

# An Independent Review and Accountability Mechanism for the Sustainable Development Goals: The Possibilities of a Framework Convention on Global Health

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## Abstract

The Framework Convention on Global Health (FCGH), a proposed global treaty to be rooted in the right to health and aimed at health equity, could establish a nuanced, layered, and multi-faceted regime of compliance with, and accountability to, the right to health. In so doing, it would significantly strengthen accountability for the health-related Sustainable Development Goals (SDGs), which it would encompass. Legally binding, the FCGH could facilitate accountability through the courts and catalyze comprehensive domestic accountability regimes, requiring national strategies that include transparency, community and national mechanisms for accountability and participation and an enabling environment for social empowerment. A “Right to Health Capacity Fund” could ensure resources to implement these strategies. Inclusive national processes could establish targets, benchmarks, and indicators consistent with FCGH guidance, with regular reporting to a treaty body, which could also hear individual cases. State reports could be required to include plans to overcome implementation gaps, subjecting poorly complying states to penalties and targeted capacity building measures. Regional special rapporteurs could facilitate compliance through regular country visits, while also responding to serious violations. And reaching beyond government compliance, from capacity building to the courts and contractual obligations, the FCGH could establish nationally enforceable right to health obligations on the private sector.

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Universal health coverage, universal access to nutritious food, clean water and sanitation, and adequate housing, and the “pledge that no one will be left behind”: the promises for health in the Sustainable Development Goals (SDGs) are prodigious—and necessary.<sup>1</sup> The central unanswered question is in their implementation; universality and leaving no one behind mean ending deeply rooted discrimination, changing power structures, and securing significant new funding.

The risk of a great disjuncture between promises and reality resembles the present status of the right to health, where continuing profound national and global health inequities bear witness to the chasm between the universal guarantee of the right and the realities of its implementation. Indeed, had this right’s commands received universal adherence, the health-related SDGs would be today’s reality rather than still tomorrow’s promise.

One proposed response to both present and potential implementation gaps is a Framework Convention on Global Health (FCGH), which would be a global treaty grounded in the “right to the enjoyment of the highest attainable standard of physical and mental health,” and aimed at closing health inequities.<sup>2</sup> The FCGH would establish standards on rights-based universal health coverage to achieve equal access to health care and public health services—the promise of the SDGs—along with a national and global health financing framework absent from the SDG agenda. The FCGH would seek to empower people to claim their health rights, advance the social determinants of health, and ensure that governments respect and advance the right to health in all policies, which are all critical to achieving the right to health and the SDGs. The treaty would aim to elevate the right to health in other international legal regimes and sectors, filling in another gap in the SDG agenda. A global health treaty would also ensure that with the diversity of the 17 SDGs, health remains a central focus.

As binding law and with the potential to establish a nuanced, layered, and multi-faceted regime of compliance with and accountability to the right to health, the FCGH could fill perhaps the most potentially harmful SDG shortcoming: an in-

adequate accountability regime. Without effective accountability, the entire endeavor is at risk.

Paul Hunt has emphasized the need for a formal independent review of the SDGs, with an independent process “one vital feature of accountability.”<sup>3</sup> The FCGH could serve this role, even going far beyond the “lean...independent body” that the former Special Rapporteur proposes.<sup>4</sup> And in the process, the FCGH could help incorporate the human rights underpinning promised in the UN resolution promulgating the SDGs, the 2030 Agenda for Sustainable Development, into the goals’ implementation.<sup>5</sup>

While not encompassing the entire SDG agenda, the FCGH would fully incorporate goals and targets covering universal access to health services and underlying determinants of health including water, sanitation, food, and housing, along with other targets, such as those regarding domestic violence and safe working conditions. It would also address social determinants of health, another significant component of the SDGs, including equality, gender, education, employment, and violence.

