JALI Research Questions on the

Framework Convention on Global Health

July 2013
(January 2014 update)

Introduction

Engage in a historic opportunity to help shape a global health treaty that could mark a new era in global health! The Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI) would welcome your contributions to determining the contours and content of a Framework Convention on Global Health (FCGH), aimed at resolving today's vast health inequalities between and within countries. The FCGH would be grounded in the human right to health, achieve universal coverage of health care and the underlying determinants of health while responding to the broader social determinants of health, help empower people to claim the right to health, establish far greater accountability, raise the priority of health in other sectors and international legal regimes, and meet major challenges in global governance for health, such as poor coordination and inadequate financing.

Along with extensive and inclusive consultation, cutting-edge research and analysis is required to determine that nature of and specific elements and responsibilities to be included in the FCGH. We gave developed an extensive set of questions, arranged by topic, that we invite you to consider answering (http://www.jalihealth.org/research/). With your permission, we will post your response to the research section of the JALI website.

As you will see, there are many questions. You may want to look through the topic areas, see which most interest you, and focus on the questions in those areas, rather than reviewing the full set of questions. We would also be glad to discuss your interests, and help direct you to the areas and questions that are likely to best match your interests and expertise. You may also decide to use the questions as guideposts, some issues to consider, if you would like to share your perspectives on how the FCGH should address a broader topic, such as the right to health or accountability. We would also welcome your perspectives on the FCGH that might not fit easily within one of the topics, or that cuts across issues.

The goal of these questions and the responses to them is not to provide definitive conclusions on what an FCGH will include – though your recommendations are most welcome. Rather, we hope that responses will enable informed and meaningful, broad and inclusive, discussion on the contents of an FCGH – especially among the communities who have, and civil society who work on behalf of those who have, the least access to quality health services, who are furthest away from enjoying the right to health, who stand – and need – to benefit most from an FCGH.

We also welcome your feedback on any additional questions or issues that should be part of the research towards an FCGH that are not reflected below. Though we have identified many questions and issues, we want to know your expectations of the FCGH. If these are not reflected in these questions, please let us know.

While your responses should take whatever form you prefer, we recommend the following structure to facilitate sharing your findings and perspectives:

At the top of the contribution, provide the heading, title, or question(s) that you are addressing (e.g., "How the FCGH should address X"), followed by your name/organization, and the date of your contribution. Then provide your main recommendations for the FCGH for the question(s)

you are addressing or, if you did no have specific recommendations, then the different options that an FCGH could take, including brief summary of the advantages and disadvantages of each option. Follow this with your main analysis of the issues involved and how you have reached the recommendations, or more in-depth analysis of the different options and their advantages and disadvantages. This final section might also include relevant policy recommendations (e.g., most effective policies in a given area, how human rights law should address a particular issue).

Please direct any questions or feedback to the JALI Secretariat: info@jalihealth.org. Thank you.

Table of Contents

I. Substance of the FCGH

Right to Health

Fundamental human rights standards

Maximum available resources: How could the FCGH further operationalize, with respect to the right to health, the ICESCR obligation that states spend the maximum of their available resources towards fulfilling the rights in the Covenant? What are appropriate metrics for determining maximum available financial (including international sources of funding) and other resources? How to determine the "maximum" available resources? What should be considered the "available" resources? How, for example, to address resources that the state could potentially use but are not currently utilized by the state, such as because of capital flight, low royalties for natural resources, low tax rates, or corporate tax exemptions? Should there be required or presumptive benchmarks in these (capital flight, tax rates, etc.)? If so, what should they be? Is the FCGH the place for this? How should spending levels in comparable states factor into determining the "maximum"? How to address the fact that the maximum available resources requirement is not only for the right to health, but cuts across all economic, social, and cultural rights? Should the FCGH address maximum of available resources requirement with respect to other resources (e.g., human, financial)? If so, how?

Progressive realization: How should the FCGH operationalize the ICSECR requirement that states progressively realize the right to health? What are the appropriate metrics to measure progressive realization? Should progressive realization be measured through comprehensive metrics (such as changes in life expectancy)? Changes in key indicators (such as maternal mortality)? With metrics for a wide range of health issues (e.g., improvements with respect to HIV, different non-communicable diseases, maternal mortality, and so forth)?

Core obligations and immediate realization: What aspects of the right to health should be immediate obligations, and what aspects should be subject to progressive realization? What should the immediately realizable core obligations encompass?

