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A Word from the Editors

The health concerns of the world's 370 million indigenous people have been largely neglected by the international community. [1] As Andrew Pinto and Janet Smylie (2013) observe, "obtaining accurate data on Indigenous peoples is difficult. In many regions of the world they are unrecognized, uncounted and invisible."[2] Indeed, despite progress in advancing indigenous rights during the two International Decades of the World's Indigenous Peoples (1995-2004; 2005-2014), the passage of the Declaration on the Rights of Indigenous Peoples (2007) and the establishment of the Permanent Forum on Indigenous Issues (2000), indigenous health remains marginalized.

The obscurity of indigenous health has not only been to the detriment of indigenous peoples, rather, it has blinded the international community from rich perspectives relevant to global discourses and debates. Indeed, "[i] ndigenous peoples have diverse and rich understandings of health that are highly relevant to the current global debates regarding the need to refocus health care systems away from acute care, high-cost treatments towards upstream prevention."[2] In light of all this, the upcoming 12th session of the Permanent Forum on Indigenous Issues (20-31 May 2013), which will be a review session, represents an important moment for garnering attention on indigenous health as it will be placing a special emphasis on health, in addition to culture and education.

Health Diplomacy Monitor

The Health Diplomacy Monitor aims to report and inform readers about key international negotiations currently underway which have a significant impact on global health. The objective is to "level the playing field" by increasing transparency and making information about the issues and proposals being discussed more readily available.

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In the lead-up to the 12th session, this edition of the Monitor has made indigenous health its primary theme. In the first commentary, focusing on Canada, Jo-Ann Episkenew and Cassandra Opikokew suggest that we need to move beyond the social determinants of health framework, and begin to appreciate the legacies of colonialism in informing contemporary public policy and governance; in particular, the role of policy in contributing to the negative health outcomes of indigenous peoples in Canada. Due to a combination of factors, indigenous populations are particularly vulnerable to noncommunicable, as well as communicable, disease. In her commentary, Pamela Orr focuses more specifically on the governance challenges confronting action on the disproportionate caseload of tuberculosis in the world's indigenous populations.

Challenges confronting the governance of indigenous health are not restricted to the biomedical implications of disease. Indeed, Viviane Weitzner's contribution highlights the impact of the extractive sector on the social, cultural and physical well-being of indigenous peoples, while Michelle Maillet and James Ford address the impediments confronting indigenous participation in the climate change regime, despite the significant impact of climate change for the world's indigenous peoples. Priyanka Kanth considers the link between the Convention on Biological Diversity (CBD) and health.

The contributions in this issue are thus suggestive of a critical issue in the governance of indigenous health; specifically, the need to enhance indigenous participation in global health through the right to self-determination. Citing Roger Maaka and Augie Fleras, Episkenew and Opikokew observe that for far too long, indigenous people have been perceived as "minorities with problems" as opposed to "peoples with rights." This issue of the Monitor hopes to shed light on this insight, by highlighting the critical role for enhanced indigenous participation in the field of global health.

In addition to the special focus on indigenous peoples' health, this issue of the Monitor also provides an update from the recent meeting of the Commission on the Status of Women (CSW) by Tammy MacLean, and an overview by Miriam Sangiorgio of developments related to the implementation of the right of the child to health discussed at the 22nd Human Rights Council.

Mark Pearcey and Bente Molenaar Neufeld

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Guest Commentary: Indigenous Health Issues in Canada: "Minorities with Problems" or "Peoples with Rights"?

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Several years ago the Institute for Aboriginal Peoples' Health, one of the Canadian Institutes of Health Research, coined the term "complex interaction of factors" to describe those things that affect indigenous peoples' health that go well beyond the social determinants of health. This term is appealing for indigenous health researchers because it allows us to dig deeper, to look for the causes of those determinants that cause ill health, such as the inability to obtain and retain sufficient employment, poverty, poor housing, poor diet, access to health services, social exclusion, and so on. In Canada, the causes all relate to how the country was settled, the attitudes of the settlers, and the settler government's "Indian" policies.

Reading this, many contemporary Canadians will despair, expressing common sentiments like "Those things happened long ago!" and "My grandparents came from [insert oppressed country], worked hard, and now look where I am today, so you should do the same!" So where are we going with this? We want to introduce a few more factors to add to that complex list that interact to place our families and communities in the state of ill health we find ourselves in today, namely Canadians' ignorance of the history of the settlement of this land and their resentment of the rights that indigenous people acquired in exchange for agreeing to share the land. Combined, these two factors have created the conditions for ill-informed policy makers who create poor public policy.

Treaty education in Canada only began after the release of the report of Royal Commission on Aboriginal People in 1996, and only then in some provinces. Young people still learn the myth of the brave settlers arriving in a land sparsely populated by primitive nomadic hunter-gatherers who quickly succumbed to European diseases. These settlers faced untold hardships but ultimately built Canada into the great nation it is today. Not until university, and rarely there, do young people learn about the sophisticated and complex societies that existed before contact or about the settlers' attitudes of superiority to the indigenous peoples and, indeed, "non-whites" in general. Roger Maaka and Augie Fleras [1] describe how this mis-education leads to a framing of indigenous peoples as "minorities with problems" as opposed to "peoples with rights." And, only after stories of abuse in residential schools became public have Canadians begun to learn about the oppressive policies that their duly elected governments created to express, embed, and support these attitudes.

In 1996, after conducting 178 interviews, visiting 96 communities, consulting with numerous experts and reviewing endless research, the Royal Commission on Aboriginal Peoples concluded that "the main policy direction, pursued for more than 150 years, first by colonial then by Canadian governments, [had] been wrong." In 2009, during his official apology on behalf of the federal government for the creation of Indian residential schools, Prime Minister Stephen Harper stated that, "this policy has had a lasting and damaging impact on aboriginal culture, heritage and language." Even though policy makers know the harm their policies have wrought, little has changed. Despite Prime Minister Harper's apology, there are even more aboriginal children in the care of the state today than there were at the height of the residential school era, and First Nations' education continues to be chronically underfunded. Furthermore, in his 2011-2012 report, the Correctional Investigator of Canada gave Canada a failing grade based on racism in Canada's correctional system and suggested that policies should focus on increasing aboriginal peoples' access to education, rather than incarceration.

A misinformed populace carrying colonial baggage has created a policy system that further perpetuates its biased beliefs and marginalizes indigenous health, all while failing to acknowledge the need for new and better ways of doing business based on a shared understanding of history and context. Canada's reluctance to sign onto the UN Declaration on the Rights of Indigenous Peoples is yet another example of indigenous peoples' exclusion "from the policy making process, including the design, implementation, and evaluation of policies and programs that directly impact their lives and life chances" [1]. But since 2005 Canada's political landscape has changed. Not only have the natives

become restless (Idle No More!), they are becoming politicized and, many non-indigenous Canadians are expressing support. Now, perhaps more than ever, there is a call for Canada to work in partnership with indigenous people to improve the health of our families and communities. The question is: will they listen? We certainly hope so.

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Guest commentary: Tuberculosis in indigenous peoples: a call for global leadership

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At the February 28, 2013, Vancouver meeting of the North American Region of the International Union Against Tuberculosis and Lung Disease, indigenous and non-indigenous researchers, health workers and health advocates gathered to share solutions to the control of tuberculosis among the Inuit/Eskimo, Aleut, First Nations/American Indian, and Métis. Successful strategies included the management and control of TB programs by local health workers among the Navaho (United States), the use of performance targets in Alaska (United States), community activism to increase local health resources in Labrador (Canada), and the reinstitution of intensive community-based active case finding in Nunavut (Canada).

Indigenous peoples throughout the world experience a disproportionate burden of morbidity and mortality due to infectious and chronic disease. Tuberculosis (TB) figures prominently among the former. In 2011 the incidence of TB among the Inuit of Canada's Nunavut region was 253 times the incidence in Canadian-born non-indigenous peoples.[1] In the United States, TB incidence is more than five times greater in American Indians and Alaskan natives compared to non-Hispanic white people.[2] In the Antioquia region of Colombia, in South America, the incidence of TB is nine times higher in 10 indigenous communities surveyed compared to the general population.[3] Indigenous groups in Russia suffer a high burden of TB compared to the general population.[4] Behind these broad statistics lie the stories of endemic and epidemic disease supported by the seeds of infection spread from one generation to the next.