This article will explain how the regime of accountability the FCGH establishes for the right to health and for complying with the FCGH could be a framework of accountability for the SDGs. In addition to the mechanisms described here, civil society movements that press their governments to comply, while using their expertise to facilitate government action, will be vital to both FCGH and SDG implementation.

These proposals, extending beyond current human rights compliance mechanisms, could form a comprehensive FCGH compliance regime, a “web of accountability.”<sup>6</sup> Given the political challenge of securing such a regime, the proposals might be considered a menu of possibilities, though, as argued elsewhere, shared interests in global health security, sustainability, and stewardship, would give states reasons to desire effective right to health accountability.<sup>7</sup> These mechanisms could also inform possible human rights and global health treaties besides the FCGH, and in some cases merit independent consideration.

## Empowering national accountability

### *Legal accountability: Claiming rights through the courts*

As the SDGs are not legally binding, courts—the paragon of independent review mechanisms—are missing from the SDG follow-up and review process. By bringing a substantial portion of the SDG agenda under the banner of the right to health, the FCGH could bring judicial accountability to the SDGs.

The FCGH could require states to provide judicial remedies for FCGH violations, thus ensuring the justiciability of the right to health in all FCGH parties. Further, the FCGH could require measures to promote accessible and effective judicial remedies, in line with states' commitment to equal justice under SDG 16. These could include legal aid and community-based paralegals, lenient standing criteria and training judges and lawyers on the right to health and on right to health litigation in other countries, and increasing their understanding of health to aid evidence-based decision-making.<sup>8</sup> These and other possibilities, such as legislative guidance to courts to ensure that judicial action promotes equality (or even such guidance from the FCGH itself), could mitigate the concern that right to health litigation can exacerbate inequalities, primarily by requiring states to provide expensive medicines, thus ensuring the justiciability of the right to health is in concert with the SDG “pledge that no one will be left behind.”<sup>9</sup>

Even if court judgments support the right to health and SDGs, other branches of government may refuse to implement them. Some judiciaries have forceful remedies; others could adapt their approaches. The Constitutional Court of Colombia has required immediate implementation in certain cases, with non-compliance resulting in the Court holding the government in contempt.<sup>10</sup> In Brazil, the threat of imprisonment of recalcitrant officials encourages compliance, and courts can fine the authorities for every day they fail to implement an order.<sup>11</sup> In their right to education cases, Indian courts have issued judgments with time limits and penalties.<sup>12</sup> More traditionally, courts appoint monitors for continued oversight until implementation is complete.

Still, institutional constraints may weaken courts' inherently limited enforcement capacity. Regular public reports on implementation and publicizing court opinions could keep decisions in the public spotlight, be fodder for civil society advocacy, and connect the judiciary to the rest of the “web of accountability,” such as civil society coalition-building and political advocacy.<sup>13</sup>

### *National health accountability strategies*

The 2030 Agenda offers valuable principles for follow-up and review processes, including participation, gender-sensitivity, and an emphasis on poor and marginalized populations. The FCGH could translate such principles into a set of interacting and complementary measures by requiring countries to develop national health accountability strategies. These would build on existing processes, structures, mechanisms, and human rights principles—including transparency, indicators, improved data, resource tracking, and reviews; public participation, civil society engagement, and social accountability; and non-judicial government structures (health ministries and parliaments, for example) and independent national human rights institutions—and on ongoing accountability efforts, such as those promoted through the accountability framework of the Global Strategy on Women's, Girls' and Adolescents' Health.<sup>14</sup>

As well as ensuring accountability for the health-related SDGs at the local and national levels, these strategies could be readily expanded to cover the full scope of the SDG agenda. They would also support SDG targets on access to justice and disaggregated data. A first step in developing these strategies could be a collaborative process of assessing challenges to existing health accountability measures.