Highest attainable standard of health: How has the "highest attainable standard" element of the right to health be interpreted, and how should it be interpreted? Attainable globally with a high degree of cooperation? Or something less than the highest global standard, in which case, what and how is this to be determined? The highest degree of health as attained by the healthiest people (top quintile? Top 5%?) of that country's population? Or by the wealthiest people (so as to minimize differences based on biological factors)?

ICESCR obligations and current interpretations: What have human rights scholars, UN special rapporteurs, the Committee on Economic, Social and Cultural Rights, and domestic courts said about measuring and operationalizing these explicit elements of the ICESCR (maximum available resources, progressive realization, highest attainable standard)? In the context of the right to health? For maximum available resources and progressive realization in the context of other rights in the ICESCR? What can we learn about current approaches to understanding these obligations from how they have been interpreted in the context of the right to food, water, and

other economic, social, and cultural rights?

Clarifying equity, participation, and accountability: What have human rights scholars, UN special rapporteurs, the Committee on Economic, Social and Cultural Rights, and domestic courts said about other aspects of the right to health, principles such as participation, accountability, equity and an emphasis on marginalized and vulnerable populations, and equality and non-discrimination? How have they interpreted and reacted to the minimum core obligation of the right to health, including its connection to available resources? (General Comment 14 described the core obligations as non-derogable, as does General Comment 15 on the right to water. But several early General Comments [General Comment 3 on overall state obligations and General Comment 12 on the right to food], include a link to resources.)

Calibrating guaranteed health goods and services to certain level of health: Is there a certain level of health that any minimum standards in an FCGH should guarantee? If so, what level, or how to determine that level? What implications does this have for level and nature of health systems and services to be guaranteed to all people under and FCGH? For how an FCGH would address underlying determinants of health and the broader social determinants of health?

Universal conditions for good health and variations in country wealth: Under the right to health, would there be any differences with respect to the health goods and services that should be guaranteed to all people (i.e., those included as part of the core minimum obligations) through the FCGH based on different wealth and development levels of countries, or the current health status of their populations? To what degree might specifics vary by country (potentially being less in less wealthy countries)? Or if by their nature these guarantees must be the same for all people, in every country, how might (if at all) required timelines for achieving them vary by country (including based on wealthy and current level of ensuring conditions in which all people can be healthy?)? What flexibility should countries have in these timelines? Should only other aspects of the right to health, those subject to progressive realization, that are the basis for differences in state obligations towards their populations, to ensure that wealthier countries that are largely already providing the health goods and services to be secured for all people expand beyond these goods and services, whereas the core obligations should be the same across all countries in terms of level of health that they should achieve?

International assistance responsibility under the right to health: Under the right to health, how far does – and should – the international assistance responsibility extend beyond minimum core obligations?

Avoiding undermining right to health in other countries: Beyond obligations related to specific areas (e.g., trade; see section on global governance for health), should the FCGH include a general provision on respecting (not undermining) the right to health in other countries? What are circumstances such a provision would come into effect? How could such a provision be operationalized given the extent to which current policies (e.g., excessive greenhouse gas emissions) do undermine the right to health elsewhere? Or is it just the simplicity of this command and far-reaching implications that would give such a provision great potential?

Right to health accountability and education

Right to health education: What are the most effective approaches to enabling people to understand and claim their rights? What are good models (e.g., comic books explaining rights)? How, and how often, are human rights incorporated into school curricula? What is the role of the media? How can and should the FCGH facilitate these approaches? How can it help transform knowledge into true understanding and the ability to act on this understanding?

Current right to health education efforts: What are the main organizations/efforts underway to enable people to understand and claim their rights, in particular the right to health? How could an FCGH enhance these present efforts? Beyond the FCGH, can JALI support these efforts in any way (networking, compiling lessons learned, evidence)?

National human rights bodies: How do governments bodies mandated to raise public awareness on human rights (e.g., South Africa Human Rights Commission) do so? How effective are these approaches? What are challenges and lessons to be learned? How might these inform an FCGH?

Health worker right to health training: Should the FCGH require health workers to be trained on human rights, including the right to health? Are there also other ways for the FCGH to promote health worker understanding of, respect for, and promotion of the right to health?