The renowned physician Sir William Osler noted that tuberculosis is a social disease with a medical aspect. It serves as an outcome measure of the inequities between indigenous and non-indigenous groups in both the developed and the developing world. Poverty, malnutrition, limited education, unemployment, inadequate housing, inadequate provision or access to culturally appropriate health services, government neglect, racism, stigmatization and social exclusion are among the root causes of tuberculosis. These factors may be found in many countries throughout the world, but even among the poor and socially marginalized, indigenous peoples often bear the greatest burden. In 2010 United Nations Secretary-General Ban Ki-moon noted that indigenous peoples "make up some 5% of the world's population—but one-third of the world's poorest."[5]

The World Health Organization (WHO) estimates that in 2011 8.7 million new cases of TB occurred globally, and 1.4 million people died of the disease.[6] However, we do not know how many of the estimated 370 million indigenous people in the world develop or die from TB yearly. Although some countries, including Canada, Australia, the United States and New Zealand report TB statistics according to indigenous status, most countries in the world do not. Without such data, how can we advocate for, and mobilize, the appropriate resources and approaches required to control TB among indigenous peoples? Could it be that if you are not counted, it is because you do not count?

The United Nations Permanent Forum on Indigenous Issues and the Stop TB Partnership of the WHO have both called for a global indigenous Stop TB plan to be developed in partnership with indigenous groups. At a meeting held in Toronto, Canada, in 2008 the elements of a strategic plan were developed.[7] They included engagement and education of the international community, development of adequately resourced and culturally appropriate TB surveillance and control programs, capacity building and health advocacy, and action to redress poverty. Although the plan called for an indigenous peoples' TB secretariat within the Stop TB Partnership, with a mandate to operationalize the plan, this recommendation was rejected. Why?

It is time for the WHO to assume leadership in prodding, urging and encouraging countries to report on TB statistics and control efforts among their indigenous peoples. The Millennium Development Goals (MDGs) are focused on large global targets. With a nod to Bentham's utilitarianism, are we content to have them achieved while fragile indigenous minorities experience threats to their current and future health and viability?[8] Tuberculosis is only one health indicator among many, but worthy of special attention as a marker of social inequality, of the state of national and regional health care systems, and of the political will of governments to take responsibility for the health of their people.

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The Impact of Extractives on Indigenous Peoples' Health: Can the Current 'Catastrophic' Approach be Turned on its Head? What Role for International Health Diplomacy?

Photo: http://www.qtha.org.au/

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BACKGROUND

THE ISSUE

As demand for minerals and metals soars globally, the health of indigenous peoples worldwide is being significantly and adversely affected. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," noting that "[i]ndigenous peoples have a similar understanding of health, as well-being is about the harmony that exists between individuals, communities and the universe."[1] Yet the often irreversible negative impacts of extractive industries on indigenous peoples and their lands not only affect their health and well-being; they affect their very cultural survival. Health issues are seldom assessed or addressed in decision making.

GLOBAL HEALTH IMPACT

Indigenous peoples constitute five percent of the world's population, and one-third of the world's 900 million extremely poor rural people. They suffer from disproportionally high rates of poverty, health problems, crime and human rights abuses compared to non-indigenous people.[2] These problems are intimately linked to systemic racist and discriminatory policies whose legacies continue long after they are officially over. Extractive activities affecting ancestral lands compound these pre-existing conditions, leading to devastating human rights, cultural and socio-economic effects that far outweigh the benefits promised.

THE ROLE OF DIPLOMACY

The United Nations (UN) Special Representative on Indigenous Peoples Rights is dedicating his mandate (ending in 2014) to addressing issues at the crossroads

of indigenous peoples' rights and extractives; linking with efforts by the UN Permanent Forum on Indigenous Issues and the UN Expert Mechanism on the Rights of Indigenous Peoples, among others.[3] Yet the international health community could play a key role and join in on the momentum of these efforts by placing extractives and indigenous peoples' health issues on the agenda at its May Health Assembly meetings. Invaluable contributions could be made to, among other topics: ensuring global health data is collected that makes indigenous peoples visible and disaggregates the impacts of extractives; and strengthening health impact assessments of extractives, through processes that are shaped and implemented by indigenous experts.

INTRODUCTION

The riches embedded in indigenous lands are among the most coveted by extractive industries willing to go farther and into ever-more remote areas in search of minerals and metals. From the Arctic to the tropics, from the deep seas to the deserts, new technologies are enabling resource extraction companies to explore and mine just about anywhere.

Fuelling this rush to extract resources is a global thirst for commodities and investments resilient to the impact of financial crises and an insatiable demand for consumer products driven by the world's growing population. Canadian companies are at the forefront, with over 75 percent of the world's exploration and mining companies headquartered in Canada.[4]

Yet for the world's 370 million indigenous people who call some of the remotest areas of the globe home, this obsession with extracting the riches from their lands is not new. It dates back to European contact, when empires were built from the gold and silver found in new worlds. And just as it was then, the impacts of extractive activities on indigenous lands today can be absolutely devastating.

"Negative, even catastrophic" is the way James Anaya, UN Special Rapporteur on the Rights of Indigenous Peoples, has described the impact of extractive industries on indigenous peoples' social, cultural and political rights.[5] Indeed, he sees this as one of the critical issues affecting indigenous peoples today, and has targeted his mandate, which ends in 2014, to examining the issues at stake. He will also develop a set of extractive industry guidelines informed by indigenous perspectives, for uptake internationally.

COMPOUNDED EFFECTS—BEYOND HEALTH, A QUESTION OF SURVIVAL

Already, the health of indigenous peoples is among the most precarious worldwide. According to the State of the World's Indigenous Peoples launched in 2010, indigenous peoples constitute five percent of the world's population, and one-third of the world's 900 million extremely poor rural people. They suffer from "disproportionally high rates of poverty, health problems, crime and human rights abuses" compared to non-indigenous people.[2] These problems are intimately linked to systemic racist and discriminatory policies whose legacies continue for decades—even generations—after they are officially over.

But when extractive activities are added to the mix, these vulnerabilities are compounded, and a myriad of social problems result. From denial of land rights and forced relocation leading to violence and cultural erosion; to soaring rates of alcoholism, substance abuse and suicides; to family breakups, violence against women, prostitution and increased transmission of HIV/AIDS; to contamination of water sources and desecration of important spiritual sites; to undermining traditional authorities and fostering community division—the evidence suggests that the negative impacts of extractive industries far outweigh their potential benefits for affected indigenous peoples.[6]

Indeed, for peoples whose very notion of health is inextricably related to maintaining the links between the animals, the waters, the forests, the sky, the lands and peoples' activities within these lands—and whose territory informs their spirituality and world views—extractive activities pose a particular threat not only to peoples' health but to their very survival. Consider, for example, the following concept of "territory" as defined by the Embera Chamí of the Cañamomo Lomaprieta Indigenous Reserve in Colombia:

> We understand our territory as a physical and symbolic space where our day-to-day life takes place. The territory is the fabric that weaves together our knowledge, thoughts, experiences, traditions, culture and spirituality. Territory is thought, life, tradition, it is the essence of life. Our territory is ours by right and by inheritance; it is what underpins our Laws or Origin, and our Higher Law.[7]

Or, the words of a Colombian elder, who said: "Without territory, there is no life."[8] Official recognition of ancestral territories is at the heart of many indigenous peoples' struggles to maintain their peoples' health and well-being.

In this context, extractive “development” activities often clash with indigenous world views, where concepts such as “life plans” (planes de vida) or “living well” (buen vivir) are central, rather than mainstream concepts of development as a means to grow economic profit.

Tragically, in some cases it is the very physical health effects of mining that are bringing together communities once divided by the potential benefits of mines. “We’re documenting increased miscarriages, and increased deformities in our children,” reports an advisor to a Mexican indigenous community affected by open-pit gold mining. “Sadly, this is bringing our community together, and we now see a swell of community women at our assemblies.”[9] Health impact assessments are not mandated in impact assessments in Mexico, and for many in the community these impacts came as a complete surprise, according to the advisor.

