with women more likely to turn to

marriage as a survival strategy, while experiencing decreased power in household decision-making and greater vulnerability to sexual harassment and violence both at home and in the workplace. All of these factors impacted women's health, including maternal and sexual health, demonstrating the need to consider macroeconomic policies as social determinants of health, both broadly, and in relation to MNCH (Jacobson, 1993; Lugalla, 1995; Petchesky, 2000).

Although the era of SAPs has ostensibly ended, the neoliberal development frameworks on which they rely remain popular and powerful. Yet factors related to macroeconomic policies, as well as international economic relations, are excluded from the Muskoka Initiative, as are issues such as poverty and inequality, to which they have been linked. This exclusion has resulted in criticism within earlier studies and commentaries on the Muskoka Initiative, claiming that it failed to engage in the root causes of maternal health, including social determinants of health (Huish and Spiegel, 2012; Keast, 2017; Lewis in Berthiaume, 2010; Tiessen, 2015). My analysis supports these critiques, and explicitly demonstrates how these exclusions can be linked to the technocratization of development, and to the overarching medicalized framework of MNCH as a project of individualized risk management that characterizes the Muskoka Initiative.

8.2.4 Medicalized Contraception and Reproductive Stratification

As outlined in section5.3 family planning within the texts is mentioned infrequently, and only in relation to contraception. When included, family planning is primarily situated as a form of medical care, and as a means of preventing maternal deaths by preventing pregnancy (and hence childbirth) itself. One project even identified the number of maternal deaths calculated as having been avoided through the prevention of pregnancy via increased use of contraception among the target population. As such, contraception is configured as a means by which to mitigate the risks associated with pregnancy and childbirth, and by extension, to reduce maternal mortality rates. Despite references to contraception as a means by which women can fulfill their reproductive preferences, contraception is thus largely situated as a medical intervention that can help women manage the risks associated with pregnancy and childbirth.

Speaking to the development and release of the birth control pill in North America, Tone (2012) states that this pharmaceutical breakthrough marked the beginning of the medicalization of contraception and family planning. She argues that prior to the development of 'the pill', birth control was not primarily understood as falling under the purview of medicine, and women generally did not discuss family planning methods with their doctors (Tone, 2012). However, with the advent of pharmaceutical contraception, birth control was medicalized, requiring a prescription, as well as medical surveillance in order to manage associated side-effects. By positioning contraception as a form of healthcare, the Muskoka texts reiterate this understanding of contraception as a medical issue. Furthermore, by situating contraception as a means of ensuring health/preventing death, contraception is further medicalized, positioned almost as an inoculation against pregnancy and its associated complications, rather than as a means by women can enhance their reproductive and sexual autonomy.

Notably, Tone (2012) explicitly identifies the medicalization of contraception as a process that was desired and welcomed by women in North America, many of whom embraced the availability of a reliable contraceptive that would allow them to more effectively control their reproduction. Again, in analyzing the medicalization of contraception within the Muskoka Initiative, my goal is not to challenge the provision of contraception to women in the Global South, many of whom also desired increased access to contraception, and to the reproductive control it can provide. Rather, I am concerned with how the medicalization of contraception is used to perpetuate reproductive norms of risk-avoidance, as part of an individualized and depoliticized framework of development. Specifically, I argue that the medicalization of contraception within the Muskoka Initiative depoliticizes family planning by situating it as a tool for risk management rather than as a key component of gender equality and/or reproductive justice. Furthermore, by situating contraception as a means of managing risk among marginalized women, the texts perpetuate reproductive norms that serve to govern women's reproduction choices, and contribute to the stratification of reproduction, by which reproduction within marginalized communities is devalued and discouraged (Ginsburg and Rapp, 1995).

In analyzing the medicalization of contraception within the Muskoka Initiative, I have found it useful to draw on Johnstone's (2017) work on the medicalization of abortion within Canada. Despite the absence of any reference to abortion within the Muskoka texts, the discourse of contraception as a medical service aligns with the (often strategic) discursive construction of abortion as a medical service within the Canadian context. In analyzing this dominant framing, Johnstone (2017) acknowledges that the positioning of abortion as a necessary medical service has been an effective strategy that has helped to ensure that therapeutic abortions are available to Canadian women. She argues that situating abortion as a necessary medical service helped to depoliticize abortion within Canada, and has served as a means of shielding abortion rights, to some extent, from attacks by conservative groups who wish to control and/or abolish them. By positioning abortion as a medical necessity, feminist and reproductive rights advocates have been able to strengthen their argument that to be anti-choice is to be anti-women, pushing the narrative that abortion must be made accessible in order to save the lives of women whose health is threatened by complications during pregnancy, or by the risks associated with illegal and unregulated 'back-alley' abortions. This discursive construction of abortion as a medical necessity that saves lives, aligns with the language deployed in relation to contraception within the Muskoka Initiative, which serves to depoliticize the issue of family planning through its construction as a form of medical risk management.

Despite the success that has been associated with the medicalization and depoliticization of abortion, Johnstone argues that, ultimately, this discursive strategy has distracted from and weakened feminist arguments in favour or abortion as a reproductive right and as a key component of gender equality. Furthermore, she argues that by positioning abortion as a decision 'between a woman and her doctor', the medicalization of abortion reifies medical authority and expertise as a key component of reproductive decision making. In response, Johnstone argues for an approach to abortion that recognize the necessity of medical care during and after abortion, while expanding feminist frameworks beyond the medicalized approach in order to more effectively advocate for abortion rights not only as a medical necessity, but as a key component of sexual and reproductive justice.

Drawing from Johnstone's analysis, I argue that the medicalization of contraception within the Muskoka Initiative presents a narrow approach that, while presenting family planning in a way that is more palatable to those who oppose reproductive rights, may also limit the capacity of family planning initiatives to function as sites of reproductive justice. Just as the medicalization of maternal health has been theorized as a form of depoliticization, so too does the focus on contraception as a form of biomedical risk management depoliticize issues of family planning, delinking it from women's reproductive and sexual rights and autonomy. Furthermore, as with the construction of medical care as the key means by which to address maternal risk, the positioning of contraception as a tool for biomedical risk management ignores the ways in which maternal risk is shaped by social determinants of health, along existing lines of marginalization.

As I outline in section 5.3.2, contraception is positioned as a means by which maternal death can be prevented, and mortality rates brought down. Implicitly, women who are perceived as overly 'at-risk' during pregnancy are thus encouraged to make reproductive decisions based not only on their reproductive desires, but also in response to their perceived vulnerability to medical risk. As such, women are impelled to act 'rationally', minimizing risk by avoiding pregnancy and hence childbearing altogether. By promoting the use of family planning as a means of mitigating the risks associated with childbearing in the 'developing' world the Muskoka Initiative not only deploys a medicalized discourse of contraception as a form of risk management, but also promotes risk-avoidance as a form of reproductive governance. This construction is at odds with a reproductive justice framework that values every woman' right to have children, and which recognizes that reproductive decisions are shaped by understandings of the risk in ways that can constrain reproductive decision making. Perceptions of reproduction as risky are of particular concern when understandings of who is at risk align with existing lines of oppression. Thus, without interrogation of who is considered or made to be 'at risk' of maternal death, a medicalized, risk-based approach to contraception is likely to perpetuate reproductive stratification.

As Tait (2008) outlines in her work on responses to Fetal Alcohol Syndrome (now Fetal Alcohol Spectrum Disorder, or FASD) in Indigenous communities within Canada, the use

of contraception as a response to 'risk' can easily become a means by which the reproduction of marginalized women is governed, and the reproduction of marginalized communities curtailed. Her research demonstrates that by promoting birth control as a response to high rates of FASD in indigenous communities, Canadian organizations situate blame for the epidemic on Indigenous women themselves, rather than recognizing it as the outcome of historical and ongoing processes of colonization. Instead of seeking to address FASD through the provision of addiction services, or by addressing the political, cultural, and economic marginalization with which it is associated, advocates have instead sought to reduce its incidence by promoting contraceptive use on reserves. As such, these advocates contribute to reproductive stratification in which the reproduction of Indigenous communities is devalued and discouraged in comparison to the reproduction of settler communities. Whether intentionally or not, birth control advocates thus contribute to the perpetuation of colonial erasure of Indigenous populations. Similarly, by promoting contraception as a means by which to reduce maternal mortality rates, the Muskoka texts reiterate a devaluation of 'developing' world women's reproductive rights and autonomy, as well as the goal of controlling developing world populations. By encouraging pregnancy prevention as a response to maternal risk, these interventions seek to limit the reproduction of women whose vulnerability to risk may indeed be exacerbated by systemic marginalization. Rather than addressing systemic determinants of health, these strategies situate the solution to maternal mortality in the governance of developing world women's reproduction. In doing so, (whether intentionally or not) these interventions align themselves with population control policies that sought to limit the reproduction of racialized women in the Global South.

The construction of contraception as a form of risk management, alongside the presentation of increased use of contraception as a positive outcome of development projects, illustrates how risk discourse operates as a form of reproductive governance within the Muskoka Initiative. Within neoliberal contexts, individuals are not only encouraged, but understood as obligated, to protect themselves and their health by successfully avoiding and managing risk (Peterson and Lupton, 1996). Furthermore, this operation of risk as a form of governance is based on individualized understandings of risk as something which can be managed and avoided through appropriate, rational, individual action (Ruhl, 1999). Thus,

by promoting contraception as a form of risk management, the Muskoka Initiative continues to put forward an individualized and depoliticized framework of health, which effects change by providing individuals with the means to change their reproductive behaviour, rather than by addressing the systemic issues that produce and exacerbate maternal risk within the 'developing' world. Furthermore, through the medicalization of contraception, risk operates as a tool of biopolitical governance, by which individual reproduction is managed in order to produce effects on the population at large; in this case, lower maternal mortality rates. In this way, even in the absence of explicit, direct, or coercive population control policies, the Muskoka Initiative contributes to the biopolitical project of reducing population growth within the developing world while demonstrating how risk discourse can operate as a form of biopolitical governance within the global context.

Recent studies of international biopolitics have tended to focus on technologies of securitization, by which members of certain populations are seen to pose a risk to either national or global populations, and who must thus be managed (Berman, 2010; Elbe, 2005; Indra 2002; Sanford, 2013). While the Muskoka Initiative does promote the use of contraception in a way that governs fertility among 'developing' world women, it does so without explicitly engaging in a discourse of population control, and avoids situating the growth of 'developing' world populations as a risk to the global population. Rather, unborn (or more accurately, unconceived) populations are configured as a risk to developing world women's bodies, due to the dangers of pregnancy and childbirth. Thus, framework of securitization can thus, to a certain extent, be applied the Muskoka Initiative due to the use of risk discourse to justify contraceptive promotion, as well as its implicit alignment with population goals. Yet the international biopolitics of maternal health is also focused on processes of normalization, by which 'developing' world women are incited to act as responsible, health-maximizing subjects. In this sense, the implicit 'risk' of developing world populations is addressed through interventions that impel these populations to become self-regulating subjects. Significantly, the effect is the same, with racialized women in the Global South encouraged to decrease their fertility. Thus, in addition to demonstrating the depoliticization and individualization of 'development' as situated in

individual decision making, the Muskoka Initiative's promotion of family planning contributes to global reproductive stratification.

8.3 Depoliticization and Construction of Canadian Leadership, Partnership and Expertise

As I have argued, the (bio)medicalization and depoliticization of maternal health within the Muskoka Initiative is key to the construction of maternal and child mortality as a problem that is easily 'preventable'. The problem of MNCH is identified as rooted in the inability of 'developing' countries to provide adequate medical care to their populations, and specifically to women and children. Solutions are thus framed as straightforward capacity building projects that improve the ability of states and communities to improve their delivery of healthcare, including through improved monitoring of their populations. These solutions in turn are positioned as needing only political will on the behalf of wealthier nations in order to be implemented. As such, the configuration of MNCH as a problem of capacity building allows for the discursive construction of Canada as a global leader who is able to address MNCH by providing resources and expert knowledge, and by rallying other countries to do the same. Furthermore, this construction situates the problem of maternal health, including its causes, directly within the developing world. This construction is key to the depoliticization of maternal health, as by presenting the problem as the outcome of factors internal to developing countries themselves, the Muskoka Initiative obscures the role that Canada plays in perpetuating health inequalities, including through its economic and environmental policies. As such, localizing the problem of maternal health within developing countries contributes to depoliticization of development, and of MNCH, on a global scale, while allowing for the construction of Canada as a global leader, playing a key role in solving the MNCH crisis.