Right to health knowledge and evidence of impact: Is there any evidence for improvements in health outcomes from education on the right to health? If so, what is the evidence? What is other evidence of the benefits (besides improvements in health outcomes) of this information?

Local right to health accountability mechanisms: What is the evidence for improvements in health outcomes and improved health services from right to health accountability mechanisms (e.g., village health committees, community scorecards)? Do these address health care as well as underlying and broader determinants of health? How might an FCGH support these mechanisms?

Specific right to health topics

Transnational corporations and other transnational non-state actors: How could the FCGH exert control over transnational corporations (and other transnational non-state actors)? Upon which states should the obligations to regulate these corporations fall (e.g., where corporation is incorporated?)? What regulatory mechanisms should states employ? [Note question also in the global governance for health section.]

Obligations of non-state actors: Should the FCGH create direct obligations on corporations (and other non-state actors), as opposed only through states as the intermediaries, with requirements to regulate non-state actors? If so, how would the FCGH create these direct obligations, particularly assuming that non-state actors are not direct parties to the FCGH? [Note question also in the global governance for health section.]

Natural disasters and humanitarian crises: Should an FCGH address specific right to health responsibilities during natural disasters and other humanitarian crises (e.g., in the context of refugee and internally displaced populations)? What special right to health obligations do (and should) these crises create?

States in conflict: Should an FCGH address directly situations where governments do not have full control over all of their territory? If so, how should the FCGH address these situations? What are obligations of governments, non-state actors controlling territory not controlled by the government, and international actors?

Right to health assessments in non-health sectors: Should the FCGH require right to health assessments of planned non-health sector activities? Which sectors? Under what conditions should these assessments be required? That is, what circumstances should trigger these assessments? How specific or general on situations where laws require environment impact statements, and what are the possible lessons for right to health assessments?

National, provincial, and local right to health capacity: Where is national capacity for right to health implementation? In national human rights commission, judiciary? How could an FCGH support capacity for these institutions? What about local capacity (e.g., municipal health authorities, village health committees), and how could an FCGH support capacity of these institutions?

National right to health laws: What are examples of national laws and policies explicitly based on the right to health? How effective are they? How might they inform an FCGH?

Laws undermining the right to health: What are examples of national laws and policies that directly or indirectly oppose or undermine the right to health (e.g., budgeting restrictions)? How might an FCGH address such laws and policies? Are there specific types of laws and policies that the FCGH should prohibit? Should the FCGH include a general ban on laws and policies that undermine the right to health?

Health systems: What health system changes would a right to health approach entail? In general? In specific countries?

Patient safety: How should the FCGH address the rights of patients to safe health care (an integral part of quality care)?

Global organizations: How should the FCGH address the roles of global institutions (e.g., WHO, the Global F und, the World Bank) in advancing the right to health?

Right to health capacity fund: Should the FCGH develop a special right to health capacity building funding channel? If so, what should it cover (e.g., right to health education of the population and authorities, national right to health infrastructure such as units within health ministries, right to health ombudspeople and commissions, community and civil society organizations addressing the right to health, local health accountabilities mechanisms)? Should it

include funding for both non-state actors (civil society, media, academic institutions) and governments? Should institutions in high-income countries (only non-state institutions, or governments as well?) be eligible? How should such a funding channel be structured and funded? Should it be an independent fund? Or should the funding channel(s) be incorporated into or otherwise linked to other health (or human rights) funding streams? Should the capacity fund's funding be encompassed within the overall funding framework of the FCGH? How should the funding channel(s) relate to or be incorporated into other health (or human rights) funding streams? [Note question also in the capacity building section.]

Health worker professional responsibilities: Should the FCGH include a requirement that governments respect the professional obligation of health workers to the health (and rights) of their patients (e.g., by not requiring them to report violations of e.g., immigration, drug, abortion laws to authorities, as this might reduce utilization of health services and reduce trust between health workers and patients)?

Health worker rights: How should the FCGH address the rights and needs of health workers (e.g., safe working conditions)?

International human rights machinery: How should an FCGH relate to existing international human rights machinery (e.g., human rights treaty bodies, UN special rapporteurs)?

Funding

Overall scope of funding targets

Main elements of targets: Should the FCGH financing framework comprehensively cover the effective health systems and underlying determinants of health/public health services (water, sanitation, etc.) to which everyone is entitled, and that are guaranteed under the FCGH? Should these targets include any funding for social determinants of health, or would these be outside the funding framework?