INTERNATIONAL CONCERN

While James Anaya is alarmed by these “negative, even catastrophic” impacts and will be examining potential solutions throughout his mandate, others are similarly alarmed, and efforts will be made to ensure synergy between initiatives.

For example, in May, Anaya will be dialoguing with the UN Permanent Forum on Indigenous Issues, an advisory body to the Economic and Social Council (ECOSOC) with a mandate to discuss indigenous issues related to economic and social development, culture, the environment, education, health and human rights. The Permanent Forum’s May meeting will consider, among other issues, recent studies commissioned to examine the impacts of extractive industries on communities in Mexico and Australia. It will also include participation by the UN Expert Mechanism on the Rights of Indigenous Peoples, established to provide the UN Human Rights Council with thematic advice, who will exchange information about recent research on indigenous peoples’ participation in decision making on extractives.

Yet, in the last decades several international initiatives have focused attention on the detrimental effects of extractive industries on indigenous peoples.

Most notable was the World Bank’s Extractives Industries Review (2001-2003) commissioned in response to growing criticism that investment in extractives countered the bank’s mandate to alleviate poverty.[10] Consultations with indigenous peoples, together with well-documented evidence, resulted in strong recommendations, including the need for indigenous peoples to be able to determine whether extractive projects should take place on their lands and, if so, how.

But it took the bank’s management almost a decade to agree to condition its private-sector loans to obtaining the free, prior and informed consent of affected indigenous peoples. This is now enshrined in the new International Financial Corporation (IFC) Performance Standards which came into effect January 2012.[11] Despite critics’ contentions that IFC’s standards fall short of placing human rights front and centre, their uptake of consent has set important precedent for other financial institutions worldwide.

More recently, regional cooperation bodies such as the Arctic Council, the Organization for Economic Development, and parliaments in Canada, the European Union (EU), the United Kingdom (UK) and Norway, among others, have debated concerns about the impacts of extractives and how to curb what UN Special Representative on Business and Human Rights John Ruggie has called the “wrongful acts” of companies who have in many cases been able to operate with impunity for violations to human rights and impacts on the environment.[12]

A series of guidelines and industry codes have emerged, some with potential mechanisms for mediating complaints. The problem is that these codes and mechanisms are voluntary and non-binding; they lack the “sanction” and “remedy” Ruggie argues are needed to address impunity;[13] and they do not include explicit recognition of the right-to-consent of affected indigenous peoples. These “solutions” have been described as “greenwash,” keeping intact the permissive environments for extractive companies to continue business as usual.

INTERNATIONAL RIGHTS RECOGNITION AND INTERNATIONAL CHALLENGES

A tipping point in discussions came in 2007 with the approval of the UN Declaration on the Rights of Indigenous Peoples.[14] This document makes very clear the “minimum standards” that states, companies and other actors should uphold in interactions with indigenous peoples. It sets out fundamental rights with regard to, among others, self-determination, lands and resources, health, cultural identity, and free, prior and informed consent with regard to activities affecting ancestral lands.

The declaration, together with cutting-edge decisions in international and national jurisprudence, has

become an important lever for indigenous peoples in negotiations around their health and cultural survival, and in dealing with the extractive sector.

Yet the tremendous power imbalance that exists between indigenous peoples on the one hand, and companies and often (home and host) governments enabling extractive activities on the other, has made the assertion of internationally recognized indigenous rights extremely difficult in practice. And in some cases, attempts to assert rights have been met with violence. In Bagua, Peru, for example, in 2009 a demonstration by indigenous peoples opposing natural resource extraction laws and policies that curtailed their rights turned violent, resulting in the death of at least 32 people,[15] or in Colombia, where leaders speaking out for their rights have been disappeared. "When indigenous peoples have reacted and tried to assert their rights, they have suffered physical abuse, imprisonment, torture and even death," declares the State of the World's Indigenous Peoples.[2]

While select companies are actively considering changes to policy and practice, to date the translation of rhetoric to practice has been extremely slow and fraught with misunderstandings of how to implement rights appropriately on the ground.[16]

INDIGENOUS RESPONSES—TAKING THINGS INTO THEIR OWN HANDS

As a result, indigenous peoples have started taking things into their own hands in a diversity of responses.

In Guatemala, for example, a Peoples Health Tribunal was established and international experts invited to assess the impacts of the Canadian company Goldcorp. Following days of hearing testimony and site visits, the tribunal issued a "guilty" verdict. It also recommended practical changes that could mitigate health impacts considerably should they be implemented, and helped bring international media attention.[17]

In Colombia, indigenous peoples are linking with Afro-descendent communities to protect their own ancestral mining from being declared illegal, and have established their own management plans and verification mechanisms. They are also developing protocols outlining how companies—and the state—should obtain their consent for activities affecting their lands. Some are declaring their homelands off-limits for large-scale mines and associated activities, particularly given the context of armed conflict and implications for the health and safety of the people.[18]

And in Canada, while some indigenous peoples are fighting to have their right to say "no" respected with sit-ins, marches and barricades, others have determined that the only way to ensure rights to health and lands are potentially respected in the face of a project that will go ahead, is to negotiate impact-benefit agreements. Mechanisms are established to provide ongoing monitoring of socio-environmental impacts, and to address those that arise.[19]

Aside from these indigenous-led responses, national and international coalitions have been established to push for changes in corporate and government policy and practice, and to support affected communities.[20] Cutting-edge tools have also been developed to assess impacts, such as the Akwé:kon Guidelines, upheld by the Inter-American Court on Human Rights as a key tool in assessing indigenous rights impacts.[21]

THE WAY FORWARD—A MATTER ALSO OF INTERNATIONAL HEALTH DIPLOMACY

As the rush of extractive companies exploring for minerals, metals, oil and gas intensifies, so too will the health impacts for the world's indigenous peoples whose lands contain a veritable "treasure chest" of riches.

Initiatives that specifically target indigenous peoples—such as those that are taking place at the UN Permanent Forum on Indigenous Issues, the UN Expert Mechanism and under the mandate of the UN Special Representative on Indigenous Peoples Rights—are clearly imperative.

But as these issues intensify and escalate into more conflict worldwide, and as the poorest of the poor—namely, indigenous peoples—continue to be adversely affected, it will be critical for the impacts of extractives on the health and very survival of indigenous peoples to become central in international discussions tackling global health issues.

Already, the World Health Organization (WHO) has made efforts to highlight the specific health issues affecting indigenous peoples,[22] noting that the WHO's very own definition of health embraces holistic notions which are akin to those shared by indigenous peoples. According to WHO Fact Sheet No. 326 (2007):

> Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity… Indigenous peoples have a similar understanding of health, as well-being is about the harmony that exists between individuals, communities and the universe.[1]

Yet achieving the WHO's definition of health and well-being—particularly for indigenous peoples affected by extractives—implies addressing social determinants of health from a human rights perspective, and assessing also environmental and cultural dimensions. Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, underscored this strongly when he said:

> Indigenous peoples globally have actively noted the importance of a human rights based approach to addressing their disadvantage and to ensuring the survival of their cultures. An approach to social determinants that fails to recognize the fundamental connections between health status and the enjoyment of human rights will fail [my emphasis].[23]

As delegates gather for the 66th World Health Assembly in May, there is an important opportunity to build synergy with international efforts to address the urgent and devastating effects of extractives on indigenous peoples. The international health community has invaluable contributions to make towards ensuring, among other things, that:

- appropriate global health data are collected that makes visible indigenous peoples, including disaggregating the impacts of extractive industries;
- rigorous, inclusive and rights-oriented health impact assessments are undertaken;
- indigenous organizations are involved in designing these processes, shaping the data to be collected, and collecting them;
- guidelines, rules and regulations—together with appropriate monitoring and mechanisms for redress—are established to help curb the negative health impacts of companies operating at home and overseas.

The moment is ripe to join in global efforts to stem the negative, even catastrophic, effects of extractive activities on indigenous peoples' health, their lands and their future generations.