Along with a judicial component, with measures such as those described in the previous section, the strategies, with budgeted plans of action, could cover at least the following elements:

1. Transparency, access to information, and anti-corruption measures: The strategies could establish standards, such as:

- the public accessibility of health laws, policies, and budgets, including at the community level;
  - transparency in health-related contracting and officials' assets; and
  - measures to protect against informal payments and to remove "ghost" health workers from payrolls.<sup>15</sup>
2. Local health accountability and participatory policymaking mechanisms: The strategies could:
- ensure the existence and functioning of, and funding for structures such as village health committees;
  - facilitate use of community scorecards to rate local health services and develop actions to improve them;
  - promote community auditing to ensure proper expenditure of health resources;
  - establish local health assemblies to engage health authorities and government officials; and
  - support health service monitoring, such as using SMS data or telephone hotlines to report health worker absenteeism, discrimination, and other irregularities and misconduct.<sup>16</sup>
3. National health accountability and participatory policymaking mechanisms: These could:
- include national human rights institutions, such as human rights commissions; parliamentary capacity to monitor the right to health and ministry of health capacity to implement it; national health assemblies; maternal and child mortality audits; social audits; scorecards; and targeted studies; and
  - encompass transparent, participatory, and independent review mechanisms—with high-level political endorsement—to review progress, measure core indicators, and recommend corrective measures.<sup>17</sup>
4. An enabling environment for social empowerment: Measures could encompass:

- educating the public and health workers on the right to health;
- funding to facilitate civil society and marginalized population engagement with policymakers; and
- ensuring the political space for right to health organizations (indeed, all civil society organizations), free of constraints (bans on foreign funding for human rights activities, for example).<sup>18</sup>

Strategies might include cross-cutting themes, such as use of technology (for example, electronic databases for court cases, the Internet for transparency, and mobile phones for local accountability).<sup>19</sup>

### *Capacity building*

The SDG national reviews have no dedicated funding, though effective participation in these processes, especially for marginalized populations, will require funding. The FCGH could help by establishing a "Right to Health Capacity Fund" that echoes the mandate in the Optional Protocol to the ICESCR (Article 14.3) to establish a UN trust fund to build national capacities for implementing economic, social, and cultural rights.<sup>20</sup> This fund could be resourced by governments, foundations, and individuals, and could finance accountability measures, encompassing mechanisms with an SDG review mandate but also reaching beyond, from public education to civil society advocacy through to government right to health-related functions and institutions, including parliamentary committees and human rights commissions.<sup>21</sup> The fund could support civil society organizations engaged in right to health activities, particularly at the grassroots level, and networks of marginalized populations, along with educational exchanges to share lessons on advocating for the right health and incorporating the right into policy.

Such a fund could stand on its own or be linked to other funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, which itself offers important support for human rights organizations and activities, includ-

ing for law reform, legal aid and literacy, human rights training, community-based monitoring, and policy advocacy. The new fund could learn from the Global Fund's well-developed human rights infrastructure, including domestic and regional civil society networks to offer human rights technical assistance, a Human Rights Reference Group, human rights champions on staff, and an information note to provide clear guidance and examples of funded activities.<sup>22</sup>

### International compliance and enforcement mechanisms

The 2030 Agenda rightly recognizes the need for both national and global accountability processes. Similarly, while accountability at the national level may be most important, the FCGH would incorporate international compliance mechanisms as well.

#### *Targets, benchmarks, and indicators*

Indicators and targets will be central to the FCGH compliance regime, establishing unambiguous expectations and benchmarks to assess progress, enable monitoring policy effectiveness, and expose neglected issues and populations. They would include relevant SDG indicators but would stretch well beyond to include—consistent with recognized right to health indicator practices—structural, process, and outcome indicators and targets, with disaggregated data.<sup>23</sup>