8.3.1 Localizing the Problem of MNCH within 'Developing' countries

Within the Muskoka texts, developing countries are constructed as having a limited capacity to provide healthcare services to their population. The focus on building capacity through interventions that provide resources and improve managerial capacity implicitly situate MNCH as a problem of inadequate healthcare systems, which are identified as

unable to provide sufficient medical care due to the limited resources and expertise currently at the disposal of 'developing' country states, communities, and health professionals. In addition to providing physical resources such as medical supplies, vaccines, and buildings, interventions operate as a site of knowledge transfer, training medical professionals to provide improved levels of care and helping build the managerial capacity of health systems and institutions. While contributing to the reification of 'western' knowledge and Canadian expertise, these interventions also situate the problem of limited or poor healthcare in the deficiencies of the 'developing' world, without addressing why it might be that governments, institutions and communities lack the capacity to ensure appropriate healthcare. That is to say, the problem of limited capacity is not examined in relation to histories of colonialism, national and global politics, economic relations, or any other external factors that may need to be redressed. The focus on capacity building, not just of individual women, but of developing countries themselves can thus be understood as part of the depoliticization of development, and its configuration as a series of straightforward, technical interventions.

8.3.2 Depoliticizing Development through the Construction of Canada as Development Actor

The construction of poor health systems management as a key problem of healthcare systems contributes to the construction of 'developing' countries as places of poor governance and insufficient knowledge, in addition to maternal risk. In contrast, by constructing Canada and Canadian funded programs as able to provide training not only to medical professionals, but to governments, bureaucrats and communities, the Muskoka Initiative draws on and strengthens the construction of Canada as a site of good health and development expertise. This construction, which helps to justify the leadership role Canada has taken on in relation to MNCH, is further supported by the construction of Canada as site of uniformly good health.

In 7.1.2, I addressed how Canada is constructed as a site of good health, where mothers and children are able to get the healthcare they need and hence, to thrive. Yet this construction obscures the divergence and inequities in healthcare access and health outcomes that exist within Canada's own population. Maternal and child outcomes within

Canada are known to differ based on socioeconomic income, race and geographic location, and are still particularly inequitable between Indigenous and non-Indigenous communities (Frohlich, Ross and Richmond, 2007). By obscuring these inequalities, the text not only upholds the construction of Canada as a site of uniformly good health, but also the construction of MNCH as a problem that can be identified and defined on a national scale. Acknowledging the health disparities that exist within both 'developed' and 'developing' countries troubles the distinction between these two categories, while highlighting the need to consider factors beyond national health systems that affect health access, choices, and outcomes. Yet, the Muskoka Initiative relies on national, or at time regional, mortality rates, which are not disaggregated along any socioeconomic factors. This reliance on comparisons of maternal and child mortality rates between the 'developed' and 'developing' world supports the construction of 'developed' countries such as Canada as having 'solved' the problem of maternal health, and thus, as being well-positioned to share its expertise with countries who have not. This construction obscures the ways in which Canada's ability to provide good healthcare for (some) of its population is also the product of Canada's history as a settler colony, which has benefited from the colonization of First Nations, as well of countries within the Global South; its rich endowment of natural resources; the geopolitical advantages gained from proximity to the world's biggest economy; merit-based professional immigration policies that have enabled it to provide selective entry to the best educated and most skilled migrants (including from countries that Canada's MNCH programming targets); and the benefits it accrues from domestic and overseas of activities of Canadian corporations. Instead, good health within Canada is constructed as both universal, and as the product of good fortune, rather than systemic factors, domestic and international, that produce inequalities on the national and the global scale.

The construction of Canada as having the expertise needed to help 'developing' countries solve the problem of maternal health is further supported by the references to Canadian expertise and values, outlined in section 7.1 Together, the construction of Canada as a site of good health, and of expertise is significant in that is positions Canada as having the authority to act, and indeed to lead, on issues of maternal health. As I demonstrate in section 7.1 this construction is further supported by Canada's financial commitments, which

indicate Canada's ability and willingness to provide the resources needed to address maternal health. Notably, Canada's construction as able to address maternal health due specifically to its ability to mobilize financial resources and expertise depends on the overarching construction of MNCH as a problem that can be solved through the provision of physical resources and knowledge sharing. Thus, the construction of Canada as a capable development actor relies directly on the depoliticization and technocratization of maternal health delineated above.

8.3.3 Obscuring Canada's Role in Producing Poor Social Determinants of Health

The construction of Canada as a leader in the global community, working to solve the problem of global health, further legitimizes Canadian action on MNCH. Through references to the global community, and globally agreed upon goals such as the MDGs, Canada is positioned as working towards a goal that has been agreed upon by the global community, but which the community as (so far) failed to adequately address. Canada is thus able to be constructed as taking a leadership role as a global advocate for MNCH, without being read as imposing its own development goals on either the global community, or recipient countries.

Situating Canada as part of a global community working towards MNCH constructs the field of global politics as one of cooperation between countries, in the name of the global good. Yet while MNCH is constructed as a global problem, being tackled by a united global community, the Muskoka Initiative is implemented through the distribution funds by the Canadian government. As such, the Muskoka Initiative is a national project. While national development policy is certainly influenced by international norms and frameworks and is in part shaped through international agreements such as the International Muskoka Initiative, it is nevertheless ultimately enacted by national governments in ways that align with their own interest. Additionally, although the International Muskoka Agreement laid out priority areas and funding commitments, these too were constructed, agreed upon and signed by representatives of said national governments. As it was implemented by the Canadian government, the Muskoka Initiative can thus be expected to have aligned with international commitments, as well as with Canada's own national interests. This factor is

important in considering why development policy constructs and addresses problems such as maternal, newborn and child health through a technocratic framework.

As Proulx, Ruckert and Labonté (2017) have argued, Canada's establishment of MNCH as its top development priority can in part be explained as a strategy by which the Canadian government sought to build Canada's global reputation. By positioning itself as a global leader on MNCH, Canada not only constructed itself as a moral actor/saviour, but also as an influential member of the global community. Notably, Proulx, Ruckert and Labonté (2017) address the motivations behind Canada's prioritization of MNCH in part because of the perception that this focus "conflicts with the government's recent alignment of development assistance with security and trade-related interests", two frameworks that more straightforwardly illustrate how development policy is deployed to support national interest. Yet, while the prioritization of MNCH may seem out of place beside these more explicitly self-interested foci, I argue that in treating maternal health as a problem with roots internal to developing countries themselves, Canada continues to serve its own national interests. The localization and technocratization of maternal health eclipse the way in which Canada's pursuit of trade and security goals re-entrench global systems of power, as well as macroeconomic inequality. So too does this configuration obscure how Canada's support for 'development' activities pursued through the promotion of corporate actors might further undermine the economic development and wellbeing countries prioritized for development assistance (Black, 2013). For instance, Canadian mining companies have long been critiqued for the environmental damage they cause, as well as disruption they bring to local communities, without necessarily sharing the economic benefits of their activities (Clark, 2006; Nolin and Stephens, 2010). Such activities can be understood as undermining economic and social development, while also contributing to poor maternal and child health. Yet, by configuring maternal health in terms of access to healthcare, attainable through the capacity building of local communities and the education of individual women, Canada can be constructed as solving the problem of maternal health without changing any of its own policies or economic activities, including its positive relationship with mining companies.

8.3.4 Obscuring Power through Discourses of Partnership and Support

The way in which development policy aligns with donor country interests if obscured by the discursive construction of Canada as working in partnership with 'developing' countries, as well as with NGOs. The language of partnership denotes a relationship of relative equality and has been used in development discourse and programming as a means by which to denote, and to create more equitable relationships between donors and recipients (Baaz, 2005). Thus, in constituting Canada's relationships with developing countries are partnerships, the Muskoka texts de-emphasize the power dynamics that characterize these relationships. For instance, the texts' discursive construction of development as 'country-led' situates interventions and goals autonomously set by developing countries themselves. This construction helps inoculate Canada against accusations that it is imposing its own development interventions onto recipient countries. However, even where an intervention may be identified as 'country-led', goals may nevertheless be shaped by international norms, including those circulated by international governance institutions. Research on the turn towards the related concept of 'country ownership' of interventions as a tool to improve aid effectiveness has highlighted the continued tension between attempts by donors to promote country ownership, while continuing to impose conditions on development aid (Hasselskog and Schierenbeck, 2017). Similarly, given that the International Muskoka Initiative was developed by the G8 countries, those countries were likely able to exercise significant power in delineating what global priorities and commitments would be set, and shaping how committed resources would be distributed and used. As the distributor of funds committed through the Muskoka Initiative, the Canadian government was also able to decide which countries, groups, and projects would receive resources. As one of my interview participants pointed out, in outlining funding priorities, the Government of Canada influenced what kinds of projects would be pursued by development organizations, as well as how these projects would be framed. Therefore, the discursive construction of relationships between the Canadian government and 'developing' countries, and/or NGOs, can be understood as obscuring, rather than materially dismantling the power dynamics that characterize these relationships.

The discourse of partnership and country-led development can also be linked to neoliberal development frameworks of capacity building. As Baaz (2005) argues, the rise of partnership discourse has been linked not only to a desire to forge more equitable relationships between donors and recipients, but also to understandings that development aid should provide a 'hand up' rather than a 'hand out'. As 'partners' aid recipients are expected to take an active role in their own development. This expectation can be observed in the Muskoka Initiative, wherein interventions seek not only to provide health services directly, but also to build the capacity of 'developing' world governments, institutions, and communities. Such interventions seek not only to build the capacity of 'developing' world actors, but also to responsibilize them. In this way, the discourse of development as 'country-led' aligns with neoliberal frameworks that position development as improving the capacity of local actors rather than as pursuing systemic change. The focus remains on making existing systems more efficient, rather than challenging systems of power within and between countries. As such, while the discourses of partnership and support appear to signal an attempt to dismantle power relationships, by obscuring power differentials while responsibilizing developing world countries, they work to further depoliticize development.

As I outline in section 7.3, while relationships with developing countries and NGOs are characterized as partnerships, relationships with the private sector are described slightly differently. In these instances, Canada is said to 'leverage' the resources of the private sector, suggesting that Canada is to some degree using the private sector to attain its goals. The connotation is that Canada does exercise power in these relationships, in contrast to their relationships with 'developing' countries. This shift in language works to downplay concerns regarding private/public partnerships, including that they serve private interests over public interests. Yet given how language can hide rather than dismantle power differentials, this positioning raises questions regarding to the extent to which private interests may have continued to benefit from their involvement in development interventions, as well as the maintenance of the status quo.

The construction of Canada as a capable development actor, able to instigate change by mobilizing resources and sharing knowledge both contributes to a project of nation

building while sustaining technocratic, neoliberal development frameworks that focus on building local capacity rather than challenging existing systems of power.

8.4 Governance and Responsibilization of Developing World Women

In her analysis of the Muskoka Initiative, Tiessen identifies and critiques the discursive construction of women in the Global South as passive victims in need of being saved. Specifically, she addresses the discourse of 'saving lives' as constructing women in the Global South as lacking in agency and voice, a positioning that is strengthened through repeated references to 'women and children' as one group. My analysis similarly identifies the construction of 'developing' world women as vulnerable, and as in need of being saved by Canadian funded interventions. Women in the 'developing' world are constructed as vulnerable populations, due to their limited access to healthcare, as well as 'harmful' cultural attitudes and repressive gender norms that further impact their ability to access care. Yet alongside this construction of women as passive victims, my findings demonstrate that women in the 'developing' world are also constructed as *potentially* agentic. That is, they are positioned as having the capacity to become responsible, health-seeking citizens, if activated through particular forms of intervention. This narrative of women as victims who can, if aided, become active and responsible subjects, aligns with dominant discourses of empowerment that permeate contemporary development discourse (Chant, 2012; Potvin, 2015). Within this framework of empowerment, women are constructed as capable of becoming health-seeking actors, and are in turn as able to take responsibility for their own health, as well as the health of their children, and by extension, the population. Through this responsibilization, the Muskoka Initiative further aligns with neoliberal forms of governance that promote individual responsibility for health through the promotion of dominant norms (Peterson and Lupton, 1996).

As critical development scholars have argued, capacity building approaches to development draw on the understanding that individuals and communities can 'develop' into rational (economic) actors with the ability to navigate poverty and social inclusion and eventually pull themselves out of the 'cycle' of poverty (Li, 2007; Shani 2012). Similarly, projects that aim to 'empower' women have been identified as attempting to help women

to become rational *reproductive* actors, who are able to manage their reproduction in order to maximize their own self-interest, while also contributing to economic and social development (Switzer 2013; Chant 2012). Within the Muskoka texts, women in the developing world are positioned as victims who are capable of developing into rational risk-minimizing subjects by learning how to properly manage their own health as well as the health of their children. This configuration is demonstrated by awareness raising and education interventions that specifically seek to increase women's willingness to access healthcare services during pregnancy and childbirth.