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Climate Change Adaptation, Indigenous Peoples and the United Nations Framework Convention on Climate Change (UNFCCC)

Photo: http://urbanhabitat.org/

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BACKGROUND

THE ISSUE

Climate change has been identified as one of the biggest threats to health this century.[1-3] Key risks include increasing exposure to infectious diseases, exacerbated water and food insecurity, natural disasters and population displacement, with the World Health Organization (WHO) estimating that climate change could already be causing more than 150,000 deaths and the loss of approximately five million disability-adjusted life years per year.[4] Not everyone will be equally affected, however, with potential for winners and losers. Those at highest risk include populations with an existing high burden of ill health, who are sensitive to climate-related health risks and live in nations with limited technological capacity, weak institutions, high levels of poverty, and political inequality. Developing nations, particularly the Least Developed Countries (LDCs) and Small Island Developing States (SIDS) are commonly believed to have the highest vulnerability. Indigenous populations have also been identified as being highly sensitive to climate change.

GLOBAL HEALTH IMPACT

The vulnerability of indigenous populations stems from habitation in regions undergoing rapid change, livelihoods closely linked to the environment, socio-economic disadvantage, political inequality, and colonial history.[5-7] Health impacts herein may be direct, where changing temperature and precipitation regimes increase the probability, duration and severity of extreme weather events and their outcomes (e.g., flooding, erosion) with implications for water quality, while creating newly

hospitable environments for encroaching or introduced pathogens. Warmer, wetter seasons may also have the potential to increase the risk and incidence of waterborne, foodborne, zoonotic and vector-borne diseases. There will also be indirect pathways through which climate change will affect physical and mental health, and which are particularly important for indigenous populations who maintain strong cultural, emotional and spiritual connections to the environment.

THE ROLE OF DIPLOMACY

In light of the risks posed by climate change, finding ways to adapt in order to reduce negative effects and take advantage of opportunities has been the focus of considerable policy debate in the general climate policy field. Targeted funding streams have been created to enhance adaptive capacity and reduce sensitivity to climate change impacts through the United Nations Framework Convention on Climate Change (UNFCCC).[8-10] Similarly, in an indigenous health context, a growing body of research has focused on understanding the determinants of climate change vulnerability and resilience, and has begun to outline opportunities for adaptation. Indigenous organizations and activists have also begun to lobby for adaptation support through the UNFCCC. Below, we examine how indigenous populations are currently being integrated into discussions over adaptation in the UNFCCC, identify barriers that may limit more meaningful engagement, and suggest avenues for greater engagement. Our focus on the UNFCCC reflects important ethical dimensions surrounding impacts, with poor and marginalized communities contributing the least to climate change but expected to experience the greatest impacts. For many vulnerable populations, adaptation support through the UNFCCC is the only source of assistance to help manage these impacts.

INTRODUCTION

The United Nations Framework Convention on Climate Change (UNFCCC), the core of today's international climate change regime, was negotiated and ratified in the mid-1990s in response to growing concerns over the potential impacts of climate change.[9-12] Instrumental in the global governance of climate change mitigation and adaptation, this intergovernmental institution has since: (i) implemented a set of principles, norms and goals for climate policy; (ii) imposed procedural duties on signatory parties to monitor and review planning and implementation through National Communications (NCs) and National Adaptation Programmes of Action (NAPAs); (iii) contributed to improving technical and scientific understanding through its subsidiary bodies, working programs and working groups; and (iv) facilitated action through the provision of financial and technical assistance to developing nations through various programs. Here we examine engagement of indigenous populations in the UNFCCC; to our knowledge this is the first such analysis of its kind.

INDIGENOUS PEOPLES AND THE UNFCCC

Beginning in 1995, 195 nation states have sent national delegations to annual meetings of the UNFCCC, known as Conference of the Parties (COP). Since 2005, these events have also served as the annual meeting of the Parties to the Kyoto Protocol (CMP).[13] COP/CMPs are hosted by different countries every year and bring together a diversity of people including delegates, support staff, civil society observers, researchers, activities, and the media. There are multiple concurrent negotiation and plenary sessions, as well as side events, exhibits, press conferences and closed party meetings. Indigenous peoples' organizations (IPOs) often attend many of these events as observers, although high-level segments and key meetings are often closed to observer organizations. IPOs can issue statements, proposals and recommendations themselves as accredited observers, or through bodies like the International Indigenous Peoples Forum on Climate Change (IIPFCC), or other UN bodies like the Permanent Forum on Indigenous Issues (UNPFII) and the High Commissioner for Human Rights (UNHCR). Many IPOs also hold side events in the form of panel discussions, either through a specific IPO or in collaboration with researchers and other civil society. For example, the Coordinator of the Indigenous Organisations of the Amazon Basin (COICA—Coordinadora de las Organizaciones Indígenas de la Cuenca Amazónica) regularly holds side events. Although events of this nature are numerous and often have high attendance, there is no way of ensuring that these issues are carried through to party delegates; there are no existing unified mechanisms to ensure meaningful participation of indigenous peoples in setting national priorities, or fair representation of indigenous peoples in national delegations.

Throughout the 2000s, parties have put in place a number of adaptation financing mechanisms subsidized by voluntary contributions from Annex I countries, and through taxation of the Kyoto Protocol's Clean

Development Mechanism project activities.[9] These funds are summarized in Table 1 below, and while they do not solely target health, health initiatives have been funded both directly and indirectly in supported projects. It is also noteworthy that adaptation funds through the UNFCCC are targeted at developing nations only, and, while vulnerable regions (e.g., SIDS, LDCs) are prioritized for adaptation funding, indigenous populations are not.[7] Although there is a potential for adaptation funds to trickle down to groups in developing countries, as it currently stands, vulnerable indigenous communities in developed nations may not receive funds through the UNFCCC.[14]

Table 1: Operational adaptation financing mechanisms under the UNFCCC.[13]

Fund	Scope	Recipients
Special Climate Change Fund (SCCF)	Mitigation and adaptation	Developing Countries
Least Developed Countries Fund (LDCF)	NAPAs	Least Developed Countries
Green Climate Fund (GCF)	Mitigation and adaptation	Developing Countries
Adaptation Fund (AF)	Adaptation	Developing Countries
Fast-start finance (FSF)	Mitigation and adaptation	Developing Countries

All parties to the UNFCCC must submit, according to predetermined timelines, national reports on implementation of the Convention in terms of both mitigation and adaptation (known as National Communications or NCs). Most Annex I countries have submitted their fifth NC, the first having been submitted in 1994-1995 with the sixth due in January 2014, as have most non-Annex I countries.[13] Very few NCs discuss the sensitivities and adaptation needs of indigenous peoples beyond what appears to be tokenism.[15] But the general trend is that indigenous issues are increasingly being featured in the more recent NCs from Annex I nations, with New Zealand's NCs at the forefront, focusing in depth on explicit needs and adaptation strategies for Maori communities; something that has yet to be showcased in the Australian, Canadian and American NCs. The lack of indigenous focused content likely stems from a lack of enforceable procedures guiding indigenous peoples' participation in the development of national reports.

National Adaptation Programmes of Action (NAPAs) on the other hand are only prepared by Least Developed Countries (LDCs), with financial support from the Least Developed Countries Fund (LDCF) and technical support from the LDC Work Program. NAPAs are submitted to the Convention as a way to help LDCs identify and address adaptation needs and facilitate implementation of adaptation actions and projects.[13] A number of NAPAs discuss the health implications of climate change. However, similarly to NCs, very few NAPAs explicitly discuss or even mention indigenous peoples' needs in LDCs.[7] It is interesting to note here, however, that most NAPAs do recognize the value of traditional ecological knowledge in strengthening adaptive capacity.