Costs of underlying determinants of health: What would be the cost of ensuring everyone each of the underlying determinants of health (see section on Ensuring For All Universal Conditions of Good Health, including footnotes 3 and 4, and questions addressing which underlying determinants [and public health measures] the FCGH would include)?

Social determinants of health: If the social determinants of health are outside the FCGH financing framework, should the FCGH address their financing at all? If so, how? If they are included in the FCGH financing framework, then which should be included, and how? Given their expanse and in some cases, their expense, what impact would this have on the political feasibility of the FCGH?

Collective or disaggregated targets: Should the FCGH have a collective funding target across all relevant sectors (health, water/sanitation, etc.), and if so, which sectors? Or should the FCGH have specific targets for each sector? What are the advantages and disadvantages of each approach?

Evolving funding goal: How can the funding goal be designed to reflect changing disease-burdens, priorities, and costs? Should the FCGH include processes to review and update funding targets if the overall health investments that they must cover changes? Should there be a regular review of funding targets? If so, by whom? What would the process be?

Country differences and common funding target: Would standards in the FCGH be sufficiently precise to serve as the basis for an overall financing target from which the international portion could be derived, even if adapted at national level to meet community expectations and respond to country circumstances? If not, how to account for variations across countries? To the extent that needs are determined nationally – and thus investment needs will be the aggregate of country needs – a bottom-up process – can (or how can) there be an overall funding target determined before each country undertakes a process (which the FCGH might require) from which the cost emerges? If FCGH funding requirements to not take account these national processes, would any additional financing required based on higher country-determined standards be funded through domestic resources, or possibly be supported by additional innovative financing strategies or assistance outside the financing framework?

Country differences and domestic financing targets: Given varying country circumstances and community expectations, how should the FCGH set domestic funding targets? Might some areas (e.g., health care) have a common funding target across all countries, while certain underlying

determinants of health have a range, and possibly criteria for which countries would fall within the range (e.g., high spending requirements to achieve adequate sanitation for the entire population for countries for countries with low levels of sanitation coverage)? Might the FCGH include default (indicative) budget targets, along with stipulations on inclusive national processes for adapting these targets domestically? Are there areas where country spending needs vary too much for the FCGH to include any domestic targets?

Regional funding targets: Should the FCGH have different funding targets for different regional groupings, and if so, based on what justifications, and using which groupings? Should they be regional (e.g., African Union) or sub-regional (e.g., West Africa)?

Global to national goal-setting: Might a process be developed whereby after a certain period of time, an initial goal is replaced by a bottom-up approach that is based on funding gaps in national health and development strategies that are designed to universal health coverage for health and the underlying determinants of health?

Economic policy constraints: How (and how much) do macroeconomic (or other economic, e.g., trade regime) policies constrain national health spending, or otherwise impede health, in developing countries? In practice, what control do developing countries (and other countries seeking support from international financing institutions) themselves (as opposed to international financial institutions) have over these policies? Are there specific changes needed in international financial institution practices that would enable countries to increase health and health-enhancing spending? If so, what, and should the FCGH respond to the need for these changes? Similarly, outside of international financial institutions, such as in the area of trade, are there rules or policies that impede on health and health-enhancing government spending? How should these be changed, and what is the role of the FCGH in these changes? [NOTE: Question also in the global governance for health section.]

Health funding efficiency: Are there measures (besides those addressing transparency and accountability, discussed elsewhere) that the FCGH could include to increase the efficiency of health spending (to achieve improved health services and outcomes for equivalent amounts of health funding)?

Eligibility for international funding: What domestic requirements (if any?) should the FCGH attach to receiving funds through the FCGH financing framework (i.e., requirements related to countries receiving this funding)?

Legitimately missing the target: What are legitimate reasons for which countries might not meet funding targets?

National

Health system costs: Many states will provide services (perhaps certain specialty care, or teaching hospitals) that may extend beyond estimated costs of well-functioning health systems to which everyone is entitled. How should these be factored into funding targets? What about the likelihood, that even if well-meaning efforts, spending is not likely to be wholly efficient, further driving up costs beyond any estimate – particularly developed global, but possibly also at the

national level.