As I have demonstrated, Canadian maternal health policy is constructed as an attempt to address 'preventable' maternal and child deaths, primarily by increasing access to health services in countries where maternal and child mortality rates are highest. Increased access is pursued in part by interventions that aim to change the behaviours of women themselves, increasing their capacity and willingness to access healthcare during pregnancy and childbirth, and modifying their everyday behaviours. As such, interventions seek to improve health by promoting particular reproductive decisions. Specifically, the medicalized approach to reproduction outlined above is used to construct medical care during pregnancy and childbirth as a 'rational' choice, which will necessarily be pursued by women once they become aware of its importance. In this way, the Muskoka Initiative's reliance on medicalized understandings of reproduction not only perpetuates an individualized model of health as risk-management, but also governs women's reproduction through the establishment of reproductive norms.

8.4.1 Governing Reproduction by Constructing Medicalized Birth as Rational

As outlined in section 6.2.1, certain project descriptions focus specifically on education and awareness raising activities aimed at increasing women's inclination to access healthcare services, as well as their ability to assess when they should do so. By constructing awareness raising activities as an effective means of increasing women's use of healthcare services, these interventions communicate an understanding that women largely fail to choose medicalized care not only because of external barriers, but because of their presumed ignorance of the benefits these services will provide for themselves and

their children. This assumption reflects, and contributes to, the construction of racialized, developing world women as 'backwards' and uneducated, while situating westernized, medical approaches to pregnancy and childbirth as superior to alternative/local and potentially less medialized approaches. Within this framing, a failure to access medical services is not only *attributed* to lack of knowledge, but is taken as *indicative* of a lack of knowledge and/or agency, as it becomes unfathomable that a woman who is knowledgeable of the health benefits of medicalized care and who has access to it would fail to utilize it. By situating these practices as the only means by which to reduce reproductive risks, medicalized pregnancy and childbirth in the form of prenatal checkups and medically attended childbirth are constructed not only as reproductive norms, but as the only rational response to reproductive risks. By situating access to medical care as a rational response to risk, programs can enforce access as a reproductive norm while side-stepping accusations that they are imposing specifically 'western' values. In this way, risk-discourse allows for governance across national borders.

The assumption that once women are made aware of the benefits of medical care they will necessarily choose it does not align with the actions of various groups and individuals, including those in developing countries, who disrupt medicalization, either by rejecting formal medical care or combining it with alternative practices. The growth of the 'natural' birth movement in western contexts as a specific response to and rejection to certain forms of medicalization exemplify the limitations of a framework that positions medicalized birth as the only tenable birthing choice. Although some women resist medicalization due to an understanding that it may exacerbate reproductive risk, decisions often include additional factors such as feelings of control and understandings of maternity, femininity and identity (Johnson, 2016; Cosminsky, 2012). Although many women within both the developed and developing world do desire increased access to medical care during pregnancy and childbirth, these desires also reflect negotiations of various values, expectations and identities, as well as culturally specific understandings of risk (Johnson, 2016). Furthermore, resistance to medicalization may constitute attempts by communities to resist colonization by resisting the ways in which medicalized knowledge has been deployed not only to save lives, but to govern marginalized communities (Cosminsky, 2012). In such contexts, access to medical care again constitutes a negotiation between various factors,

often resulting in approaches that combine traditional, local and medical components (Johnson, 2016; Cosminsky, 2012). Indeed, part of what feminist perspectives on medicalization have offered is an understanding that medical care is desired, sought and resisted differently by different communities and individuals, even when their experiences are shaped by similar expectations and norms. Thus, the narrative of women straightforwardly embracing medical care once they are 'enlightened' to the ways in which it will reduce medical risk obscures the diversity of women's relationships to medicine, as well as the factors that influence these relations and the agency that women enact when they negotiate them. It also obscures the way in which medicalized birth is itself promoted as a particular norm.

8.4.2 Governing Reproduction Through Discourses of Medical Risk and Healthism

In addition to presuming a particular course of action that over-simplifies women's decision-making processes, the construction of medicalized pregnancy and birth as a key means by which to reduce risk also reinforces medically attended childbirth as a reproductive norm to which women are expected/compelled to comply. Although situated as 'education', attempts to raise awareness of the benefits of attended childbirth are aimed not solely at information sharing, but at promoting attended childbirth as a reproductive choice. This distinction is exemplified by project descriptions that describe teaching women when they should be accessing care. Rather than positioning knowledge as a tool that helps women make the right birthing decision for themselves, knowledge is associated with the identification of the correct/rational course of action. As such, the awareness raising interventions described operate as site of governance wherein women are encouraged to make particular decisions about their reproductive health. This construction relies on the logic of risk-minimization wherein rational subjects are expected and compelled to make responsible decisions based on which option will reduce their exposure to risk (Peterson and Lupton, 1996). Again, failure to make this decision is not understood as an agentic choice, but as a failure to understand the benefits of this choice, and/or an ability to enact it due to external barriers. Furthermore, by situating particular healthcare decisions such as prenatal checkups and attended childbirth as means by which risk can be

managed, these interventions continue to focus on individualized approaches to maternal health that emphasize risk mitigation through treatment, rather than through addressing the social and political determinants that exacerbate particular reproductive risks.

The texts construct certain barriers beyond lack of awareness are identified as preventing women from seeking medical healthcare. In addition to raising awareness among women themselves, interventions seek to address the social and cultural norms, as well as gendered power dynamics that might prevent women from accessing healthcare. Yet even these interventions prioritize the outcome of accessing healthcare over increasing the decision making power of women themselves. As previously addressed, the project description that seeks to increase access by educating male partners and community members of the importance of medical care for pregnant women prioritize a particular outcome (accessing medical care) rather than the ability of women to make decisions about their pregnancies. From the perspective of health as risk-minimization, this prioritization is logical, as it is understood as benefitting women and children by increasing their chances of survival. This perspective is thus indicative of a healthist approach, by which good health is held up as the most important achievement (Crawford, 1980). From the perspective of reproductive justice, which values not only access to maternal health, but also the ability for women to make informed and culturally appropriate decisions about their birthing plans, merely increasing exposure to healthcare is an inadequate solution. Even in contexts where women would themselves pursue medicalized reproductive experiences, there is a distinction to be made between being able to make that decision and having it imposed. The former is a key component of reproductive justice as including not only well-being, but autonomy and dignity.

By seeking to educate community members and male partners on the importance of healthcare for pregnant women, as well as to reduce barriers such as cost and transportation, Muskoka funded interventions seek to clear the path to healthcare for women in developing world contexts. But interventions such as these which may seem emancipatory act as a form of governance, constructing healthcare at particular moments not only as norms, but as the only rational means by which to address the risks constructed as inherently associated with pregnancy, childbirth and even childhood. Thus, in focusing on increasing

availability of health services while simultaneously raising awareness among women about when they should seek medical help, these programs seek to create a context in which particular choices, such as attended childbirth, are not only available, but will necessarily be chosen. Within these contexts, women are understood as having the capacity to manage their own health by mitigating the risks associated with reproduction, both to themselves, and to their children, again promoting healthism. Awareness raising and education activities that seek not only to inform women of their choices, but to promote particular choices as the right ones, can therefore be seen as endeavours to prompt women in the 'developing world' develop a "risk consciousness", ostensibly shaping them into risk-minimizing actors who, once services are available, will use them in ways deemed appropriate (Hannah-Moffat and O'Malley, 2007, p. 3). Despite a stated commitment to state and community supported health systems, programs funded through Muskoka promote a healthcare model that relies on individualized notions of responsibility, individualized approaches to medical care, as well as neoliberal assumptions about rational subjects as risk-minimizing actors.

8.4.3 Maternal Healthism and Everyday Action

In addition to promoting particular forms of medical care, the texts associated with the Muskoka Initiative seek to improve maternal and child mortality outcomes by changing women's everyday behaviour. Interventions encourage women to engage specific child feeding practices, with a particular emphasis on breastfeeding. Again, this behaviour change is largely sought through educational programs that provide women with information and 'counselling' on nutrition and best practices in child feeding and food preparation, as well as training to develop skills such as home-based agricultural production. Interventions explicitly identify breastfeeding as a best practice, and as previously outlined, list increased rates of breastfeeding as a project outcome, implicitly situating it positively. As with attended childbirth and contraception use, increases in rates are explicitly identified as the desired outcome, rather than women's ability to make informed, agentic decisions and whether and when to breastfeed. As I addressed in section 6.2.2, increases in breastfeeding rates are presented in isolation from any discussion of the numerous factors that may affect women's decision whether or not to breastfeed, including

the effect it might have on her health and/or lifestyle. Indeed, descriptions of breastfeeding are articulated in relation to how many children have been breastfed, making women discursively absent from the process of breastfeeding itself. This discursive absence further obscures breastfeeding as a decision that individuals make based not only on the benefits it may bring to a child, but also on their own health, interests and preferences. In addition to governing women's child-feeding behaviours, this construction contributes to the harmonious model of maternal and child health that characterizes Muskoka's overarching framework, discussed in more detail below.

In addition to nutritional practices, interventions seek to change women's behaviour by promoting sanitation practices and by seeking treatment as well as preventative care in order to diminish the incidence and effects of disease. Women are encouraged to wash their hands effectively, use mosquito nets and to seek treatment for their children should they show particular symptoms. These behaviours, alongside nutrition and feeding practices invoke an understanding of health as something that can be achieved through engaging in the right kinds of behaviours, and in particular, through behaviours that minimize risks. Within the Muskoka Initiative, women, and to a lesser extent community members and children, are positioned as capable of taking responsibility for health by engaging in healthy behaviours. The emphasis on child health means that, for women, the actions taken are bound up in their roles as caregivers, such as feeding and washing their children, as well as monitoring their symptoms for signs of disease. Thus, the focus on everyday behaviour change both promotes an individualized approach to health as risk-management while articulating responsibility for child health as the specific responsibility of mothers and caregivers.

The positioning of individual behavioural change as a key component of maternal health programming draws on and reinforces the medicalization of everyday life, as discussed by Crawford, by which health outcomes are configured as the result of everyday decisions and actions (1980). Within this framework, aspects of everyday life are understood in terms of their effects on health, and specifically, the risks that they pose to wellness. To a certain extent, this framework also acknowledges the role of social determinants of health, and the ways in which our everyday environments and contexts impact our health. Yet while

factors such as nutrition and sanitation are acknowledged, the response is again depoliticized, and configured in terms of how individuals can best manage a lack of food security or poor sanitation infrastructure rather than in interrogating, as Raphael suggests, what systemic issues created the circumstances that necessitate such navigation (2016). Thus, social determinants themselves are not addressed, but are rather presented as challenges to be overcome by appropriate action on the part of the individual. In this way, women in particular are made responsible for improving child health outcomes by engaging in appropriate, risk-minimizing behaviour.

8.4.4 Maternal Healthism as Instrumentalization

By constructing reproductive risk as able to be prevented through access to healthcare, responsibility for maternal health is situated with countries and communities, who are responsible for providing healthcare, as well as with individuals themselves, who are responsible for understanding and seeking healthcare. Thus, while women in the 'developing' world are not configured as solely responsible for ensuring health, they are constructed as having an extremely important role to play. By encouraging women to take part in particular actions, the texts analyzed rely on and support understandings of women as having a responsibility not only to care for their own health, but also to ensure the health of their children. This expectation, which I discussed in broader terms in section 3.1.7, constitutes a particular, gendered form of healthism. Healthism, as defined by Crawford (1980), is a framework in which individuals are compelled to seek health through their everyday decision making, and as such, are made responsible for health outcomes. As the work of feminist scholars has demonstrated, healthism is a gendered framework that interacts with expectations of femininity, and in particular, maternity. As scholars such as Ruhl (1999) and Lupton (201) have pointed out, women who are pregnant are expected make decisions and adopt lifestyles that will minimize risk not only to themselves, but to their fetus. This configuration relies on an understanding of risk as a linear causation, with adverse birth outcomes attributed directly to actions taken by the pregnant woman. It also relies on ideals of femininity and maternity that value, expect and even compel maternal sacrifice. This particular iteration of healthism is what I have referred to as 'maternal healthism'.

In constructing pregnancy and childbirth as periods of risk, the texts analyzed situate both pregnant women and children as vulnerable to risks that endanger their health and well-being. These risks are in turn constructed as manageable through appropriate use of healthcare services, as well as suitable everyday behaviours. Significantly, the same behaviours and health interventions are positioned as helping to save the lives of both mothers and children, allowing the Muskoka Initiative to configure 'maternal, newborn and child health' as one cohesive project.