A number of subsidiary bodies and work groups (WGs) have been created under the UNFCCC to serve various functions. The Subsidiary Body for Implementation (SBI) reviews the information in the NCs, assesses the effectiveness of the Convention, reviews financial assistance given to non-Annex I countries, and provides guidance to the financial mechanisms. The Subsidiary Body for Scientific and Technological Advice (SBSTA) provides parties with scientific and technological guidance relating to mitigation, greenhouse gas (GHG) inventories, and impacts, vulnerability and adaptation information. The Ad Hoc Working Group on Long-Term Cooperative Action under the Convention (AWG-LCA) seeks to enhance action beyond 2012 through a comprehensive process, and the Ad Hoc Working Group on Further Commitments for Annex I Parties under the Kyoto Protocol (AWG-KP) has now completed its mandate. The Ad Hoc Working Group on the Durban Platform for Enhanced Action (ADP) is the most recent of the working groups, and focuses on developing a protocol and/or other legal instruments to be implemented in 2020.[13] Although some of these bodies, particularly the SBI, interact with the IIPFCC, there are again no clear mechanisms by which to assure indigenous representation within these bodies. Similar to the WGs, but not directly linked to the UNFCCC, the Intergovernmental Panel on Climate Change (IPCC) also contributes to further global understanding of the potential impacts of climate change. A recent study by Ford et al. (2012), however, demonstrates the limited extent to which indigenous issues have been integrated in IPCC assessments. This neglect of indigenous issues in the IPCC and WGs is likely to have significant policy implications.[16]

CHALLENGES

Most of the challenges faced by indigenous peoples in terms of meaningful participation and representation in the various processes within the UNFCCC stem

from the underlying assumptions that govern the institution. Discursive practices in the UNFCCC focus almost solely on the nation-state scale, the Convention's original mandate being to provide a forum primarily for negotiating climate change mitigation agreements between states (as per Article 2 of the Convention). The pathway to a solution to the climate change problem itself is framed through the principle of common but differentiated responsibility between states (as per Articles 3.1 and 3.2).[17] This principle recognizes the historic contribution of developed countries to anthropogenic climate change, holding them accountable and requiring them to assist particularly vulnerable developing countries address the impacts and transition to a low-carbon economy. Adaptation in the UNFCCC was, and remains, framed primarily as a developing country issue (as opposed to a transboundary issue affecting vulnerable/marginal populations locally and globally). Such state centrism is a typical feature of global governance bodies, guided by the overarching principle of state sovereignty.[18] Hence, there is very little discursive space allocated to issues of indigenous needs and rights in the negotiations process in the UNFCCC.

The implications of this are twofold. First the governing assumptions limit the potential for indigenous peoples to meaningfully participate in the process as party delegates, and even more so as distinct parties to the Convention. Although there are channels through which IPOs can submit statements, recommendations and proposals to the parties, there is currently no mechanism through which to ensure that indigenous rights are respected, or that the demands of indigenous people are incorporated. Second, indigenous peoples from developed countries have unfortunately been discounted from the adaptation discourse in the UNFCCC; adaptation fund flows are unidirectional towards developing countries. Moreover, since there are no enforceable mechanisms governing indigenous participation in the development of NCs and NAPAs, the extent of coverage of indigenous issues including health in national strategies overall has been uneven, and meaningful involvement of indigenous people has been difficult to identify, and is likely limited.

NEXT STEPS

The lack of structural and discursive avenues for meaningful engagement of indigenous people is becoming increasingly problematic, particularly with growing health impacts of climate change in remote indigenous communities globally and locally, but even more so since the adoption of the United Nations Declaration on the Rights of Indigenous Peoples in 2007. Articles 41 and 42 of the declaration clearly state that the UN system, its bodies and specialized agencies shall promote respect for indigenous peoples rights, shall establish means of ensuring participation, and contribute to the full realization of the provisions of the declaration though the mobilization of financial cooperation and technical assistance.[19] Numerous recommendations have been made by indigenous peoples themselves to address the shortcomings of the UNFCCC, but these have yet to be actualized through formal agreements.[20-22] There are a few "low hanging fruits," however, that have the potential to improve representation of indigenous voices in some of the institution's bodies and would be relatively simple to enact within the existing structure of the UNFCCC, including, but not limited to: required representation of IPOs in subsidiary bodies, working groups and fund management boards; the creation of protocols to guide indigenous peoples' participation in national reporting processes; the establishment of a voluntary trust fund to allow indigenous people to better engage in the UNFCCC process; and the establishment of an adaptation fund that would focus explicitly and solely on indigenous peoples' projects from all regions of the globe.

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Promoting the Link between the Convention on Biological Diversity and Health of All

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BACKGROUND

THE ISSUE

In October 2010, at the 10th meeting of the Conference of the Parties (COP) to the Convention on Biological Diversity (CBD), the executive secretary was asked to strengthen collaboration with the World Health Organization (WHO) and other organizations and initiatives. The purpose was not only to explore how mainstreaming of biodiversity issues in health plans could be promoted, but also to investigate how the implementation of the Strategic Plan for Biodiversity 2011-2020, which was adopted in 2010, can support work to address global health issues. [1]. A regional workshop on the inter-linkages between biodiversity and human health for Africa will be held in Maputo, Mozambique, from 2-5 April 2013. The workshop will be co-hosted by the Secretariat of the Convention on Biological Diversity, World Health Organization (WHO) and the WHO Regional Office for Africa (WHO/AFRO).

GLOBAL HEALTH IMPACT

The health impact of changes in the environment is well known and understood but not always well quantified. On a very basic level, “well-functioning ecosystems provide goods and services essential for human health.”[1] Marginalized populations are the most vulnerable, and the world's indigenous populations are disproportionally under threat from environmental impacts.[2]

THE ROLE OF DIPLOMACY

The CBD, one of the relatively few international instruments that explicitly mention indigenous peoples, was adopted at the Rio Earth Summit in 1992. Its interests are to protect all biological diversity—animal, plant and human; ensure sustainable use of its components and, recently added, to ensure fair and equitable sharing of risks and benefits arising from the use of genetic resources. Several protocols exist within the CBD: the Cartagena Protocol on Biosafety, also called the Biosafety Protocol, and the Nagoya Protocol on Access and Benefit Sharing, known as the Nagoya Protocol. The Nagoya Protocol seeks to ensure that benefits that arise from the use of genetic

resources are shared in a fair and equitable manner. While it has not yet entered into force, and will only do so once there have been 50 ratifications, it was seen as a landslide victory for developing countries. It was the product of nearly two decades of negotiation on access and benefit sharing and has clear health links. The issue of access and benefit sharing was hotly debated at the World Health Assembly (WHA), in the context of virus sharing and viruses with pandemic potential. The Cartagena Protocol, which was adopted in January 2000, safeguards biodiversity against the risk resulting from biotechnology genetic modifications.[2] The Strategic Plan for Biodiversity 2011-2020 consists of 20 biodiversity targets to be met by 2020, developed in close coordination with other organizations such as the United Nations Environment Program, the United Nations Conference on Sustainable Development and others. These 20 targets are also called the "Aichi Biodiversity Targets."[3] Within these 20 targets, Target 14 most closely captures health, although some other targets capture broader development issues in general, such as Target 2, where focus is placed on building biodiversity values into "national and local development and poverty reduction strategies…," and several other targets on maintaining healthy ecosystems in general.

INTRODUCTION

The Convention on Biological Diversity (CBD) covers a wide range of areas that have a direct or indirect impact on human health. There are direct links to trade, intellectual property rights, regulation on genetically modified organisms; sharing of biological samples and benefits, which in the case of health was important during the negotiations on virus-sharing that occurred at the World Health Organization (WHO). Traditional knowledge and, within this, traditional medicines play an important role in the CBD. In Article 8, parties to the CBD are requested to "as far as possible and as appropriate…respect, preserve and maintain knowledge, innovations and practices of indigenous and local communities…"The Aichi targets support the above, and Target 18 holds that, "[b]y 2014, adequate measures to respect and protect traditional knowledge and customary sustainable use and the rights of indigenous and local communities over their traditional knowledge, innovations and practices, have been put in place."[4] Additionally, Target 14 holds that "[b]y 2020, ecosystems that provide essential services, including services related to water, and contribute to health, livelihoods and well-being, are restored and safeguarded, taking into account the needs of women, indigenous and local communities and the poor and vulnerable."[5]