Basis of national funding targets: How should domestic health funding targets be defined (e.g., percentage health sector spending, funding levels need to achieve specific health outcomes or provide certain goods and services, or achieve certai standards fo health systems and underlying determinants of health)? How should overall economic strength (e.g., GNI) and capacity for generating additional revenue (such as through domestic financing mechanisms; see below) be incorporated into determining these targets and resource availability? What other factors, if any, should factor into domestic health funding targets?

Existing national funding targets: What are the rationales behind existing national targets for health, agricultural development, etc. (e.g., Abuja Declaration, Maputo declaration on agriculture and food security in Africa)? How sound are these rationales as possible rationales for FCGH targets? Should any existing targets be incorporated into the FCGH?

Substitution effect in health spending: What factors account for developing countries reducing domestic spending in response to increasing international health assistance (the substitution effect)? To what sectors and purposes are these domestic resources diverted? Are these other sectors and purposes promoting health? Human development more broadly What are possible implications for the FCGH? Particularly to the extent funds are diverted to non-health-promoting activities, should the FCGH include strategies or incentives that will help reduce this substitution effect, or are clearly defined national and international funding targets (or processes for developing national targets) sufficient?

Increasing tax collection: Should the FCGH promote strengthened national tax systems and innovative domestic financing mechanisms and (e.g., taxes on tobacco and unhealthy foods, dedicated taxes for health financing, methods to capture capital flight, improved tax collection)? If so, what mechanisms and how should the FCGH support them? To what degree is it possible for global health treaty to reach into overall revenue collection?

Sources of revenue: Should the FCGH include various categories of potential revenue (e.g., taxes, royalties) that countries should utilize in advancing the right to health? What sources? Or simply all sources?

International

Range of countries with international funding responsibilities: Beyond OECD countries (traditional “donors”), what countries should have international funding responsibilities under the FCGH? Those with a certain income threshold, and if so, what threshold? Should all countries have international funding responsibilities, where the level of responsibility for poorer countries is miniscule compared to the funding that they would receive under the treaty, meaning that poorer countries would participate in this system as an act of solidarity (without materially affecting their finances?)? How would (if at all) their own rights to international funding under the treaty be affected, if at all, by the level of their international funding?

International financing target connection to overall health financing goal: How should

international funding responsibilities relate to an overall health financing goal? Would it simply be the overall health financing goal less the domestic responsibility? Or would there be another way for determining the international financing target?

International health assistance target: Should the FCGH have a specific international health assistance funding target? If so, what should it be? What sectors should it cover? Should it be a portion of GNI? How would it relate (if at all) to the long-standing 0.7% GNI commitment of "economically advanced countries" and any other existing commitments? What other commitments?

Evolving international health assistance target: Would a given country's international health assistance obligation, rather than being a set level, vary based on the total international financing target? Might other factors then affect international funding obligations (e.g., number of countries participating in the FCGH financing framework?

Allocating international responsibility: Should the FCGH have uniform international funding targets (e.g., X% of GNI) or take another approach to dividing health funding responsibilities among members of the international community, such as specifically agreed figures that vary by country income or other (what?) issues related to country capacity (and potentially their own needs), and which might be included in an annex or protocol to the treaty? Should the FCGH have different responsibilities for OECD member (i.e., traditional "donors") and other countries with international financing responsibilities under the treaty (e.g., emerging economic powers)? If so, how would the responsibilities differ? Should the FCGH have different levels of funding targets, with the proportion of GNI (or other measure of economic strength) increasing as the country becomes richer, with countries therefore having higher funding obligation as their wealth increases (e.g., 0.01% for lower-middle income countries, 0.05% for upper-middle income countries, 0.2% for high-income countries)? If so, what would these targets be?

Other possibilities for international funding targets and allocating responsibility: Are there other possible approaches to funding targets that an FCGH could incorporate that are not proposed above? What are they, and what are their advantages and disadvantages?

Financing framework and incomplete participation: How should the international funding obligations and the FCGH financing framework be structured to account for the high probability that not all countries, including possibly significant funders of global health (e.g., the United States) will ratify the FCGH, at least not initially? For example, if the international financing need is $100 billion but countries that under financing formulas would be responsible for only $60 billion ratify the FCGH, how to respond to the $40 billion gap? Would the $60 billion be allocated to all countries in needed of funding, but at lower levels? Or would certain countries or needs be prioritized? What lessons might come from the Global Fund to Fight AIDS, Tuberculosis and Malaria and debates within and around the Fund about allocating insufficient resources?