Rather than prescribing targets and deadlines, the FCGH could include guidelines for inclusive processes to translate the standards and requirements in the FCGH into national targets, benchmarks, and indicators, including ones tailored to particular contexts and populations.<sup>24</sup> The FCGH Secretariat, in cooperation with the World Health Organization, the Office of the UN High Commissioner for Human Rights (OHCHR), and independent experts, and with input from states, could develop common metrics. Work of the UN high level task force of the Working Group on the Right to Development can stimulate creative thinking, including on extraterritorial responsibility.<sup>25</sup> Meanwhile, with the SDG global indicators to be

complemented by others (the 2030 Agenda refers specifically to indicators developed by states), the FCGH indicators could also feed directly into the global SDG reviews, enhancing the reviews' focus on equity, accountability, and participation.<sup>26</sup>

#### *Monitoring and reporting*

Like other human rights treaties, the FCGH would develop an independent monitoring and reporting process, whether through the UN Committee on Economic, Social and Cultural Rights (CESCR) or by establishing its own treaty body, which could follow UN human rights reporting processes. Either way, the responsible body could serve as the independent SDG global monitoring body that Paul Hunt calls for, part of the “network of follow-up and review processes at the global level” to which the high-level political forum charged with global SDG review could be linked.<sup>27</sup>

Beyond the treaty body's own findings, including through state reports and national dialogues with government officials, in line with the CESCR's reporting processes, civil society could submit shadow reports and other written submissions, and make oral statements, all contributing to the SDG review process.<sup>28</sup> The CESCR or an independent FCGH treaty body could go beyond CESCR's current guidelines, requiring states to identify shortcomings and obstacles for each treaty provision, and provide plans to overcome implementation gaps, many of which would also impede achieving the SDGs. The specific obligations of the FCGH would provide far greater scope for the treaty body to examine and engage governments on their right to health records than under the ICESCR or through the SDGs alone.

The FCGH Secretariat could publish annual summaries of treaty body reports, perhaps using the tier system of the US State Department's annual human trafficking reports, with the lowest ranking countries subjected to penalties and special measures (examples could include targeted capacity building assistance and funding local media and civil society to facilitate advocacy).<sup>29</sup> Civil society could use the reports in advocacy, including as evidence of non-compliance in national courts.



The reporting process could facilitate additional pressure points. The FCGH might have a process to designate states regional FCGH leaders based on right to health implementation. The regional FCGH leader could review, comment on, and offer recommendations on neighboring states' FCGH reports, a mutual accountability process that could be another source of input for the independent review process. This peer review could increase pressure to comply, as countries aim to look good in the eyes of their neighbors, while reputational benefits of being regional leaders could also be a small incentive for FCGH compliance.

The FCGH could support community-based participatory action research, with findings feeding into FCGH reports and the SDG review process, while also contributing to local change. Members of geographic or identity-based communities would identify right to health shortcomings; their concerns would inform national reporting mechanisms. Community members would also directly work to change these circumstances through a cycle of action, reflection, and further action.<sup>30</sup>

#### *Detailed implementation guidelines*

The FCGH Secretariat, with WHO and OHCHR, could turn the FCGH principles—for example, Health in All Policies—into specific implementation measures, providing precise expectations, as happens under the Framework Convention on Tobacco Control.<sup>31</sup> These would be far more specific than treaty bodies' general comments and recommendations in the international human rights regime. The guidelines can create expectations that civil society could use for advocacy, or even be persuasive authority in courts, even though not binding international law. UN technical guidance on maternal mortality and human rights could serve as models.<sup>32</sup> Such guidelines would also inform states on desired practices for SDG implementation, such as rights-based universal health coverage.