To support the development of a more systematic and pro-active approach to identifying and understanding key current and future changes impacting global public health, there needs to be an increased awareness and willingness to collaborate across organizations. At its 10th meeting, the Conference of the Parties (COP) decided, in paragraph 17 of Decision X/20, to ask the CBD executive secretary to further collaborate with the WHO as well as with other initiatives and organizations that are relevant in the context of promoting and mainstreaming biodiversity in health programming and plans, and to explore how implementation of the Strategic Plan for Biodiversity 2011-2020 can help address and support work in global health.[1] At COP 11, in Hyderabad, India, held in October 2012, in the final decision,[5] UNEP/CBD/COP/11/L.16, the member states were invited "to raise awareness of links between biodiversity and health and to report on the issue to COP 12." It also "encourages parties… to make use of Strategic Plan indicators that may be relevant to links between biodiversity and health." Finally, it called on the secretariat to "further develop health-related indicators and to establish a joint work programme with the WHO."[6]

INTERSECTORAL COOPERATIONS

As preparation for COP 11, the executive secretary put together a note on "Collaborative and mainstreaming activities with the health sector: progress report."[7] Here health is introduced first as a basic human right and "therefore one of the most important indicators of sustainable development." It highlights the key ways in which health and biodiversity "co-benefit" each other: "(a) ecosystem integrity…and vector borne diseases; (b) drinking water…and water-related disease; (c) non-communicable diseases, lifestyle and diet changes and biodiversity conservation; (d) traditional knowledge, nutrition, poverty reduction…; and (d) climate change…and human health impacts." In 2010, during COP 10, 17 decisions were adopted "making reference to human health and well-being," which are taken up, to a much more discrete and subtle extent, in the Strategic Plan. Additionally, the report also tracks progress on developing outreach materials and activities, such as the organization of workshops together with the Pan American Health Organization/World Health Organization (PAHO/WHO); and an editorial in the EcoHealth journal on "strengthening international cooperation for health and biodiversity," amongst others. Finally, the report highlighted steps being taken to foster a stronger engagement with the WHO and the progress made on that front.[7]

REGIONAL WORKSHOPS TO ADDRESS ISSUES RELEVANT TO BIODIVERSITY AND HEALTH

In order to support the implementation of the Strategic Plan for Biodiversity 2011-2020 and work towards achieving the Aichi targets, the Government of Japan has provided financial support to organize capacity-building workshops. The first workshop, in the Americas, took place in Manaus, Brazil, in September 2012, and was jointly organized with PAHO, with the support of the Oswaldo Cruz Foundation and the Government of Brazil. Conference participants from 25 countries produced a series of recommendations; and undertook to continue collaboration and to "include the role of communities, particularly indigenous and local community women as managers, protectors and transmitters of traditional knowledge, on health and food security."[8]

The next workshop will bring together African participants in Maputo, Mozambique, in early April 2013. As in Manaus, the workshop is intended to provide a forum for parties to discuss the implementation of the Strategic Plan, specifically as it relates to health issues. Organizers also stress that it is an opportunity to discuss regional best practices in terms of incorporating biodiversity and health considerations in domestic biodiversity conservation programs, as well as how to promote joint activities and support networks on health and biodiversity issues and strategies.[9]

FINAL REPORT AND NEXT STEPS

The final report from COP 11 reiterates the main thrusts of ensuring cooperation with the health sector at the national level through policy alignment with national health strategies and internationally through partnerships with international organizations, specifically the WHO, the specialized agency for health. The 12th session of the COP will review progress when it meets again in 2014 in Korea. Between sessions of the COP, workshops such as the one being held in Maputo will help raise awareness of the link between health and biodiversity. Working groups, such as, for example, the working group for Article 8(j) on traditional knowledge, will meet to continue work on specific provisions within the CBD. The regular schedule of meetings both within health (such as the World Health Assembly) and non-health areas (World Intellectual Property Organization, the World Trade Organization) will continue to take place, and the world will start to more intensely negotiate the post-Millennium Development Goals (MDGs) framework. In all this, the awareness of the biodiversity-health link is important, as is the imperative to ensure that the interests of minority groups, such as indigenous peoples, are safe-guarded.

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Four Steps Forward: "Historic" Negotiations Lead to New Global Consensus toward Eliminating VAWG

Photo: http://www.girleffect.org/

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BACKGROUND

THE ISSUE

It has been 20 years since the international community first recognized violence against women as a problem worth addressing.[1] This year, the Commission on the Status of Women (CSW), an inter-governmental body of the United Nations (UN) Economic and Social Council (ECOSOC), convened around the priority theme of "eliminating and preventing of all forms of violence against women and girls" (VAWG). Established in 1946, the CSW meets annually to evaluate progress, identify challenges, and set standards and policies to promote gender equality and women's empowerment worldwide. The 2013 meeting culminated in a set of agreed conclusions that build on the existing global legal and policy framework to address VAWG.

GLOBAL HEALTH IMPACT

VAWG is a global human rights and public health concern that can result in numerous physical, mental and sexual and reproductive health problems. These include physical injuries, depression, post-traumatic stress disorder, suicide attempts, substance abuse, unwanted pregnancies, gynaecological disorders, sexually transmitted infections, and increased risk of HIV/AIDS, among others.[2] These health implications can last a lifetime for survivors and span generations, imposing significant costs to families and communities.[3] While prevalence data remain sparse, the World Health Organization (WHO) multi-country study undertaken in 15 settings found that 15-70 percent of ever-partnered women reported physical and/or sexual partner violence.[4] There is no single cause of VAWG, but rather numerous biological, social, cultural, economic and political factors that interact at various levels—including individual, relationship, community and societal levels—that influence the risk of perpetrating or experiencing VAWG over the life-course.[5]

THE ROLE OF DIPLOMACY

The CSW comprises 45 UN member states, elected based on an equitable geographic distribution, to serve a four-year term. Other UN member states can participate in the deliberations and submit reservations on the draft document, but only CSW members can adopt the Agreed Conclusions. While not legally binding, this document can be used to pressure governments to fulfill the commitments contained within. A record 131 member states gathered for CSW's 57th session in New York from 4-15 March 2013, along with some 6,000 NGO representatives participating in 128 side events. Pressure for members to reach global consensus ran high, as CSW negotiations failed to reach an outcome document last year, as well as in 2003 when VAWG was last addressed. To facilitate political consensus, UN Women convened two ministerial meetings and a stakeholder's forum in the lead-up to this year's meeting. The 2013 CSW also arrived on the heels of several high-profile cases of VAWG that fuelled global outrage and demands for gender justice, including a Taliban attack on 15-year old Malala Yousafzai for promoting girls' education in Pakistan, and a widely publicized gang rape in India.

COMPREHENSIVE, MULTISECTORAL APPROACH TO ELIMINATE AND PREVENT VAWG

In what UN Women Executive Director Michelle Bachelet termed an "historic" event,[6] the 2013 CSW adopted a set of Agreed Conclusions urging states to "strongly condemn all forms of violence against women and girls."[7] The accord highlights that while progress to address VAWG has been made in a number of key areas, significant gaps remain on implementation. These gaps include establishing and implementing legal and policy frameworks, securing sufficient financial and human resources, and ensuring efforts are comprehensive, coordinated, sustained, adequately monitored and evaluated. The document comprises four components that outline a holistic and multisectoral approach to address VAWG:

1. Strengthen implementation of legal and policy frameworks and accountability;
2. Address structural and underlying causes and risk factors;
3. Strengthen multisectoral services, programmes and responses; and,
4. Improve the evidence base.

Several contentious issues dominated the negotiations. One developed-country delegate reported that members were divided into three negotiating blocs: one bloc of mostly religiously conservative countries was somewhat less concerned with arriving at a consensus, while the other two were driven by different motives to ensure that Agreed Conclusions

were reached. Of the latter two, a group of primarily OECD countries sought strong language to protect women and girls. They recognized the need to build on momentum gained from recent UN Security Council resolutions on women, peace and security, as well as the potential of the post-2015 development agenda to advance efforts to improve the global status of women and girls. The second group in favour of an outcome—comprised mostly of emerging countries—was somewhat more concerned with how UN Women, established in 2010, would be viewed by the global community if the CSW failed to reach another outcome document. The complexity of the negotiations was demonstrated by the fact that country positions within these blocs also tended to overlap at times.