Financing framework and non-FCGH parties: Might one way to respond to incomplete FCGH ratification be through side agreements with non-ratifying countries that stipulate their anticipated global health funding (or failing this, estimated like likely health financing), with the

remainder to be apportioned among FCGH ratifying countries? Might then a formula for international funding responsibilities be adjusted annually based on the number and capacity of FCGH parties and estimated funding of non-parties?

Financing framework shortfalls and innovative financing: What role might innovative financing have in covering the difference between identified need and international resources available through the FCGH financing framework in light of incomplete ratification?

Financing framework and growing participation: Would international funding obligations under an FCGH be affected in any way be the number of countries contributing to this financing (e.g., reducing obligations as more countries join? If a critical mass of countries join the FCGH financing framework, such international funding obligations be targeted to the full international health-related funding needs, but with international funding obligations for each FCGH party falling as additional countries ratify the treaty, reducing the health assistance required from current parties to meet the overall funding need?

Ensuring reliability of international health financing: What structures and safeguards can be developed or strengthened to ensure the long-term reliability of international health financing? Should the FCGH establish a global health trust fund (or other such mechanism), to be used to compensate for unmet commitments? How would this be structured, and could it be designed and financed in a way that does not reduce the availability of funds for current health needs? Should the FCGH include a strategy to collectively compensate for funding shortfalls from other parties to the FCGH, and if so, how might such a compensatory mechanism be designed?

Global Fund for Health: Should an FCGH establish a Global Fund for Health? Would this cover all aspects of health that the FCGH financial framework encompasses? What would the Global Fund for health contribute to enhanced sustainability and predictability of health funding?

Global Fund for Health governance: If there is a Global Fund for Health, what governance structures should it have? What is and is not working for the Global Fund to Fight AIDS, Tuberculosis and Malaria (and other global funding organizations) that could inform a Global Fund for Health?

International funding and national strategies: What measures can countries take to ensure that global health funding is aligned with their own strategies and priorities, and how can the FCGH support these measures? To what extent should the FCGH require that international funds be provided through national strategies and structures, rather than any separate bilateral programs? All funds? A certain proportion? Should the FCGH set a standard in this area?

Human rights and other responsibilities through international health funding: What responsibilities attach to global health funding (e.g., participation, equity, accountability),[1] and how could the FCGH help operationalize these responsibilities? What additional principles

[1] *See* Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights, adopted in Maastricht, Netherlands, September 28, 2011, at para. 32, http://www.maastrichtuniversity.nl/humanrights.

(besides participation, equity, and accountability) might come into play vis-à-vis global health funding (e.g., harmonization and alignment), and how prescriptive should the FCGH be in operationalizing them? Or if all funding is through national structures and strategies, does this question become largely irrelevant?

International health funding and community involvement: What approaches to channeling global health resources to countries would be the most effective, equitable, and efficient for involving communities and civil society and achieving accountability? For example, a Global Fund for Health, or direct support to countries through sector wide approaches (SWAps), or a combination of approaches? What criteria can be used to measure and compare these (and other?) approaches?

International funding and equitable coverage: How can international health financing best complement national health financing schemes to maximize coverage and equity? How should the FCGH address this?

Vertical funding: What should be the role, if any, of disease-focused (vertical) funding streams in a revised global governance for health?

Accountability and international health funding: What are the best ways to ensure the effective, efficient, and accountable use of international health funding (e.g., anti-corruption policies, reporting requirements)? How should these requirements be designed (e.g., to have effective reporting without overburdening countries with reporting requirements, and developing processes to ensure that where problems are identified, countries and other partners take necessary steps to address them)?

Innovative financing mechanisms: What existing or proposed innovative financing mechanisms for health can the FCGH advance or institute? What level of funding would these mechanisms likely raise, and how might and should they impact traditional government assistance (from national foreign assistance budgets)? How can these mechanisms be designed to ensure that they do not compete with other international funding needs related to global social justice (e.g., climate change mitigation and adaptation measures)? Would funding raised through non-traditional sources be within or outside the scope of the FCGH financing framework?

Private health financing: What role should private financing (including from individual charitable giving, corporate charitable giving, foundations, and investors) have in meeting global health funding needs, and how might an FCGH address this? Are there any innovative financing approaches for health that would give a financial return on investments, thus encouraging health investments? Would these raise ethical and human rights, or other, concerns? Would such private financing be within or outside the scope of the FCGH financing framework?