#### *International and regional dispute mechanisms and courts*

The FCGH could help bring effective remedies,

which are central to the human rights accountability framework, into the SDG accountability regime.<sup>33</sup> Like other human rights treaties, the FCGH could create a committee to hear individual cases, or utilize the CESCR for this purpose, the latter approach avoiding duplication and reducing the risk of competing legal views on common aspects of economic, social, and cultural rights. A special rapporteur could assist individuals and groups in bringing matters before the committee. The committee might be able to launch its own investigations and investigate assertions of non-compliance by state parties, akin to the inquiry procedure and inter-state communications in the ICESCR Optional Protocol.<sup>34</sup>

As with the Inter-American system, the FCGH could establish an appeals process from this committee to a regional human rights court issuing binding decisions (with appropriate amendments to those courts' charters), or even establish its own court. Cases could involve state failings with respect to the SDGs that are also right to health violations. These might include excluding undocumented migrants from universal health coverage schemes, which would preclude achieving of the SDGs' universal health coverage target, or state failure to remedy discrimination against women in health facilities, which impedes efforts to reduce maternal mortality.

Sustained attention will be important to ensure that states implement committee and court recommendations and decisions. Borrowing from the regime established through the International Covenant on Civil and Political Rights' (ICCPR) Human Rights Committee, the FCGH could establish a position similar to the Special Rapporteur for Follow-up on Concluding Observations, who analyzes state action on the Human Rights Committee's recommendations. While state implementation often remains highly problematic, the Special Rapporteur's assessment is a creative approach to monitor progress and maintain awareness, with the potential for feeding into civil society advocacy, particularly with the Committee having developed an easily accessible grading system on state implementation.<sup>35</sup> Beyond monitoring, the designee under the FCGH could be charged with

advocating for and supporting efforts to implement recommendations and decisions (for example, mobilizing technical assistance and commanding media attention). This position would, in effect, serve as a monitor and catalyst for action in situations where state action is most at odds with SDG targets.

### *Inspections*

A rigorous inspection regime is central to compliance in the arms control context, and periodic visits to examine treatment of people deprived of liberty are an important component of the European Convention for the Prevention of Torture.<sup>36</sup> Likewise, and as another form of independent SDG monitoring and contributing to SDG implementation, FCGH inspections could be both part of a regular process to support right to health compliance and a response to alleged serious violations. This could entail a new set of special rapporteurs, augmenting the capacity of the current UN special rapporteurs on the right to health and related rights. The UN special rapporteur on the right to health could choose to focus on non-FCGH parties and, along with continuing to issue reports and recommendations on right to health matters of their choosing, integrate findings of the new special rapporteurs into broadly applicable conclusions.

Charged with FCGH monitoring and reporting, these new special rapporteurs would come from the region to ensure understanding of country and cultural contexts, increasing national resonance. Civil society could use their reports for advocacy. The special rapporteurs could help stimulate national discussions, facilitate meetings between civil society and policymakers, organize regional forums for sharing lessons and building capacity, and press governments to improve compliance. They might also contribute to right to health capacity in regional organizations.

Several states have sought to weaken special rapporteurs, particularly those with individual country mandates and the rapporteur on freedom of expression in the Americas.<sup>37</sup> The less overtly political nature of health, the link to the SDGs, and the regional nature of the proposed rapporteurs may increase acceptability. Meanwhile, public reporting

on state cooperation with the special rapporteurs could encourage cooperation.<sup>38</sup>

### *Sanctions*

Public international law is founded on the expectation of cooperation and consensus, not coercion and sanctions. As part of this legal fabric, FCGH success, like that of the SDGs, would depend primarily on states' willingness to carry out its precepts. Nonetheless, sanctions may have a supplementary role, as with the World Trade Organization (WTO), adding additional pressure to remedy right to health violations that impede SDG implementation.

The FCGH could specify violations that warrant sanctions, empower an independent body (such as the same committee that hears disputes) to assess compliance and apply a tier system as described above, with sanctions for the lowest stratum, or direct the Conference of the Parties (CoP) to develop a calibrated response to serious FCGH violations, including sanctions as appropriate.