Within this configuration, interventions promoting prenatal care and maternal nutrition are positioned as helping to ensure the health of the future child. This discursive construction relies on the understanding of maternal health as a potential site of risk to future children. Similarly, several projects descriptions describe the need to address mother to child transmission of HIV, situating the maternal body as a potential vector for disease, and hence again as a site of risk to the fetus/child. These configurations of the maternal body as a source of risk contribute to the overall construction of maternal health both as vulnerable to the same forms of risk as the fetus, and as a means to ensure fetal, and ultimately child, health. By addressing maternal nutrition and infection, risks emanating from the maternal body can be mitigated and the health of the fetus/child is understood as being ensured.

As I outline in section 3.1.8, maternal healthism is generally bound up in ideas of maternal altruism and sacrifice. Yet within the Muskoka texts, the framework instead relies on the understanding that maternal and child health are in complete alignment. By positioning MNCH interventions as mutually beneficial, the Muskoka programs are in turn able to obscure any possible tension between the health of mothers and their children. Whereas studies of maternal responsibility in the 'developed world' have interrogated the way women's self-interest (or irresponsibility) can itself be understood as a potential site of risk to the fetus (Lupton, 2012; Ruhl, 1999), in the case of Muskoka, the conflation of maternal and fetal interests means that this particular configuration of risk is discursively absent. Although, as outlined above, the maternal body is positioned as a potential site of fetal risk, such risks are configured as risks to both the maternal and the fetal body. The actions women are encouraged to take to minimize risk are thus not positioned as sacrifices, but

merely changes in behaviour that will have no harmful effects on women themselves. Analysis of the texts did not reveal any instances where maternal health and child health might be at odds, or where there might be resistance from women themselves to engaging in celebrated practices once they were made 'aware' of their benefits. Rather, resistance to practices deemed 'healthy' was situated in a lack of awareness of the potential benefits, to be addressed through education and awareness raising, as outlined above. This conflation of maternal and child health thus both simplifies and strengthens the positioning of particular choices as 'rational', understood as being in the best interest of mothers and their children.

8.4.5 Maternal Healthism, Instrumentalization and the Exclusion of Abortion

In acknowledging the absence of any reference to tension between the health of women and children my intent is not to deny or minimize the ways in which the health of pregnant individuals and the fetuses they carry are intertwined. Neither do I wish to deny or minimize the feeling of altruism that women may feel towards their children, nor to situate self-sacrifice as only ever the outcome of women's internalization of patriarchal norms. Rather, I am interested in how the harmonious model of maternal healthism allows for the construction of a health framework that responsibilizes women, and in doing so re-entrenches the instrumentalization of women in development programming.

As I addressed in both my introduction and my literature review, the inclusion of women in developing programs has often been based on discourses of instrumentalization, which emphasize how women can benefit the project of development, rather than, or in addition to how development will benefit them (Chant and Sweetman, 2012). As I have argued elsewhere, discourses of maternal altruism are central to such instrumentalist arguments, upholding the narrative that women will share any benefits they receive with their families and communities, and can thus be understood to be a 'good investment', with high returns (Potvin, 2015). Within the Muskoka Initiative, women are situated as risk-minimizing subjects who, given access to the right resources and knowledge, will ensure their own health and the health of their children, and in doing so, will ultimately help solve the problem of maternal, newborn and child health. Viewed through the lens of neoliberal healthism, we can see this configuration as justifying a focus on women's health both

through a moral imperative to 'save' women and children, and as a way of positioning women as key sites of intervention through which to improve global health. This construction in turn relies on the configuration of women as risk-minimizing actors who will fulfil their duty to protect their own health, and by extension, the health of their children. As such, the framework adopted by the Muskoka Initiative draws on and extends the emphasis on individual responsibility and empowerment that characterize neoliberal frameworks of development, in which a 'bootstrap' rhetoric of empowerment situates development success in improving the ability of developing world populations to make rational, self-interested decisions, in ways that are explicitly gendered (Li, 2007; Shani, 2012).

Understanding the framework of maternal healthism within the Muskoka Initiative can help illuminate why maternal health was chosen as a key development priority by a Conservative government that had largely moved away from gender-sensitive approaches to global development (Tiessen and Carrier, 2015). By adopting an instrumentalizing approach to maternal health, the Canadian government was able to put women at the center of the development agenda without explicitly prioritizing their needs or interests, and while excluding any aspect of women's health that fell outside this instrumentalist framework. Furthermore, the framing of maternal and child health as a cohesive project, in which a pregnant women's health or interests are never in conflict with the health of the fetus allowed for an outright exclusion of abortion, either as a means ensuring reproductive autonomy, or as a maternal health intervention. I argue that the exclusion of abortion from the Muskoka Initiative is thus made logical by the focus on women as instruments of development, and in particular, the configuration of maternal health as a means by which to ensure the health of the population.

Thinking through how maternal health programming, although explicitly focused on women's health, continues to rely on an instrumentalist rationale also highlights how these interventions operate as a site of governmentality. Indeed, instrumentalization requires governance, for it relies on those being instrumentalized acting as expected and desired. Thus, the instrumentalization of women within the Muskoka Initiative is closely linked to the governance of their health, reproduction and everyday lives.

8.5 Reproductive Justice: Contributions and Limitations of the Muskoka Initiative

Reproductive justice is an approach to reproductive rights that moves beyond the dominant binary of pro-choice and /pro-life by situating reproductive rights within a broader framework of social justice. As I outlined in section 3.2, reproductive justice stipulates that "all fertile persons and persons who reproduce and become parents require a safe and dignified context for those most fundamental human experiences" (Ross and Solinger, 2017, p. 9). Ross and Solinger explicitly identify "access to specific, community-based resources including high-quality health care" (2017, p. 9) as one of many key requirements to ensuring reproductive justice is achieved. As such, maternal health programming, including family planning, has the potential to contribute significantly to reproductive justice. Furthermore, reproductive justice is identified as requiring access to "housing and education, a living wage, a healthy environment, and a safety net for times when these resources fail" as "safe and dignified fertility management, childbirth and parenting are impossible without these resources" (Ross and Solinger, 2017, p. 9). Development programming that seeks to improve living conditions thus has the potential to further advance the cause of reproductive justice by improving access to these additional resources. In the following section, I address some of the ways in which the Muskoka Initiative in particular was able to contribute to reproductive justice in the Global South, as well as key limitations that I argue ultimately undermined these contributions. Specifically, I address the provision of healthcare and family planning, the limitations of a technocratic approach, the governing of women's reproduction, and the failure to address both reproductive and sexual rights.

8.5.1 Contributing to Reproductive Justice by Increasing Access to Healthcare and Family Planning

Access to reproductive and maternal healthcare is a key component of reproductive justice (ACRJ, 2005; Ross and Solinger, 2017). Thus, by providing increased access to medical care during pregnancy and childbirth, the Muskoka Initiative did, to some extent, contribute to the ability of women within the Global South to reproduce in a "safe and dignified context". Furthermore, given that reproductive justice also promotes the ability to parent

children in “safe and healthy environments”, increased access to healthcare for children can also be considered an important means by which the Muskoka Initiative has supported the goals of reproductive justice. While I do address the limitations of these contributions below, I feel it is important to acknowledge the significance of improving access to healthcare for women and for children, and to recognize that by improving access to medical services the Muskoka Initiative has contributed to an important component of reproductive justice.

Although family planning was not emphasized in overall framings of Canada’s MNCH programming, my analysis demonstrates that it was a key focus of some of the programs funded through the Muskoka Initiative. Given reports of a continued unmet need for family planning within the Global South (UN, 2017), the provision of family planning through the delivery of contraception has the potential to significantly improve women’s ability to control their reproduction. Despite the problems that exist in how contraception was framed and distributed, I feel it is therefore also important to acknowledge the significance of this contribution. By improving access to contraception for those who desire it, interventions funded through the Muskoka Initiative thus further contributed to the project of reproductive justice.

Despite the Muskoka Initiative’s contributions to maternal health and family planning, there are key exclusions in the type of health services it provided. As other critics have pointed out, the exclusion of abortion is a significant limitation, (Tiessen, 2015; Webster, 2010) with abortion recognized as a key component of both maternal health, and reproductive justice (Higgins, 2006; Ross and Solinger, 2017). Furthermore, the focus on maternal health as health during pregnancy and childbirth means that engagement with medical treatment of infertility is absent. This absence is particularly troubling given that a reproductive justice approach promotes not only individuals’ right *not to* have children, but also *to have* children (Ross and Solinger, 2017). An inability to have children negatively impacts women’s own reproductive autonomy and fulfillment of reproductive desires, and can also impact women’s social standing within their community (Allen, 2002; Inhorn, 2009; Ombelet, 2011). While it is important to interrogate the relationship between social expectations of motherhood and the social costs of infertility, it is also important to

consider how inequitable access to fertility treatment constrains reproductive justice while contributing to reproductive stratification (Greil, McQuillan and Shreffler, 2011; Davis, 1998). The exclusion of infertility treatment, and indeed the discursive absence of infertility as a reproductive health concern, thus represent a significant limitation of the Muskoka Initiative's contribution to reproductive justice through improvements in healthcare access.

8.5.2 Limiting Contributions to Reproductive Justice by Adopting a Technocratic Approach

One of the most important contributions of the reproductive justice framework is that it situates reproductive rights, and health within broader systems of social, economic and political oppression (Ross and Solinger, 2017). Addressing maternal health from a reproductive justice approach thus requires an integrative approach to health that acknowledges how material conditions, and dominant norms, affect the ability of individuals and communities to reproduce, and to make reproductive decisions. As my analysis has demonstrated, the Muskoka Initiative adopted a largely technocratic approach to maternal health that focused on increasing access to medical care. By adopting this technocratic approach, the Muskoka Initiative was able to refrain from meaningfully engaging in social determinants of health, and with the political, social and economic conditions and systems of power that produce them. As such, maternal health was treated as an isolated issue, rather than one that is interconnected with broader issues of social justice, and/or economic development. This technocratic approach, which I have argued aligns with and reinforces neoliberal frameworks of development and health, is thus incompatible with, and undermines a reproductive justice approach to maternal health.

The technocratic approach to maternal health adopted by the Muskoka Initiative also limits its contributions to reproductive justice due to the failure to consider not only how social, political and economic systems contribute to maternal health itself, but also to reproductive experiences and decision making. For instance, while increasing access to healthcare for children contributes to the ability to parent children in 'safe and healthy environments', it does not address how this capacity to parent children is undermined by additional conditions associated with 'underdevelopment' such as economic poverty, unsafe or

inadequate housing, lack of access to education, or environmental degradation. Nor does this framework address how recognition of limited access to economic and social resources might deter individuals from reproducing (Higgins, 2006). By focusing only on health outcomes, the Muskoka Initiative thus fails to fully engage in the integrative elements of poverty and social marginalization that influence reproductive experiences and decisions, and can contribute to reproductive stratification.

While is understandable that an initiative designed to specifically address maternal, newborn and child health would focus on health, a more integrative approach that situated health within broader systemic contexts would have improved the Muskoka Initiative's ability to contribute to reproductive justice within the Global South. Furthermore, situating health within a development framework that was less focused on measurable demographic outcomes, and more on both health and reproduction as human rights would have broadened the field of action and created space for consideration of a greater range of interconnected issues. As it stands, the technocratic, depoliticized approach to maternal health adopted within the Muskoka Initiative significantly undermined its contributions not only to maternal health, but to reproductive justice.

8.5.3 Undermining Contributions to Reproductive Justice by Governing Reproduction

One of the most significant contributions of this research is its illustration of how the Muskoka Initiative operated as a site of reproductive governance. As I have argued throughout this chapter, the texts analyzed relied on a risk-based approach to maternal health to target women in the 'developing' world as in need not only of assistance, but of reproductive governance. Medicalized frameworks of reproduction are used to promote particular reproductive practices, including hospitalized birth, breastfeeding, and even contraceptive use. The ways in which the Muskoka Initiative promotes particular norms illustrates how the spheres of medicine and reproductive health can not only contribute to reproductive justice, but can also undermine it. By contributing to the reproductive governance of women in the Global South, including by promoting reduced fertility, the Muskoka Initiative undermines its contributions to reproductive justice at both the individual, and the community level.

I have argued that the governance of reproduction within the Muskoka Initiative is tied to the configuration of maternal health as a biopolitical project that seeks to maximize health. I have also argued that it is tied to the broader instrumentalization of women within the development sector, which prioritizes what women can offer development, rather than what development can offer women. Just as I argue that technocratic approaches to development are incompatible with the framework of reproductive justice, so too do I argue that instrumentalist approaches to development are incompatible with the goals of reproductive justice. If instrumentalist approaches to development configure women's reproduction as a means to a particular end, then the promotion of particular reproductive 'choices' becomes a logical component of development interventions. Instead, reproductive justice demands that individuals be able to make their own reproductive decisions, and that barriers to reproductive autonomy, whether material or social, be dismantled. Thus, for development to truly contribute to reproductive justice, rights-based approaches to health and development that situate reproductive and maternal health as rights in and of themselves must be adopted.