Private health financing and state responsibilities: Should private health financing have any role in determining whether a country is meeting its international funding responsibility? If so, what sort of private health funding would count? Would it depend on the source and destination (use) of that funding? How would this work? Or would only public health funding count towards a state's own international funding responsibilities?

Direct budget support: What role, if any, should direct budget support have in revised global health structures? Would this be one way to address the question of how FCGH should set targets for health-related spending across sectors? Might direct budget support be available to countries if they have a national strategy and standards to health-related standards under the FCGH?

Tied aid: Should an FCGH address present conditions that development partners may place on international health assistance (e.g., requiring that countries receiving this assistance purchase technical assistance, equipment, or other requirements from the country providing the assistance)? If so, what conditions, and how should the FCGH address them? Should it prohibit any of these practices entirely?

International funding and national accountability: What structures will ensure that an FCGH that enables countries to receive more international health financing nevertheless enhances, and does not risk undermining, the accountability of governments to their own people?

Funding for global health organizations: Should the FCGH have a role in ensuring funding for health-related international actors (e.g., WHO, UNICEF [Global Fund])? Should their funding needs be incorporated into the FCGH's health funding targets? If so, how?

Beyond universal conditions for good health: Should an FCGH financing framework address in any way funding beyond the universal conditions for good health (or particularly effective health systems and underlying determinants of health)? The international assistance human rights obligations may extend beyond ensuring the core obligations are met for each right (see right to health questions, above). If the universal conditions of good health to which everyone is entitled is equated to these core obligations, does their need to be a corollary to the additional obligations in the FCGH financing framework? Or for FCGH purposes, would sufficient financing to ensure for everyone the conditions of good health suffice?

Accountability and Compliance

Accountability

Community engagement: What targets, principles, or strategies could the FCGH promote or require to ensure community and civil society participation in developing, implementing, and monitoring and evaluating national and sub-national health-related plans and policies? How should this link to government obligations to respond to civil society and community concerns about implementation of plans and policies? Should the FCGH define these attendant obligations, and if so, how?

Transparency: What are best practices in transparency that the FCGH could and should incorporate (e.g., requiring health [and other?] ministries to make public officials' private assets and use transparent; competitive bidding processes; publicizing at community-level health budgets intended for those communities, as well as other intended local health resources, such as number and type of health workers expected to be at health facilities)? Should these only address the health sector, or should the FCGH also include other health-related sectors or sectors that affect health? If so, which?

Grassroots organizations: How can the FCGH strengthen grassroots organizations, including by ensuring that they are able to access international health funds?

Community-based accountability strategies: How can the FCGH support community-based accountability strategies (e.g., community scorecards, village health committees, community health monitors, citizen journalists?)? What are the most effective strategies? Should the FCGH require countries to develop national strategies for supporting community-based accountability mechanisms?

Community-based health accountability capacity building and oversight: What are the national and international roles in building the capacity for and providing oversight to and ensuring effective functioning of community-based health accountability mechanisms? What role (if any) should an FCGH have in this capacity-building and ensuring effective oversight and functioning?

Overall good governance requirements: Should the FCGH address governance reforms required for good governance, in particularly combatting corruption, generally, beyond the health or related sectors (e.g., requiring independent anti-corruption commission or equivalent processes)?

ICT and accountability: Should the FCGH address the role of health information and communications technology for accountability purposes? If so, how?

FCGH compliance

Monitoring FCGH compliance: What are the best strategies to monitor compliance with the FCGH? What are the best existing models? What besides state reporting on compliance? How can and should civil society and communities be involved in monitoring compliance? What

about other independent monitors? Is there any support the FCGH can or should provide to the media in monitoring FCGH compliance? How might information technology be used to ensure honest reporting? What role should WHO or other international (or independent) institutions have in monitoring compliance?

Peer review of compliance: Should peer review be part of the process for monitoring FCGH compliance, and if so, how should this work? As a small compliance incentive, might a country or several countries in a region that have particularly strong compliance be recognized as regional right to health leaders and have the mandate for leading regional peer review process? Should peer review come with designated resources? If so, does the FCGH need to specify, or could these simply come from an FCGH Secretariat budget?

Responsibility for monitoring compliance: Should the FCGH establish its own monitoring institution or structure, as opposed to having an existing institution (e.g., WHO) fulfill this role? How should such a monitoring structure be designed? How can and should civil society and communities be included in formal monitoring structures and processes?