A key FCGH innovation in determining possible sanctions could be local civil society's role. The FCGH could establish a dialogue with national civil society organizations to determine the best response to violations, with safeguards to protect participating organizations. Dialogues would assess the expected impact of possible sanctions, including on health. Even with negative health implications, civil society might believe that sanctions would be the most effective way to advance the right to health over time. For example, sanctions could increase public pressure on governments to meet their commitments. The CoP or independent body might then determine an appropriate response, with civil society participating in its deliberations and decision-making.

Developing a sanctions regime that promotes the right to health, is equitable across countries, and is not political fantasy is challenging. A basic form of sanctioning would be loss of benefits under the FCGH, notably international assistance. This approach has several significant shortcomings, however. First, it would impose a double burden on people in countries with poor compliance, who would be subject to reduced realization of the right

to health due to their own governments' failures, and from curtailed international support. Second, loss of assistance would be a tool that higher-income states could use against lower-income states but not the reverse, an inequity that could undermine trust among FCGH parties. We must look beyond this penalty.

International assistance could be reprogrammed to non-governmental providers, to government entities not responsible for the violations, and to NGOs contributing to people's empowerment and government accountability. Funding could be channeled specifically to organizations working to overcome the particular violation. This is akin to the Global Forum on MSM & HIV (MSMGF) proposal, after Nigeria enacted a harsh anti-gay law in January 2014, that donors reprogram funding to support LGBT rights there.<sup>39</sup>

The FCGH could block offending parties (and perhaps their nationals) from assuming global health leadership positions, akin to the UN Human Rights Council conditioning membership on not engaging in severe human rights violations.<sup>40</sup> FCGH parties could oppose their serving as board members, chairs, or executive directors of organizations such as UNAIDS or the Global Fund, or serving on WHO's Executive Board. This may at least partially counterbalance one flaw in the SDG review process: that the High-Level Political Forum on Sustainable Development will include the very governments that are perpetuating human rights violations that undermine achieving the SDGs.

State agreement to an FCGH sanctions regime would be difficult to achieve. The FCGH could adopt strategies to increase the possibility of state acceptance. For example, if an inclusive national process affirms that a state is making a good faith effort to comply, that state could be shielded from sanctions. Reliance on national processes must include assurances of their inclusive, transparent, and honest nature (for example, governments do not threaten or induce civil society participants, or control which civil society organizations participate). Similarly, countries could make submissions concerning their own noncompliance, as with the

Montreal Protocol, along with plans to rectify their noncompliance.<sup>41</sup> These plans might be developed and approved through inclusive national participatory processes, and shield states from sanctions as long as states then implement these plans.

If a state cannot justify noncompliance and explain how it will come into compliance in these ways, and sanctions are warranted, the Convention could provide for a warning period and a final opportunity to comply before sanctions take effect, much as the WTO dispute settlement process allows a reasonable period for implementation before any penalties take effect.<sup>42</sup> Also, states might need to affirmatively recognize jurisdiction of an individual compliant mechanism or court, akin to human rights courts in the Inter-American and African human rights systems and the ICESCR Optional Protocol.<sup>43</sup>

### *Incentives*

States may be reluctant to sanction another state, as this could harm relations and set a precedent where they themselves may be sanctioned. And sanctions may be insufficient to motivate compliance. Incentives are preferable.<sup>44</sup>

Regional right to health leaders and their nationals could be recognized as top candidates for leadership positions of international health and human rights bodies. These countries might be first in line for the opportunity to host regional and global health meetings, with the associated economic activity.

While its norm-setting role may extend beyond states parties, itself an important benefit of the treaty, FCGH contributions to SDG accountability will depend significantly on ratification. As a minor incentive, for states to ratify the treaty, FCGH parties could agree to not support non-parties for competitive health and human rights bodies (like the WHO Executive Board) or leadership positions of health and human rights organizations. Or, encouraging non-parties to adhere to FCGH precepts, an FCGH body could gauge right to health implementation of non-FCGH parties based on CESCR reports or select indicators, with FCGH parties weighing their candi-



dacies accordingly.