8.5.4 Limiting Contributions to Reproductive Justice by Excluding Sexuality and Ignoring the Separation of Sex and Reproduction

Reproductive justice explicitly promotes both sexual autonomy and gender freedom as a core component of its platform. In doing so, reproductive justice recognizes that the ability for individuals, and particularly women, to separate sexuality and reproduction is a core component sexual and reproductive rights, as well as gender equality (Ross and Solinger, 2017). Thus, the exclusion of explicit engagement with sexual rights and/or health further limits the Muskoka Initiative's contributions to reproductive justice.

When I initially undertook this study, I was interested in how maternal health operated as a more politically salient or 'safe' means through which to address women's sexual and reproductive health and rights. Yet in conducting my analysis, I noted the exclusion of any explicit reference to sex within the texts. References to the prevention of pregnancy through the use of contraception do implicitly evoke non-reproductive sex, however as discussed above, the focus remains on reducing maternal risk, rather than ensuring reproductive and/or sexual rights. The exclusion of sexuality, either as health or rights, was

also noted by some of my interview participants, one of whom commented that sexual health was more likely to be addressed through interventions specifically targeting HIV/AIDS. Although HIV/AIDS was addressed in some of the texts analyzed for this project, references to the disease were only made in the context of mother to child transmission, and never in the context of the spread of disease through sexual relations. Nevertheless, through references to family planning, the Muskoka Initiative, while avoiding any explicit inclusion of sex and sexuality, implicitly invokes the understanding of sex as 'risky', and hence of needing to be managed through contraceptive use. As Jolly has argued, this understanding of sex has historically characterized the development sector, which has tended to address sexuality as a site of violence and disease transmission, especially for women. I would add that this focus on sex as a site/source of risk aligns with understandings of development as a biopolitical project, in which sex, like reproduction, must be governed in order to maximize well-being (Elbe, 2005; Burchardt, 2013).

In analyzing the absence of sex and sexuality from the Muskoka Initiative, it is useful to consider not only the exclusion of sex from the maternal health framework, but also the adoption of a maternal health framework in the first place. As I have argued above, the adoption of maternal health as Canada's 'top development priority' allowed for the Canadian government to put women at the centre of their development programming, seemingly addressing their needs while instrumentalizing them in the name of broader demographic goals. Furthermore, women were able to be addressed through their traditional roles as mothers, aligning this framework with patriarchal gender norms. In contrast, discussion of sex and sexuality would require, to some extent, consideration of women as sexual subjects, which, given the generally disparagement of women who express sexual desire, may have been seen as weakening the political efficacy of the Muskoka Initiative. This aligns with the argument that the construction of women in the developing world as 'deserving' of help is dependent not only on instrumentalist discourse, but also on their construction as 'innocent' and as aligned with conservative gender norms (Dogra, 2012). In addition to constructing women as sexually 'innocent' through an erasure of non-reproductive sex, the texts construct 'developing' world women as (future) responsible, risk-minimizing subjects, further contributing to their construction as 'deserving' of help.

It should be noted that the absence of any reference to sexual health may in part be the result of the specific terms that I used in selecting texts for analysis and shaping the field of inquiry. My initial search used the term "maternal health" as by this point I was interested specifically in how maternal health was constructed in Canadian development policy. Thus, this absence should not be taken as indicative of the exclusion of sexual health or sexual rights from Canadian policy more broadly. Rather, what my analysis demonstrates is that within the Muskoka Initiative, maternal health was treated as separate from issues and practices of sex and sexuality. Although I analyze this absence, I recognize that this particular aspect of Canadian development policy is one that is need of additional research in order to strengthen this analysis. Nevertheless, I argue that by neglecting to engage with the need to separate sex and reproduction as a core component of gender equality, and of sexual and reproductive autonomy, the Muskoka Initiative undermined its contributions to reproductive justice. Furthermore, by engaging only with heterosexual, reproductive sex the Muskoka Initiative excludes the reproductive and sexual health and rights of non-heterosexual individuals, couples and communities. Similarly, by only speaking to women's maternal health, the Initiative excludes and obscures the reproductive health and rights of the trans community. These exclusions further constrained the Muskoka Initiative's contributions to reproductive justice.

8.6 Theoretical Contributions and Limitations

8.6.1 Governmentality, Agency, and Reproductive Justice

In drawing on and employing Foucauldian concepts such as biopolitics and governmentality, this dissertation follows in the scholarly tradition of feminists appropriating and adapting Foucault's theories in order to advance both feminist theory and politics. In doing so, I have not only contributed to understandings of how Foucauldian theory can be used to examine the power dynamics at work in global development, but also of how governmentality operates in ways that are distinctly gendered, relying on and perpetuating dominant discourses of motherhood, and of the relationship between maternal and child health. Yet while I argue that biopolitics is an appropriate and useful lens through which to understand maternal health programming, my research also contributes to the project of speaking back to Foucault, and negotiating the tensions that exist between his

critical scholarship and the emancipatory aims of feminism (Sawicki, 1991; Ramazanoğlu, 1993). Of particular note is how the understanding of governmentality as functioning, at least in part, through the education of desire, raises questions as to the validity of working toward reproductive freedom as defined by our ability to act on our reproductive desires. While theories of governmentality, specifically as it operates through discourses of risk, offer important critiques that help demonstrate how reproduction is both governed and stratified, there is a need to consider at what point desires and choices can be considered as both shaped by dominant discourses, and as expressions of women's agency. In using theories of biopolitics and governmentality alongside the theory of reproductive justice, I acknowledge this tension and attempt to work through it by grounding my work in the emancipatory aims of the reproductive justice movement, which both critiques the systemic factors that shape reproductive choices while ultimately trusting and respecting the choices that individuals make. In doing so, I follow Sawicki, who both critiques and defends feminist appropriation of Foucault's theory, arguing that the focus should be on "the practical implications that adopting his methods and insight will have" rather than theoretical purity (1991, 109). As such, I have used Foucault's theories with the explicit purpose of advancing the reproductive justice agenda, prioritizing material impacts over abstract theoretical concepts. Nevertheless, I recognize that moving forward, the tensions between these two schools of thought will necessitate further theorization in order to maximize impact and move understandings of biopolitics, governmentality and healthism forward.

8.6.2 Contributions to and Critiques of Feminist Discourse and Scholarship

In addition to contributing to the body of theoretical scholarship on biopolitics and governmentality, my analysis also contributes to feminist scholarship and feminist engagement with critical development studies. In keeping with the aims of feminist critical development studies, my research helps elucidate how global development acts as a site through which gendered discourses and norms are perpetuated. Furthermore, my analysis contributes to feminist scholarship by highlighting how feminist advocacy and activism has, and continues to, rely on problematic discourses that risk undermining the goals of both reproductive justice and gender quality. Specifically, my analysis demonstrates how

seemingly feminist discourses that seek to advocate for maternal health may contribute to the reification of particular reproductive practices and feminine identities, and potentially exacerbate both the stratification of reproduction and the responsibilization of 'developing' world women.

In her analysis of women's healthcare movement of the 1970s and 1980s, Murphy argues that "feminisms can offer a cultural diagnosis of their moment and are at the same time symptomatic of the conditions of their articulation" (2012, p. 178). That is to say, even as feminist actors offer critiques of existing discourses and actions, they may also reiterate dominant discourses. This is particularly true when feminist scholars and advocates engage in strategic discourses in order to garner widespread support. For instance, the alignment between reproductive rights advocates and population control advocates during the mid-twentieth century involved the promotion of demographic targets that undermined the goal of reproductive autonomy (Hartmann, 1995). While feminist advocates were ultimately influential in changing the language from population control to reproductive rights, this alignment is still one that must be grappled with (Murphy, 2010). So too does my dissertation demonstrate how pro-choice feminist discourse that contributes to the medicalization of abortion can easily be aligned with, and bolster, discourses of risk that perpetuate reproductive stratification. By highlighting how feminist, including pro-choice, discourse can perpetuate reproductive governance my dissertation contributes to critical feminist scholarship.

8.6.3 Limitations of the Study

Part of a commitment to reproductive justice is a commitment to centering the lives and experiences of marginalized women. In conducting my analysis, I have thus centered the ways in which development programming discursively constructs the reproductive experiences of women in the developing world, and acts as a means by which their reproduction is governed. Nevertheless, because my project analyzes development policy, I recognize that the lived experiences and voices of these women are entirely absent from my analysis. As I conclude this research, I remain aware of the limitations of a project that seeks to advocate for women in the Global South without engaging with them directly or amplifying their voices. While discourse analysis of development policy is a key

component of the critical turn in development studies, and acts as an important site through which to interrogate the assumptions embedded within development policy and discourse, it is nevertheless one piece of a much larger story. Although I have striven to focus on the implications of these policies for marginalized women within the Global South, without their own accounts of their lived experiences this analysis is partial. Furthermore, without direct engagement with women themselves, I am unable to speak to the ways in which the policies and programs analyzed are perceived, taken up, negotiated and appropriated by women within targeted communities. Thus, while I am confident that this research has important implications for understanding global development as a site of both biopolitical governance and reproductive (in)justice, I recognize that the story it tells is necessarily incomplete.

8.7 Areas for Future Research

Although it has been three years since the end of the Muskoka Initiative, this research project has important implications for maternal health policy and reproductive justice moving forward. As I have outlined, the configuration of MNCH as a biopolitical project, and its alignment with neoliberal development frameworks that instrumentalize and responsibilize women in the 'developing' world raises important questions as to the extent to which the mainstream development sector can act as a site of gender and reproductive justice. These questions are particularly salient given the recent establishment of Canada's Feminist International Assistance Policy (FIAP), which situates both gender equality and reproductive rights at its center. While the policy's incorporation of a gender lens and of explicit support for abortion appear to address key exclusions for which the Muskoka Initiative has been critiqued, my analysis demonstrates that the exclusion of both gender and abortion from the Muskoka Initiative are linked to the broader construction of MNCH as a problem of risk management, and its alignment with neoliberal, instrumentalist and healthist discourses. Thus, while the inclusion of an explicit gendered focus, and of reproductive rights such as abortion can be viewed as positive changes in Canada's development policies, there is a need for analysis that more closely interrogates how these issues have been incorporated into Canada's development policy, and to what end.

While I have argued that the exclusion of issues such as abortion and non-reproductive sex can be linked to the Muskoka Initiative's alignment with biopolitical and instrumentalist approaches to development, as well as patriarchal gender norms, it does not necessarily follow that inclusion of abortion signals a shift away from these frameworks. A preliminary reading of the FIAP indicates that while the policy explicitly addresses gender inequality, it continues to deploy instrumentalist arguments, potentially extending these arguments to Canada's new focus on reproductive rights. For instance, within the policy, reproductive rights are positioned both as a necessary health service, and as tool that helps women participate more fully in the formal economy (Government of Canada, 2017). This positioning appears to align with the framing of gender equality as 'smart economics' (Chant, 2012), and with the alignment of delayed fertility with women's ability to act as productive, neoliberal subjects (Switzer, 2013). Furthermore, the policy appears to extend this instrumentalization of reproduction to adolescent girls who are identified alongside women as key drivers of economic development.

It is clearly not within the scope of this dissertation to provide even a preliminary analysis of FIAP. However, my dissertation points to the need for such analysis, and specifically, of an analysis from the perspectives of both biopolitics and reproductive justice. Analyzing FIAP, and future Canadian development programming through these theoretical lenses will help illuminate how new iterations of Canadian development policy act as a site of biopolitics and of reproductive governance. Indeed, my analysis demonstrates that the configuration of development as a site of biopolitics necessitates governance, as it is largely through the governing of women's bodies and reproductive lives that the health of the population is managed. Furthermore, due to the inability of Canada to rely on sovereign forms of power to govern populations within the 'developing' world, neoliberal forms of 'governance' at a distance are central to Canada's ability to achieve its development aims. Future analysis of FIAP should thus take into account how the policy acts as a site of biopolitics, while examining its potential alignment with, and mobilization of, neoliberal, instrumentalist and healthist discourses. Of key concern will be how FIAP reconciles its instrumentalist approach with its celebration of reproductive rights and gender empowerment, and how it may act as a site of biopolitics and neoliberal governance, albeit, in a different iteration.