GIRLS INCLUDED IN GLOBAL CONSENSUS ON VAW

For the first time, girls were included alongside women in a global consensus to address violence against women (VAW). The Agreed Conclusions even expanded the global definition of VAW—first articulated in the 1993 Declaration on the Elimination of all Forms of Violence against Women[8]—to include girls. This is an important advance, since violence against women and girls often occurs simultaneously and they share many common risk factors. According to Dr Mary Ellsberg, Director of the Global Women's Institute at George Washington University and public delegate of the US delegation, "everything we know about family and community life would suggest that these two issues are intricately linked."[9]

This is a major step forward, as previous efforts to understand and address violence against women and girls have been undertaken separately. Even the Council of Europe's 2011 Convention on Preventing and Combating Violence against Women and Domestic Violence, a legally binding agreement recently hailed as the "gold standard" by UN Women,[10] uses the term "women of all ages" instead of girls.[11] Prior to this, the International Conference on Population and Development's (ICPD) five-year review in 1999 referred only to "adolescents and young people,"[12] while the 1995 Report of the Fourth World Conference on Women in Beijing separated women and girls into distinct groups.[14] Part of the challenge is that there is no globally agreed definition of "child." As one delegate highlighted, "dealing with the phrasing 'child marriage' provides a fitting example because in some countries this can mean the marriage of a girl who has not yet reached puberty," while most OECD countries recognize children to include those up to 18 years.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

OECD members pushed for strong language on sexual and reproductive health and rights to be included in the document, but faced resistance from governments holding fundamental religious views on the interpretation of human rights. In the end, some developed country delegates were pleasantly surprised with the agreed text, which calls for strengthened multisectoral services and responses to VAWG:

> Address all health consequences including the physical, mental and sexual and reproductive health consequences, of violence against women and girls by providing accessible health-care services that are responsive to trauma and include affordable, safe, effective and good-quality medicines, first line support, treatment of injuries and psychosocial and mental health support, emergency contraception, safe abortion where such services are permitted by national law, post-exposure prophylaxis for HIV infection, diagnosis and treatment for sexually transmitted infections, training for medical professionals to effectively identify and treat women subjected to violence, as well as forensic examinations by appropriately trained professionals.[14]

This paragraph was a second step forward for women and girls' rights and health. It was deemed positive by some developed-country participants for including terms such as "affordable," "safe abortion," "emergency contraception," "post-exposure prophylaxis for HIV" and "forensic examinations." Notably, the paragraph represents the first time girls have been incorporated into language on access to sexual and reproductive health services for post-assault care in a globally agreed document. While some precedent for this text was established in UN Security Council Resolution (2009), which specifies the need for women and girls in armed conflict and post-conflict contexts to access sexual and reproductive health services,[15] the CSW outcome document goes further by implicitly referring to all settings.

Some countries proposed that all language related to sexual and reproductive health and rights should be applied to women and girls. However, the final document did not include girls when referring to comprehensive education for human sexuality and reproductive rights. The preamble paragraph

outlining sexual and reproductive health and reproductive rights, for instance, only refers to women. Furthermore, the document includes adolescents, instead of girls, when referring to "comprehensive evidence-based education for human sexuality" and "access...to services and programmes on preventing early pregnancy."[16]

The outcome document also included language adopted in Beijing around reproductive rights, namely the "right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."[17] One delegate from a developed country said that most OECD countries sought to move beyond Beijing on this issue and supported the term "sexual and reproductive rights" to be included in the outcome document. However, the final compromise text referred only to "reproductive rights" and specifically "in accordance with the 1994 ICPD Programme of Action and the Beijing Platform for Action and its review documents."[18] Previously, religiously conservative governments have strongly opposed any language on rights when used alongside the terms sexuality or reproductive health, particularly since Cairo and Beijing.

NO CONSENSUS ON HOMOSEXUAL RIGHTS

The issue of homosexual rights was put in the spotlight in a landmark speech by former US Secretary of State Hillary Clinton at the UN in Geneva in 2011. During the 2013 CSW negotiations, however, language in favour of homosexual rights was only supported by a handful of countries. One notable show of support came from South Africa, whose delegate received pronounced applause from the audience after speaking in favour of the issue. Apart from this, a large group of countries, particularly from Africa and the Middle East, made it very clear at the beginning of the negotiations that no language around homosexual rights would be accepted. The terms "gender identity" and "sexual orientation" were also removed from the working document. While this year marked the first time that text on the rights of gays, lesbians, homosexuals and transgendered was proposed, according to one developed country delegate, "there was never a chance that this language would be included; we knew it would kill the whole consensus."

CUSTOM, TRADITION AND RELIGION CANNOT JUSTIFY VAWG

Religiously conservative countries were quick to reject proposed language outlining that VAWG should not be justified on cultural or religious grounds. OECD countries wanted to ensure that harmful traditional practices, such as honour killings and female genital mutilation, could not be overlooked in fulfilling obligations to women and girls. In the final stage of the negotiations, several religious states, including Iran, Egypt, Saudi Arabia, Qatar, Libya, Nigeria and Sudan, along with Honduras, Russia and the Holy See, expressed reservations about various aspects of the draft document, but did not block its adoption. Their concerns were voiced just hours after Egypt's Muslim Brotherhood released a declaration claiming that the draft document would, amongst other things, "lead to complete disintegration of society."[19] In a third step forward, the Agreed Conclusions urge states to "condemn all forms of violence against women and girls and to refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination."[20] In exchange for this wording, however, language in the preamble was added, stressing "the significance of national and regional particularities" and that "various historical, cultural and religious backgrounds must be borne in mind."[21] The term "harmful traditional practices" was not incorporated into the final document.

LARGE FOCUS ON PRIMARY PREVENTION

In a fourth step forward, CSW members demonstrated a strong commitment to primary prevention through addressing the root causes of VAWG. The outcome document incorporated language such as "transforming...social norms," "work to counteract attitudes," "address the structural and underlying causes of violence," "overcome gender stereotypes" and "change attitudes, behaviours and practices that perpetuate and condone gender stereotypes and all forms of discrimination."[22] According to Dr Ellsberg, inclusion of this text was of major significance, as "we're going from a focus that's been primarily on justice and support to prevention and dealing with social norms...I think it shows that we really have moved beyond Beijing and Cairo." The Cairo outcome document did not even mention the term "prevention," and the Beijing report only referred to secondary prevention, more commonly understood as the health, legal and police services to address violence after it has occurred. This year, however, the terms "prevent" and "prevention" were included 43 times in the 16-page Agreed Conclusions.

This year, the international community took four steps towards ending VAWG, a move that can arguably be considered a significant achievement. As one

delegate from an OECD country claimed, "it shows the extent to which the norms and perspectives are changing, are advancing. And it is being acknowledged over time that VAWG isn't acceptable and that it is something the state and international community must address."

NEXT STEPS

UN member states now have a responsibility to develop and implement national action plans to eliminate VAWG. As indicated by Bachelet in her closing statement: "We cannot stop here. We need to do so much more. Words now need to be matched with deeds, with action...We must continue moving forward, with courage, conviction and commitment."[23] In the coming years, the CSW will be pushing to ensure that realization of gender equality and empowerment of women are considered priorities in the elaboration of the post-2015 development agenda. As a step towards achieving this goal, this year's Agreed Conclusions have helped to solidify global norms around addressing VAWG. The CSW's priority themes for the next two years include achieving the Millennium Development Goals (MDGs)for women and girls, and reviewing the implementation of the Beijing Declaration and Platform for Action.

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Implementing the Right of the Child to Health: Issues Raised at the 22nd Human Rights Council

Photo: http://geneva.usmission.gov/

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BACKGROUND

THE ISSUE

At the 22nd session of the Human Rights Council (HRC), the annual full-day meeting on the rights of the child focused on the right to the highest attainable standard of health. Two panels of experts interacted with member states, national human rights institutions, international organizations and non-governmental organizations (NGOs) in a constructive debate on how to mainstream human rights into health discourses, in order to effectively translate the right of the child to health into practice.