A more tangible incentive is funding. The FCGH could establish a mechanism to finance the treaty's procedural aspects, such as developing FCGH implementation reports and national health accountability strategies, and ensuring inclusive, participatory approaches in priority-setting, policymaking, and monitoring and reporting. The mechanism could also support other compliance modalities, such as regional special rapporteurs and activities of regional right to health leaders, such as peer review and documenting their own positive practices.

### Corporate compliance

Private sector action will be important to achieving the SDGs. Will pharmaceutical companies develop better diagnostics and treatments for TB and other diseases that disproportionately affect poorer people, or price medicines beyond people's reach? Will mining companies work with communities to ensure that their activities do not harm health, or will they pollute life-giving rivers?

The FCGH could help tilt the answer towards health-promoting actions and corporations' right to health compliance. Building on the UN Guiding Principles on Business and Human Rights, the treaty could enhance state responsibilities to regulate corporations, such as by requiring corporate policies on respecting the right to health, assessing the human rights impact of their policies and practices, acting on these findings, monitoring results, and providing remedies.<sup>45</sup> Modeled after the National Contact Points of the OECD Guidelines for Multinational Enterprises, the FCGH could require states to establish national contact points to promote corporations' health and human rights responsibilities and help resolve particular issues.<sup>46</sup> Further, the FCGH could encourage or require states to permit individuals and organizations to sue corporations for right to health violations.<sup>47</sup>

The FCGH may be able to include a mechanism to make right to health obligations directly binding on corporations. A rare illustration of this

in international law comes from the WHO Pandemic Influenza Preparedness (PIP) Framework's use of contract law. Under this Framework, WHO-designated laboratories agree to share influenza virus samples only with pharmaceutical and biotechnology companies (which may desire the samples so that they can develop vaccines, treatments, and diagnostics) that enter into a contract with WHO to take measures to increase availability of vaccines, treatments, and diagnostics in developing countries.<sup>48</sup>

The FCGH could draw on this example. States could agree to incorporate provisions related to respect for the right to health into any contracts they enter with corporations, thus creating binding obligations. Contracts could have specific requirements, such as undertaking right to health assessments and acting on findings. Contract provisions could also be tailored to specific industries. For example, guided by the Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines, contracts with pharmaceutical companies could include transparency in lobbying and pricing, and promoting access to medicines in poorer countries and to poorer populations.<sup>49</sup>

### Conclusion

The compliance regime sketched here would bring such mechanisms as judicial review, capacity building, community monitoring, detailed guidance, inspections, independent institutional review and oversight, and sanctions and incentives to the SDGs' health commitments. These measures build on but go well beyond those of the ICESCR and the current UN human rights regime. A court could enhance the ICESCR Optional Protocol's individual compliance mechanism. The special rapporteur system could be expanded, with a regional focus on health and human rights. FCGH Secretariat reports could include tiers, linked to targeted sanctions and incentives. Measures to empower national and local level accountability would be central.

States could use other opportunities to encourage compliance. Much as states incorporate

labor and environmental protections into trade agreements, they could include sections in these agreements on the right to health, linked to the FCGH. They might find creative ways to leverage international assistance to promote compliance.

Compliance modalities can be synergistic. Monitoring processes can facilitate advocacy, provide evidence used in courts and at parliamentary hearings, and feed into formal SDG review processes. Even before the FCGH is adopted, possible elements of its compliance regime, such as national health accountability strategies, a Right to Health Capacity Fund, and an enhanced system of regional special rapporteurs, could be developed, buttressing SDG accountability.

Even the most powerful compliance regime the FCGH might incorporate would not ensure achieving the health-related SDGs or perfect right to health adherence. But between today's ill state of right to health compliance and the ideal is immense scope for improvement. A well-designed, multi-dimensional FCGH compliance regime, backed by civil society advocacy, could move closer to that ideal. That alone would make the FCGH transformational.

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