My analysis of the (bio)medicalization of contraception is also particularly significant given the current prevalence of family planning interventions, not only within Canada's FIAP, but also among global institutions such as the WHO, and private philanthropic organizations such as the Bill and Melinda Gates Foundation. The latter in particular partnered with the Canadian government during the Muskoka era, and helped publicize Canada's work on MNCH. My analysis adds to critical perspectives on family planning initiatives by highlighting the potential problems, not only with their configuration as the solution to overpopulation and associated environment concerns, but also as a tool through which to manage maternal risk. While, like maternal healthcare, contraception is an integral component of reproductive justice, my findings again highlight that its inclusion in development interventions does not necessarily align with a reproductive justice framework. By demonstrating how family planning approaches that adopt a medicalized, risk-based approach can be easily aligned with technocratic frameworks of development, my research points to the need for more critical interrogation of how family planning is being deployed within development discourse and programming. Specifically, more work is needed on how risk-based approaches to family planning contribute to reproductive stratification along existing hierarchies of marginalization. Given that abortion has similarly been identified as a site of medicalization (Johnstone, 2017), future research should also examine how abortion, when it is included in developing programming, might similarly act both as a key component of reproductive justice, and as tool of reproductive governance. This is of particular interest, given that the exclusion of abortion from the Muskoka Initiative, including by one of my informants, was framed in terms of the risks associated with lack of access to safe abortion. Furthermore, such analysis should be rooted in a reproductive justice framework that values the potential benefits of increased access to both contraception and abortion, while remaining cognizant of how family planning and even reproductive rights interventions can, and have, been used to govern the reproduction of racialized and economically marginalized women.

8.8 Conclusion

In using critical discourse analysis to examine how maternal health is constructed within the Muskoka Initiative, my goal has been to elucidate how maternal health is conceived of

as a development problem within Canadian development policy. By applying the framework of biopolitics to maternal health policy, I have questioned how development programs designed to address women's health contribute to their governance, and in particular, to the management of their reproduction. My findings demonstrate that within the texts analyzed, maternal health is configured as a problem of biomedical risk which can be managed through appropriate action on the part of national governments, communities, and individuals. Specifically, maternal and child mortality is constructed as 'preventable' through increased provision of health services by local governments and communities, and increased accessing of healthcare services by women themselves. Program activities are therefore specifically aimed at fulfilling these primary goals.

In this chapter, I have argued that the construction of maternal health as a project of risk-management aligns with neoliberal development frameworks that value efficiency, individual responsibility and measurable outputs. Furthermore, this construction aligns with and contributes to the depoliticization of development, which is configured as a series of technical interventions carried out by development 'experts'. My research thus aligns with and expands the work of feminist scholars and women's health advocates who have interpreted 'maternal health' as both an integral component of reproductive justice, while also (at times) acting as a means by which reproductive rights have been sidelined, and health disparities depoliticized (Harcourt, 2009; Petchesky, 2000). My research contributes to understandings of the technocratization of development by explicitly linking this process to the medicalized approach to maternal health adopted within the Muskoka Initiative. Furthermore, my analysis demonstrates how the medicalization of pregnancy and childbirth within MNCH programming, while used to promote the provision of healthcare services, also perpetuates neoliberal frameworks of health as a project of individual risk management and as a duty of citizenship. This framework, aligned with dominant ideals of maternity and femininity, situate women in the Global South as responsible for the health of themselves, and of their children. Through this process, women's health is instrumentalized, and their reproductive health and choices governed in the name of promoting the health of themselves, their children, and the population. I have argued that this instrumentalization is in particular linked to the exclusion of abortion, while helping to explain the attraction of a maternal health framework to a Conservative government.

A key goal of this research project has been to assess to the extent to which the Muskoka Initiative operated as a means by which reproductive justice was supported, and/or undermined. My findings suggest that it has done both. Although I offer a critique of the Muskoka Initiative and ultimately argue that its overarching frameworks limit and undermine its contributions to reproductive justice, I nevertheless recognize that many women and children were given access to important healthcare services that otherwise would not have been available. I take seriously that this access to healthcare is an important component of reproductive justice, just as health is itself a key component of social justice and a human right. Nevertheless, by interrogating how its reliance on a risk-based approach to maternal health has limited the Muskoka Initiative's contributions to reproductive justice, my research also provides insights into the challenges of adopting a reproductive justice approach within the realm of development. My hope is that a greater understanding of these limitations can help inform future policies, programs, advocacy and activism.

As I conclude my doctoral research, I find myself in a similar position to the one in which I found myself at the end of my undergraduate degree. I am still wary of mainstream development, and I continue to see important spaces for critical analysis of the discourses it deploys. Yet my perspective has also changed, and I also find myself more hopeful about the prospects for critical development scholars, activists and practitioners to challenge these discourses and instigate change. In this sense, I am also more optimistic about the role I have adopted as a development scholar, and my ability to support this change through critical engagement with development discourse and policy.

When I began this research project, I was motivated by a desire to challenge how women's inclusion in development has been justified through appeals to instrumentalist discourses and patriarchal norms of maternal sacrifice. I understand reproductive justice as an antidote to instrumentalism and to biopolitical governance, insisting as it does on the reproductive rights of individuals and communities, and the dismantling of systemic factors that infringe upon these rights. In conducing this research, my hope has been that my project can contribute to understandings of why instrumentalist discourses are dangerous, and how they can lead to interventions that forfeit women's reproductive rights in the name of 'development'. I have also aspired to produce research that could help illuminate what

changes would have to occur within the development sector in order to allow for greater contributions to, and alignment with reproductive justice.

In reflecting on the question of whether or not the development sector can serve as a place through which to advocate for and work towards reproductive justice, I continue to be of two minds. On one hand, my analysis has highlighted how global development, despite being positioned as 'aid', and despite undoubtedly at times being motivated by altruistic intentions, is nevertheless a project of nation building. As I have argued, while development policy seeks to help those most in need, this goal is pursued in ways that align with, or at the very least refrain from threatening, national interests. For this reason, it appears doubtful that Canada (or other 'developed' countries) would adopt policies and programs that would necessitate significant forfeiture of economic and political power. It is therefore difficult for me to imagine a future in which the dominance of neoliberal and technocratic approaches will be replaced by social justice models that truly address systemic inequality at the global level. So too is it difficult to conceive of a time when instrumentalist arguments for women's inclusion will no longer be relied upon. Although I understand the use of instrumentalist discourses in mobilizing resources that are direly needed, I remain critical of their use, given how they can be used to govern women's reproduction and sexuality, while increasing their burden of labour through responsibilization. Indeed, as I have addressed, I understand technocratic and instrumentalist approaches to be, at their core, antithetical to the goals of reproductive justice. I thus remain skeptical of the development sector's potential as a space through which reproductive justice can be achieved.

Despite my skepticism, I have also been encouraged by the ways in which women's rights organizations and advocate have challenged dominant frameworks and institutions. For instance, I am heartened by the way in which these advocates were able to influence the language of the Cairo Programme of Action, leading to the replacement of population control discourses with the explicit language of reproductive rights. Furthermore, having learned from my own participation in 'on the ground' activism, I recognize that a response to injustice need not be perfect to be worthwhile, and that activists have long been finding ways to work strategically from within problematic institutions. While I recognize the

danger that strategic alignment with problematic discourses and institutions may re-entrench systemic oppression and distract from work that addresses the root causes of oppression, I also recognize that such alignment can mean having a seat at the table, and may afford opportunities to make meaningful change, and to lay the ground work for future activism.

Ultimately, I support the provision of maternal health and reproductive healthcare to women in the Global South, even as I remain critical of the discourses and frameworks through which this healthcare was provided through the Muskoka Initiative. Despite my skepticism, it is still my hope that in delineating the limitations of the frameworks on which the Muskoka Initiative was established, my research will contribute to the development of more radical, rights based approaches to maternal health that more clearly align with the goals of reproductive justice.

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Appendices

Appendix A: List of webpages analyzed from the Government of Canada MNCH website

Number	Title	Original URL	Archived URL
MNCH1	Facts about maternal, newborn and child health	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/index.aspx?lang=eng	https://web.archive.org/web/20150918183932/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/index.aspx?lang=eng
MNCH2	Newborns	http://international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/newborns-nouveau_nes.aspx?lang=eng	https://web.archive.org/web/20160325010935/http://international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/newborns-nouveau_nes.aspx?lang=eng
MNCH3	Reducing Disease	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/reducing-reduction.aspx?lang=eng	https://web.archive.org/web/20160325010939/http://international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/reducing-reduction.aspx?lang=eng
MNCH4	Nutrition	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/nutrition.aspx?lang=eng	https://web.archive.org/web/20160325014654/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/nutrition.aspx?lang=eng

MNCH5	Accountability	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/accountability-responsabilisation.aspx?lang=eng	https://web.archive.org/web/20160325014643/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/accountability-responsabilisation.aspx?lang=eng
MNCH6	Private Sector and Innovation	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/private-prive.aspx?lang=eng	https://web.archive.org/web/20160325014657/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/facts-faits/private-prive.aspx?lang=eng
MNCH7	Canada's leadership in maternal, newborn and child health – the Muskoka Initiative (2010-2015)	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/leadership/muskoka-muskoka.aspx?lang=eng	https://web.archive.org/web/20151023181119/http://international.gc.ca/world-monde/development-developpement/mnch-smne/leadership/muskoka-muskoka.aspx?lang=eng
MNCH8	Canada's ongoing leadership to improve the health of mothers, newborns and children (2015-2020)	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/leadership/ongoing-continu.aspx?lang=eng	https://web.archive.org/web/20160325010948/http://international.gc.ca/world-monde/development-developpement/mnch-smne/leadership/ongoing-continu.aspx?lang=eng
MNCH9	WASHing practices in Ghana improve family health	http://www.international.gc.ca/development-developpement/stories-histoires/ghana/washing_practices-	https://web.archive.org/web/20160324221415/http://www.international.gc.ca/development-developpement/stories-histoires/ghana/washing_practices-

		pratiques_hygiene.aspx?lang=eng	pratiques_hygiene.aspx?lang=eng
MNCH10	Help that is making a big difference	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/haiti.aspx?lang=eng	https://web.archive.org/web/20150915113828/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/haiti.aspx?lang=eng
MNCH11	Canada helps deliver childbirth education in Ethiopia	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/ethiopia-ethiopie.aspx?lang=eng	https://web.archive.org/web/20150918182312/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/ethiopia-ethiopie.aspx?lang=eng
MNCH12	Registering birth days in Tanzania	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/tanzania-tanzanie.aspx?lang=eng	https://web.archive.org/web/20150915002036/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/tanzania-tanzanie.aspx?lang=eng
MNCH13	Canada partners with the Government of Nigeria to improve maternal, newborn and child health	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/nigeria.aspx?lang=eng	https://web.archive.org/web/20150914215351/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/nigeria.aspx?lang=eng
MNCH14	When the child is healthy, the mother is happy	http://www.international.gc.ca/world-monde/development-	https://web.archive.org/web/20150918182031/http://www.international.gc.ca/world-

		developpement/mnch-smne/stories-histoires/bangladesh.aspx?lang=eng	monde/development-developpement/mnch-smne/stories-histoires/bangladesh.aspx?lang=eng
MNCH15	Family Health Houses in Afghanistan bring health care to remote areas	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/afghanistan.aspx?lang=eng	https://web.archive.org/web/20150918181825/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/afghanistan.aspx?lang=eng
MNCH16	Community Initiatives feed school children in Kenya	http://www.international.gc.ca/development-developpement/stories-histoires/kenya/feed_school_children-nourrir_ecoliers.aspx?lang=eng	https://web.archive.org/web/20160324221456/http://www.international.gc.ca/development-developpement/stories-histoires/kenya/feed_school_children-nourrir_ecoliers.aspx?lang=eng
MNCH17	We are “Making a Difference” for healthy mothers and children	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/difference.aspx?lang=eng	https://web.archive.org/web/20160325010113/http://international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/difference.aspx?lang=eng
MNCH18			
MNCH19	Saving Lives through Immunization – YouTube	https://www.youtube.com/watch?v=jUl5sQWQspM	YouTube video is still up

MNCH20	How Civil Registration and Vital Statistics Systems Improve the Health of Mothers and Newborns	https://www.youtube.com/watch?v=inm6RetgSEw	YouTube video is still up
MNCH21	Innovations to Improve the Health of Mothers, Newborns and Children	https://www.youtube.com/watch?v=9Ed91of7eE8	YouTube video is still up
MNCH22	Improving Newborn Health to Reduce Child Mortality	https://www.youtube.com/watch?v=vVI6iJ1R3sQ	YouTube video is still up
MNCH23	Doing more to Improve Maternal Health	https://www.youtube.com/watch?v=ud9zqILSnjc	YouTube video is still up
MNCH24	Saving Lives through Nutrition	https://www.youtube.com/watch?v=QbeQIhG1KiA	YouTube video is still up
MNCH25	Doing More Together Globally to Improve the Health of Mothers, Newborns and Children	https://www.youtube.com/watch?v=k61-I4x8Qa4	YouTube video is still up
MNCH26	Saving Every Woman, Every Child: Within Arm's Reach	https://www.youtube.com/watch?v=U8CwAe6JNks	YouTube video is still up