GLOBAL HEALTH IMPACT

Childhood is a unique moment of growth and development, but it is also associated with health risks that can have consequences into adulthood and be the cause of premature death. Despite progress, child mortality and morbidity remain a major concern throughout the world, with 6.9 million children dying before the age of five each year.[1]

Survival, protection, growth and development of children in good health are indispensable for the enjoyment of all other human rights. The rights of the child to health includes the right to life, survival and development; entitlement to access facilities, goods and services without discrimination; respect for the views of the child; and the obligation to take into account the best interests of the child.[2]

THE ROLE OF DIPLOMACY

In March 2008, in its resolution 7/29 on the Rights of the Child, the HRC decided to incorporate into its program of work an annual full-day meeting on the rights of the child.[3] Resolution 19/37 of March 2012 stated that the focus in the 22nd HRC session would be on the right of the child to the highest attainable standard of health.[4] The right of the child to health is protected by Article 24 in the Convention on the Rights of the Child and its three Optional Protocols, but also by other core human rights treaties with health-related provisions that apply to both adults and children.

The full-day meeting was paralleled by the negotiation of a resolution on the right of the child to the enjoyment of the highest attainable standard of health, led by Uruguay, on behalf of the Latin American and Caribbean Group (GRULAC), and the European Union (EU).[5]

INTRODUCTION

Although several international treaties and national constitutions recognize health as a human right, the health sector has been traditionally silent regarding the question of human rights.[6] It is only in the last decade that the health and human rights movement has gained momentum at the international level, both in the academic literature and in the political realm.[7] The World Health Organization (WHO) conceptualizes three possible linkages between health and human rights: human rights violations (such as torture and slavery) resulting in ill health; reducing ill health through human rights (for instance through the right to education, the right to nutrition, and the right to water); and promoting human rights (such as the right to participate and freedom from discrimination) through health developments.[8] The promotion of human rights and health, therefore, go hand in hand, and need to be addressed together.

One sign of this evolution is the increasing collaboration between the Human Rights Council (HRC) and the WHO, and the number of health-related issues included in the program of work of the HRC. At its 22nd session, held in Geneva from 25 February to 22 March 2013, the annual full-day meeting on the rights of the child focused on the right of the child to the highest attainable standard of health. The meeting took place the day after the conclusion in Botswana of the post-2015 health consultations. The latter emphasized the need for equity as a principle to be considered in all future health-related discussions, as well as the need to scale-up efforts in the areas of child and maternal mortality.[9] In the wake of the Botswana consultations, the HRC meeting on the right of the child to health was seen, therefore, as an opportunity to mainstream human rights into health institutions and promote a human rights-based approach in the post-2015 development agenda.

Two panels of experts interacting with member states, national human rights institutions, international organizations and NGOs discussed the "Report of

the High Commissioner for Human Rights on the right of the child to the highest attainable standard of health."[10] Particular attention was devoted to ways to overcome the "implementation gap"[11] by translating the legal recognition of the right of the child to health into practice. The discussion mainly centred around three themes: laws and policies, universal health coverage, and accountability mechanisms.

LAWS AND POLICIES

The report identified the role of laws and policies as central for the implementation of the right of the child to health, by encouraging states to adopt national instruments that promote this right, while at the same time removing laws and policies with a detrimental impact.[12] It also reiterated the importance of adopting a human rights-based approach to health,[13] meaning that human rights should explicitly shape laws and policies in the field of health.

Although there is increasing recognition of the positive health outcomes of a human rights-based approach, very scarce evidence-based research is available on the subject.[14] To overcome this gap, the WHO is currently working on a project—to be released before the next World Health Assembly (WHA) in May 2013—providing evidence that human rights have contributed to the improvement of women's and children's health in four countries with different economic and socio-cultural settings (Nepal, Brazil, Malawi and Italy).

Nevertheless, the approach adopted in the report was not universally embraced, especially with regard to some sensitive topics. Bahrain, on behalf of the Arab group and supported by statements from Egypt, Algeria and Qatar, voiced its opposition with regard to the report, seen as an intrusion into the sovereign right of states to design laws and policies, with no consideration for countries' different social and cultural values, especially in the area of sexual and reproductive health. Instead, the Arab and African groups called for a major recognition of the role of families when it comes to education, information, counseling and services related to child health. The two groups also pushed for the inclusion in the resolution on the right of the child to the highest attainable standard of health of paragraphs emphasizing the role of the family. Although this was recognized in principle,[15] Egypt manifested its dissatisfaction for the lack of additional paragraphs stressing the role of the family throughout the resolution, in particular with regard to sexual and reproductive health.

Mauritania, on behalf of a cross-regional group (including several Arab countries), also suggested an amendment to the resolution recognizing countries' different legal and cultural systems, but it was rejected with 27 votes against, 10 in favour and 10 abstentions.

Given these outcomes, Egypt's delegate voiced his disappointment with regard to the turn the resolution took, adding his concern for the high level of polarization when dealing with some of the conflicting issues.

Mr Thomas Chandy, Chief Executive Officer of Save the Children India (member of the panel of experts), reminded the audience of the necessity of striking a balance between competing visions of how to address child health. The question of how to balance the rights of the child with the rights and duties of parents needs to be addressed in a culturally sensitive way, but without avoiding the discussion of sensitive issues that have a detrimental effect on children's health.

UNIVERSAL ACCESS TO HEALTH

A second important topic of discussion centred on universal access to health and the challenges posed by discrimination. Paradoxically, at the time in which the notion of health as a human right has the most prominence at international and national levels, policies of exclusion and inequalities are expanding, mainly due to the "implementation gap" of the right to health.[16] Moreover, as Gabon, on behalf of the African group, pointed out, universal health coverage is hindered by difficult socio-economic contexts, conflicts and natural disasters, to which Sudan added the obstacles posed by tradition and practices producing inequalities.

Different groups were identified as being particularly vulnerable with regard to exclusion and discrimination: Spain stressed the issue of marginalized communities, such as Roma communities within the EU; Caritas Internationalis and the Organization of Islamic Cooperation pointed out the neglect respectively of migrant children and children in occupied territories, while the Street Children Consortium called for the inclusion of street children into access policies.

In order to overcome the challenges posed by discrimination and inequalities in the access to

health, the panelists stressed the importance of removing financial barriers at the point of delivery; ensuring robust and sustained financial funding; ensuring universal birth registration; and designing specific programs to address specific situations. Save the Children and World Vision International also underlined the need for health indicators disaggregated by equity criteria, in order to increase information on discrimination.

Doctor Gustavo Giacchetto, from the Uruguayan health ministry, also raised the issue of defining a basic set of health needs to which everyone should have access without discrimination, raising the unanswered question of minimal health standards.

ACCOUNTABILITY

The last major topic of discussion was accountability, i.e., the establishment of mechanisms to check if commitments are kept. Paul Hunt (professor of law and panelist at the HRC meeting on the right of the child to health) underlined that it is part of the mainstreaming process of human rights, requiring the translation of legal terms into the public health sector. Accountability goes beyond monitoring: it is a cycle including monitoring, assessment of commitments (with an independent component which has to be authoritative, legitimate and credible), and remedial actions. Accountability also goes beyond the judicial system, as it includes a mix of devices, such as legislative bodies, national human rights institutions (that might include a commissioner for the right of the child), local authorities, hospital boards and patient communities (which need to be advised on and refer to human rights).

Several obstacles to the implementation of effective accountability mechanisms were mentioned. First of all, monitoring can be a problem in the absence of indicators and strong information systems (Sierra Leone), and in countries with no NGO monitoring machinery in place (Indonesia). Moreover, the notion of accountability seems not to be fully integrated into the health field. Symptomatic was the request by the Arab and African groups to change the section dedicated to accountability in the draft resolution on the right of the child to the highest attainable standard of health to simple “monitoring and evaluation,” as it was not clear to whom states should be held accountable. However, the main co-sponsors of the resolution (the European Union and the Latin American and Caribbean Group), did not consider this proposal, stressing the importance of accountability for the translation of human rights into practice.

NEXT STEPS

The next steps in the implementation of the right of the child to health include a summary report of the annual day of discussion on the right of the child to health (to be prepared by the high commissioner before the 23rd session of the HRC), and an invitation to the WHO to prepare, in collaboration with relevant agencies, a study on child mortality as a human rights concern before the 24th session of the HRC.[17] In addition, the place of child health and that of the right to health will be discussed in relation to the post-2015 development agenda.

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Health Diplomacy Monitor

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