MNCH27	An Interview with Dr. Margaret Chan on Maternal, Newborn and Child Health	https://www.youtube.com/watch?v=CI0Iw1g3Nec	YouTube video is still up
MNCH28	Rosemary McCarney, Co-Chair of the Canadian Network of MNCH and President and CEO of Plan Canada	https://www.youtube.com/watch?v=ZSNn46zl45I	YouTube video is still up
MNCH29	Dave Toycen, President of World Vision	https://www.youtube.com/watch?v=fauhIzhPcoY	YouTube video is still up
MNCH30	Khalil Shariff, CEO of the Aga Khan Development Network	https://www.youtube.com/watch?v=zBTMXNclSwI	YouTube video is still up
MNCH31	Seth Berkley, CEO of the GAVI Alliance	https://www.youtube.com/watch?v=z0y25d4IH4w	YouTube video is still up
MNCH32	Jennifer Blake, CEO of the Society of Obstetricians and Gynaecologists of Canada	https://www.youtube.com/watch?v=qeN0cR62d4U	YouTube video is still up
MNCH33	Peter Singer of Grand Challenges Canada	https://www.youtube.com/watch?v=hz9bGJGFJWc	YouTube video is still up
MNCH34	Maternal health	http://www.international.gc.ca/world-monde/development-developpement/mnch-	https://web.archive.org/web/20160316171632/http://www.international.gc.ca:80/world-monde/development-

		smne/facts-faits/maternal-meres.aspx?lang=eng	developpement/mnch-smne/facts-faits/maternal-meres.aspx?lang=eng
MNCH35	The Muskoka Initiative	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/leadership/background-contexte.aspx?lang=eng	Archived version unavailable
MNCH36	Saving Every Woman, Every Child: Within Arm's Reach – 69th General Assembly of the United Nations	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/leadership/saving-sauvons.aspx?lang=eng	Archived version unavailable
MNCH37	Canada helps communities tackle malnutrition in Malawi	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/malawi.aspx?lang=eng	https://web.archive.org/web/20150912185224/http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/malawi.aspx?lang=eng
MNCH38	Immunization saves lives	http://www.international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/immunization-vaccination.aspx?lang=eng	https://web.archive.org/web/20160325005651/http://international.gc.ca/world-monde/development-developpement/mnch-smne/stories-histoires/immunization-vaccination.aspx?lang=eng
MNCH39	Canada is on track	http://www.international.gc.ca/world-monde/development-	Archived version unavailable

		developpement/mnch-smne/projects-projet/track-voie.aspx?lang=eng	

Appendix B: List of Project Descriptions Funded through the Muskoka Initiative; from the Website of the Department of Foreign Affairs, Trade and Development

ID	Project Name	Project Number	Maximum CIDA Contribution	Executing Agency – Partner
P1	Accelerating Efforts to Improve Maternal and Child Health in the Simiyu Region	A035253-001	$13,017,308	African Medical and Research Foundation (Tanzania)
P2	Accelerating Nutrition Improvements in Sub-Saharan Africa – Scale-up	M013596-002	$10,200,000	WHO – World Health Organization
P3	Accelerating Nutrition Improvements in Sub-Saharan Africa – Surveillance	M013596-001	$7,800,000	WHO – World Health Organization
P4	Accelerating Progress on Child Survival	A035496-001	$3,000,000	UNICEF – United Nations Children's Fund
P5	Accelerating the Reduction of Maternal and Newborn Mortality	A034616-001	$21,000,000	UNICEF – United Nations Children's Fund
P6	Basic Health Care and Nutrition for Mothers and Children (SESAME)	A035488-001	$20,000,000	UNICEF – United Nations Children's Fund
P7	Canadian Network for Maternal, Newborn and Child Health	S065804-001	$1,814,338	Children's & Women's Health Centre of British Columbia
P8	CARE – Improved Health and Nutrition in Africa	S065348-001	$3,667,084	CARE Canada
P9	Community-Based Maternal, Newborn and Child Health	S065337-001	$688,881	World Renew

P10	Community-Based Maternal, Newborn and Child Health Services	A035234-001	$12,000,000	Plan International Canada
P11	Community-Based Nutritional Health and Southern Mali – I	A035102-001	$7,000,000	WFP – World Food Programme
P12	Community-Based Nutritional Health in Southern Mali – III	A035102-003	$15,000,000	WFP – World Food Programme
P13	Community-Led Health in Bangladesh	S065336-001	$552,110	HOPE International Development Agency
P14	Construction of the Artibonite Provincial Hospital in Gonaives – II	A034921-002	$10,000,000	UNOPS – United Nations Office for Project Services
P15	Deploying Midwives to South Sudan	A035518-001	$13,716,000	UNFPA – United Nations Population Fund
P16	Emergency Obstetrics in South Sudan	A035244-001	$19,400,000	WHO – World Health Organization
P17	Essential Health and Nutrition Services for Maternal, Newborn and Child Health	M013403-001	$75,000,000	MI – Micronutrient Initiative
P18	Family Health Houses	A035372-001	$5,200,000	UNFPA – United Nations Population Fund
P19	GAVI Alliance – Institutional Support – 2011-2015	M013404-001	$50,000,000	Gavi, The Vaccine Alliance
P20	Global Fund to Fight AIDS, Tuberculosis and Malaria – Institutional Support – 2014-2016 – Muskoka	D000514-002	$200,000,000	Global Fund to Fight AIDS, Tuberculosis & Malaria
P21				
P22	Health Centre Construction and Rehabilitation	A035567-002	$500,000	Government of the Netherlands – Ministry of Foreign Affairs
P23	Health Pooled Fund	A035360-001	$19,400,000	Government of the United Kingdom – DFID –

				Department for International Development
P24	Health services for women and girls in Haiti	A034732-001	$5,000,000	UNOPS – United Nations Office for Project Services
P25	Healthy Child Uganda	S065346-001	$3,486,734	University of Calgary – Board of Governors
P26	High-Impact Intervention for Maternal, Newborn and Child Health	A035264-001	$20,000,000	UNDP – United Nations Development Programme
P27	Implementing the Recommendations of the UN Accountability Commission – II	M013603-002	$11,000,000	WHO – World Health Organization
P28	Improved Food Security for Mothers and Children	A035171-001	$50,000,000	UNICEF – United Nations Children's Fund
P29	Improving Community Health	S065350-001	$4,913,404	Save the Children Canada
P30	Improving Community Health in Sikasso and Koulikoro regions	S065351-001	$2,624,963	Canadian Red Cross
P31	Improving Integrated Local Health Service Delivery in Zambezia Province	A035261-001	$5,000,000	Government of Mozambique – Ministry of Finance
P32	Improving Maternal and Child Health Conditions in Haiti	S065328-001	$704,926	International Needs Canada
P33	Improving Maternal and Child Health in Burkina Faso	S065374-001	$2,040,610	WUSC – World University Service of Canada
P34	Improving Maternal and Child Health: Partnership and Action for Community Transformation	S065347-001	$1,971,590	CCFC – Christian Children's Fund of Canada
P35	Improving Maternal and Reproductive Health in Six Districts of Rural Tanzania	A035251-001	$9,889,587	CARE Canada
P36	Improving Maternal, Newborn and Child Health	A035242-001	$40,350,000	Aga Khan Foundation Canada

P37	Improving Maternal, Newborn and Child Health in Pastoralist and Semi-Pastoralist Communities	S065387-001	$2,251,134	AMREF Canada – African Medical and Research Foundation Canada
P38	Improving Maternal, Newborn and Child Survival in Warrap State	D000052-001	$19,997,000	Canadian Red Cross
P39	Improving Nutrition of Mothers, Newborns, and Children	A035242-002	$6,600,000	Save the Children Canada
P40	Improving Maternal, Newborn, and Child Health and Nutrition – One UN Program	A035231-001	$36,000,000	UNDP – United Nations Development Programme
P41	Improving Nutrition through Homestead Food Production	M013707-001	$15,000,000	HKI – Helen Keller International
P42	Improving the Survival of Malnourished Children	D000058-001	$3,600,000	UNICEF – United Nations Children's Fund
P43	Increased Access to Basic Health Services	A035206-001	$20,000,000	PAHO – Pan American Health Organization
P44	Increased Maternal and Child Health Access	S065349-001	$439,357	Primate's World Relief and Development Fund
P45	Integrated Community Case Management	A035465-001	$2,809,710	PSI – Population Services International
P46	Integrated Management of Maternal and Child Health in Artibonite (2)	A035207-001	$5,000,000	CCISD – Center for International Cooperation in Health and Development
P47	Integrated Prevention of Mother-to-Child Transmission of HIV (PMCT) in Burundi	S065364-001	$509,140	L'AMIE
P48	Interprofessional Response to Disability and Maternal and Child Health Needs	S065339-001	$1,326,173	Queen's University
P49	Interrupting Pathways to Sepsis	S065353-001	$2,799,520	University of British Columbia – University-Industry Liaison Office

P50	Joining Hands – Improving Maternal, Newborn and Child Health in Tanzania	A035252-001	$12,000,000	Aga Khan Foundation Canada
P51	Joint Government of Bangladesh – UN Maternal and Neonatal Health Project	A035190-001	$19,750,000	UNFPA – United Nations Population Fund
P52	Making Motherhood Safe	D000164-001	$10,200,000	Comprehensive Community-Based Rehabilitation in Tanzania
P53	Maternal and Child Health Enhancement Program in South Sudan	S065383-001	$2,686,463	CHF
P54	Maternal and Child HIV/AIDS Health Care and Promotion	S065382-001	$423,136	IDRF – International Development and Relief Foundation
P55	Maternal and Under-5 Nutation and Child Health	A035243-001	$9,000,000	World Vision Canada
P56	Maternal Evacuation in District of Kayes	A034908-001	$14,500,000	Government of Mali – Ministry of the Economy and Finances
P57	Maternal Mortality Survey and Emergency Obstetric and Newborn Care Needs Assessment	A035362-001	$3,000,000	UNFPA – United Nations Population Fund
P58	Maternal, Neonatal and Child Health Program	S065365-001	$1,511,210	PWS&D – Presbyterian World Service & Development
P59	Maternal, Newborn and Child Health in Rwanda	S065358-001	$1,797,290	Western University
P60	Maternity Centres of Excellence (MCE)	D000472-001	$3,300,000	Jhpiego
P61	Maziko: Nutrition Foundations for Women and Children	A035288-001	$6,061,944	CARE Canada
P62	Meeting Critical Health Care and Nutritional Needs in Kenya	S065381-001	$1,675,805	University of Manitoba

P63	Mother Care and Child Survival in Underserved Regions of Mali, Mozambique and Pakistan	S065361-001	$8,352,078	Aga Khan Foundation Canada
P64	Multisectoral Support to Nutrition Activities and Policies	A035263-001	$13,500,000	World Bank
P65	Nutrition Surveillance System in Afghanistan	A035243-003	$6,430,000	WHO – World Health Organization
P66	Pakur Mother and Child Survival Project	S065363-001	$864,092	HealthBridge Foundation of Canada
P67	Polio Eradication Program	A035485-001	$18,000,000	WHO – World Health Organization
P68	Prevention of Childhood Undernutrition	M013757-001	$20,000,000	International Food Policy Research Institute
P69	Safer Obstetrics in Rural Tanzania	S065368-001	$1,863,614	Canadian Network for International Surgery
P70	Scaling Up Nutrition – Expansion of the REACH Mechanism	M013426-002	$5,000,000	WFP – World Food Programme
P71	Scaling Up Nutrition – REACH	M013426-001	$15,000,000	WFP – World Food Programme
P72	Scaling-up Birth Registration Using Innovative Technology	D000402-001	$10,000,000	UNICEF – United Nations Children's Fund
P73	Securing the Lives of Mothers and Infants	S065386-001	$1,988,099	ADRA – Adventist Development and Relief Agency Canada
P74	Shaping Local Markets for Diarrhea Treatment	A035457-001	$14,250,000	Clinton Health Access Initiative
P75	Strengthening Health Activities for the Rural Poor	A035218-001	$15,000,000	World Bank
P76	Strengthening Tanzania's Health System for Maternal, Newborn and Child Health	A034782-008	$63,000,000	Government of Tanzania – Ministry of Finance

P77	Support to Child Survival	D000145-002	$9,933,433	Micronutrient Initiative
P78	Support to Maternal and Newborn Health in the Administrative District of Ituri	S065370-001	$2,553,960	Oxfam-Quebec
P79	Support to the Increasing Demand for Childbirth Health Services	A035262-001	$3,000,000	Government of the United Kingdom – DFID – Department for International Development
P80	Support to Prosaude to Achieve Millennium Development Goals 4 and 5	A033033-007	$118,000,000	Government of Mozambique – Ministry of Health
P81	Supporting Systems to Achieve Improved Nutrition, Maternal, Newborn and Child Health	S065377-001	$3,098,402	World Vision Canada
P82	The H4+ Initiative to Accelerate Support for Maternal and Newborn Health	M013402-001	$50,000,000	UNFPA – United Nations Population Fund
P83	The Leyaata (“Rescue Us”) Project to Reduce Maternal, Infant and Child Mortality	S065355-001	$640,464	Ghana Rural Integrated Development
P84	Training Midwives in South Sudan	A035358-001	$19,484,700	UNFPA – United Nations Population Fund
P85	Vaccinating Children Against Measles	A035232-001	$3,100,000	UNICEF – United Nations Children’s Fund
P86	Water, Sanitation and Hygiene (WASH) for Maternal, Newborn and Child Health	S065331-001	$5,764,283	Centre for Affordable Water and Sanitation Technology
P87	Water, Sanitation and Hygiene in Southern Mali	A035564-001	$20,000,000	UNICEF – United Nations Children’s Fund
P88	Women and their Children’s Health (WATCH)	S065372-001	$19,335,120	Plan International Canada

Appendix C: Analysis Sheet – First Round Analysis

1. Bibliographical Data:
    - Sample #
    - Title:
    - Date of Publication:
    - Author/Institution:
    - Type of Material:
    - Date Text was First Read:

2. Contextual Data:
    - How (or through which source) can the publication be accessed?
    - Who is the identified audience?

3. Surface of the Text
    - What is the layout like? What kinds of pictures or graphs accompany the text?
    - What headings and subheadings are used?
    - How is the text structured in units of meaning?
    - What topics are touched upon in the text?
    - What topics are absent?
    - How do these topics relate to each other and overlap?

4. Problematization
    - How is the problem of maternal health defined?
    - Where is the problem located?
    - Who is addressed as having the power to 'fix' the outlined problem?
    - What goals are outlined?

5. Power Relations
    - Who has the power to defined what the problem is, where the problem is located?
    - Who is addressed as having the power to 'fix' the outlined problem and based on what?
    - What actors are mentioned in the text and how are they portrayed?
    - Who is likely to benefit from the discourse as conveyed within this text?
    - Who is included in within this text and who is not?
    - What potential problems are silenced and how?

6. Knowledge and expertise
    - What forms of knowledge does the text refer to?
    - How is the knowledge referred to?
7. Discourses of Development
    - How is development conceptualized and represented in the text? What is represented as constituting development, and how is it to be pursued? What are the conditions that frame the way it is constructed? What is absent?
    - What types of development practices are made possible/not possible by the text?
    - How are 'developed' and 'developing' countries represented and defined? What assumptions are made about each category, specifically in relation to maternal health?
8. Maternal Health
    - How is the (maternal) body conceptualized and represented in the text? What assumptions are made regarding motherhood, femininity and sexuality?
    - How is the maternal body configured as an object of development? What kinds of practices are encouraged/assumed to be desirable?
    - What sorts of maternal practices of the self are idealized/assumed?
9. Rationalities
    - How is risk addressed or referred to within the text?
    - What concept of risk does the text presuppose and convey?
    - What other rationalities does the text refer to (or bring in?)
10. Rhetorical Means
    - What kind of argumentation does the text follow? What argumentation strategy and rationalities are used?
    - What logic underlies the composition of the text?
    - What collective symbolism is used?
    - What idioms, sayings, and clichés are used and what do they convey?
    - What are the vocabulary and style?
    - What actors are mentioned and how are they portrayed?
    - What references are made within the text?
11. Other Peculiarities of the Texts?
    - Are there unique things about the text? What was surprising, unexpected, uncommon?
    - Where you reminded of similarities/contradictions to other texts? What did you notice and why?
12. What is the Overall Message of the Text?

Appendix D: Analysis Sheet – Second Round Analysis

Round 2 Analysis Sheet

Discursive Thread #1: Canada as Global Leader

How is Canada positioned as a global leader through its work on MNCH?

- How is Canada constructed as holding both a leadership and a "supporting" role in MNCH? How is Canada portrayed as "changing things", "delivering results" as active and successful? Does this contrast with how other actors/countries are represented?
- How is Canada situated as site of funding, expertise and good health?
- How is the language of partnership used to construct Canada's role in MNCH programming? With NGOs, other countries, global institutions, and 'local partners'?
- How are individual stories and quotes used to demonstrate local support, as well as their successes?
- How is this discourse contradicted/challenged/disrupted?

Discursive Thread #2 MNCH as Global Project

How is MNCH positioned as a global problem/project while simultaneously situated in particular regions/populations?

- What visual and textual elements help situate the problem of MNCH in particular regions and among particular populations?
- How do high maternal and child mortality rates function as a distinction between the developed/developing worlds?
- How is the global community constructed as working together to address this problem? How are discourses of global cooperation deployed in the text? How do these discourses help hide power imbalances/conflicts?
- How is this discourse contradicted/challenged/disrupted?

Discursive Thread #3: the Construction of women and children in the developing worl d as a vulnerable population

How are women and children in the developing world constructed as a vulnerable population?

- How are women and children in the developing world identified/constructed as vulnerable populations? What is absent in this construction? How is this vulnerability taken for granted/presented as a given? Is there any disaggregation of this population?
- What role do discourses of preventability play in the construction of vulnerable populations?
- How are pregnancy and childbirth constructed as risky/dangerous? What is absent from this construction? How are medical risks constructed? What about social and economic factors?
- Are social determinants of health present? Is there any acknowledgement social and political influences on health outcomes? Is poverty mentioned? Gender oppression? Inequality of any kind?
- How is gender deployed, even as gendered power relations are made absent? Is gender equality an explicit goal of MNCH?
- How does the construction of women and children as lives to be saved effect understandings of developing world women's role in development? Their agency, and power as development actors?
- How is this discourse contradicted/challenged/disrupted?

Discursive thread # 4: Health as Development

How is health of population and individuals situated as part of the development project?

- What are entitlements to health and health services based on?
- How is health linked to other development goals, such as productivity and education? How is the health of the individual linked to the health of the community?
- Does the text put forward an integrated approach to development? Is so, how? Is this framing disrupted by the focus on medical interventions?

Discursive thread #5: Development as Access to Services

How is development configured as increasing access to services?

- What role do discourses of medicalization and a focus on medical intervention play in this construction?
- How do activities of awareness raising and encouraging best practices? Reinforce or disrupt the framing of development as increasing access to medical services? How do these discourses potentially govern women/mothers to seek medical care? What other maternal/medical practices are constructed as ideal?
- How does the focus on strengthening health services, including building infrastructure and training medical professionals, reinforce this framing of development? What is absent?
- How are discourse of affordability, efficiency and evidence-based interventions used to perpetuate a particular model of development? What assumptions are embedded in this discursive thread? What role do discourses of accountability play?
- How are interventions framed as producing particular results? What assumptions about knowledge; about development are embedded in these framings? What do these discourses accomplish in establishing a particular model of development?
- How does the focus on measurable results reinforce the dominant framing of development as increasing access to services? What is lost or absent from this focus?
- How is the private sector positioned as a significant development actor? What is hidden or assumed in this positioning?
- How is this discourse contradicted/challenged/disrupted?

Discursive Thread #6: Population level data

How is population level data used to situate development as a biopolitical project?

- How are maternal and child mortality rates, and other health indicators used to define and locate the problem of MNCH? To track progress (globally and nationally?). To measure accountability?
- How does population level data (on health, CRVS) used to a means of constructing risk? How is this data/knowledge presented as necessary to the project of development? To the governing of the population and the resoluation of MNCH as a development problem?
- How is this discourse contradicted/challenged/disrupted?

Discursive Thread #7: Maternal, Newborn and Child Health as one cohesive project

How are maternal health, newborn health and child health constituted as part of the same problem, requiring the same solutions?

- How are mothers/maternal bodies framed as a source of risk and a tool for improving child and newborn health?
- How are interventions in maternal health represented as contributing to child health? To what extent, if at all, are these effects used to justify maternal health interventions? Are they positioned intentional, or a happy side effect?
- How are mothers and children conceptualized as part of the same life-cycle? (from pre-pregnant to childhood)? How do such conceptualizations shape understandings of maternal, newborn and child health? What is hidden/absent in this conceptualization?
- Are there any acknowledgement of possible tensions or conflicts between maternal and child(or fetus) health interests? (including possible need for abortion – medical or unwanted pregnancy?)
- How is maternal health and women's health conflated in the text? How is the maternal body constructed as necessarily feminine? How does the definition of maternal health through pregnancy and childbirth effect our understanding of women's experiences in the developing world?
- How is this discourse contradicted/challenged/disrupted?

Discursive Thread #8: Family Planning

How if family planning constructed as part of maternal, newborn and child health?

- How is Family planning presented? What resources, actions and interventions are described as part of family planning?
- Who are the recipients of family planning? How is female sexuality, as well as sexual and reproductive rights kept absent from the text?
- What is the role of family planning in reducing risk; reducing preventable maternal deaths?
- How is the language of choice and coercion deployed in reference to family planning interventions?
- How is abortion kept absent from the text?

Appendix E: Recruitment Email

Subject Line: Invitation to participate in research

You are being invited to participate in a study that we, Jacqueline Potvin and Dr. Bipasha Baruah are conducting. Briefly, the study involves participating in an one to two hour interview on the topic of Canada's maternal health policy and initiatives. The interview will take place at a time and location of your choosing

If you would like more information on this study or would like to receive a letter of information about this study please contact the researcher at the contact information given below.

Thank you,

Jacqueline Potvin
University of Western Ontario

Appendix F: Interview Guide

Interview Guide

1. Can you tell me a little bit about your own involvement in Canada's maternal heath programming?

2. Can you describe for me how Canada's maternal health policy was developed?
    a. How was maternal health identified as a top development priority for Canada?
    b. How were the areas of focus chosen?

3. What role (if any) did the concept of gender mainstreaming play in the development of Canada's global maternal health policy? (OR) Does the programming draw on gendered analysis of development, and/or the idea that gender is an important factor in development programming?

4. In your opinion, what are the strengths and/or successes of the program so far?

5. In your opinion, are there any limitations to this policy as it currently exists?

6. In your experience, how have ideas of sexuality and sexual right and health played a role in the development of this policy?

7. Do you have anything else you would like to add?

Appendix G: Ethics Approval

Western Research

Research Ethics

Western University Non-Medical Research Ethics Board
NMREB Delegated Initial Approval Notice

Principal Investigator: Dr. Bipasha Baruah
Department & Institution: Arts and Humanities\Women's Studies and Feminist Research,Western University

NMREB File Number: 106978
Study Title: Female Sexuality and Maternal Health: a critical discourse analysis of Canadian international development policy and discourse
Sponsor: Social Sciences and Humanities Research Council

NMREB Initial Approval Date: September 10, 2015
NMREB Expiry Date: September 10, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Revised Western University Protocol		2015/08/21
Revised Letter of Information & Consent		2015/08/21
Recruitment Items	Revised recruitment e-mail	2015/08/21

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Curriculum Vitae

Name: Jacqueline Potvin

Post-secondary Education and Degrees:
University of Guelph
Guelph, Ontario, Canada
2011 B.A.H.

Leeds University
Leeds, UK
2012 M.A.

The University of Western Ontario
London, Ontario, Canada
2018 Ph.D.

Honours and Awards:
Ontario Graduate Scholarship
2013-2014, 2014-2015

Social Science and Humanities Research Council (SSHRC)
Doctoral Fellowship
2015-2017

Related Work Experience
Instructor
The University of Western Ontario
2015, 2017-2018

Instructor
King's University College, The University of Western Ontario
2017-2018

Research Assistant
The University of Western Ontario
2014-2017

Teaching Assistant
The University of Western Ontario
2012-2015

Publications:

Potvin, Jacqueline. (Forthcoming). Neoliberal Governance, Healthism and Maternal Responsibility under Canada's Muskoka Initiative. In Levasseur, Paterson and

Turnbull (Eds.) *Thriving Mothers/Depriving Mothers: Mothering and Welfare*. Toronto: Demeter Press.

Potvin, Dominique A., Emily Burdfield-Steel, **Jacqueline Potvin,** and Stephen Heap. (2018). Diversity Begets Diversity: a Global Perspective on Gender Equality in Scientific Society Leadership. *PLoS ONE* 13(5)

Potvin, Jacqueline. (2016). Pernicious Pregnancy and Redemptive Motherhood: Narratives of Reproductive Choice in Joss Whedon's *Angel*. *Slayage: the Journal of Joss Whedon Studies* 14(1).

Potvin, Jacqueline. (2015) Mobilizing Motherhood: the Use of Maternal Myths in Popular Development Discourse. *Journal of Global Justice: Theory Practice Rhetoric, 8(1).*

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