Incentives and accountability for international funding obligations: What incentives, sanctions, and enforcement and accountability mechanisms could the FCGH include to ensure sustainable, predictable international funding, to ensure that states meet their international funding obligations under the FCGH?

Incentives and sanctions for compliance with obligations to own populations: What incentives and sanctions might the FCGH include to encourage countries to keep their funding and other commitments to their own populations?

Compliance and funding eligibility: Should certain global funds, or how they are delivered (e.g., outside government channels), be contingent on governments meeting their own commitments? If so, how can such approaches be designed to avoid harming the very people whom global health funding is supposed to help, who may already be among the most disadvantaged? Or would any conditioning of international funding on domestic compliance only harm countries' populations, such that this should not be part of the FCGH?

Other incentives or sanctions for compliance: What are other incentives or sanctions? Is one possibility worth considering suspension of eligibility for WHO Executive Board membership or of other WHO rights? What about incentives or sanctions that go beyond the health sector (e.g., trade-related sanctions or incentives, or targeted financial or travel sanctions?)? Could sanctions include participation in FCGH governance structures or monitoring processes (e.g., eligibility to be a peer reviewer)?

Compliance mechanisms in international law: What compliance mechanisms can be adapted for the FCGH from other areas of international law (e.g., trade)?

Domestic financing and justification for receiving international funds: Should the FCGH require states to provide justifications for needing international health funding before and after receiving it? (For example, if a state is spending only 1% of GDP on health, then the state would, before

receiving funding, need to give reasons for spending so little and account for what it is planning to spend it on. After receiving funding, the state would have to show whether it was able to meet targets and, if not, why not.)

Required national court jurisdiction for FCGH: To encourage compliance with the FCGH, could and should the treaty encourage or require states parties to grant national courts jurisdiction to hear cases brought by their populations involving FCGH violations? (This would be akin to the obligation in the International Covenant on Civil and Political Rights to an effective remedy, including "that any person claiming such a remedy shall have his right…determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy.")[2]

FCGH implementation strategy: Should the FCGH require countries to develop FCGH implementation strategies, which would include targets, benchmarks, timelines, and indicators? Would the FCGH then include a review process for these strategies? What sort of process? A few review by the FCGH Secretariat? A special multi-stakeholder body that the FCGH could establish for this review process? Some form of peer review by other countries? A process similar to the Joint Assessment of National Health Strategies, where the countries stakeholders involved in developing the national health strategies, along with and individuals and institutions not involved in the planning process (e.g., local consultants, international agencies, regional partners), jointly review national health strategies? Should there also be an ongoing review of progress on implementing these strategies? [Note this question also in the targets, timelines, and indicators section.]

Information and communications technology: Should the FCGH have specific measures related to information and communications technology to promote accountability? What measures, and how should these be incorporated? Are there other ways that recommendations of the Commission on Information and Accountability for Women's and Children's Health and its accountability framework (which included ICT) (http://www.everywomaneverychild.org/images/content/files/accountability_commission/final_report/Final_EN_Web.pdf) could be adapted to use in the FCGH?

[2] International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), art. (2(3)(b) (1966), http://www1.umn.edu/humanrts/instree/b3ccpr.htm.

Ensuring for All Universal Conditions of Good Health

Framing: Should the FCGH use the present three-part framing of the universal conditions of good health? – 1) health systems that provide quality health care; 2) the underlying determinants of health (which have been defined by General Comment 14 of the Committee on Economic, Social and Cultural Rights;[3] these are similar thought not equivalent to standard public health services);[4] and 3) the broader social determinants of health (e.g., gender equality, employment, education)?

Health systems: How should the FCGH define the standards for health systems to which everyone is entitled? Should it include general requirements (e.g., equitable distribution of health facilities, goods, and services; sufficient numbers of skilled and motivated health workers)? Should it include specific benchmarks in each area of the health system?

Health systems and health interventions: Alternatively, should the health system be defined by the nature of health services that it is able to effectively and equitably deliver? If so, what health services? To what degree of specificity should the FCGH define these health services? By category of intervention? To what could the set of interventions that WHO has used in its estimate of the cost of universal health cover serve as a guide? [5] What about national essential health packages or universally covered health services? Are there significant interventions or categories of interventions missing from these? Can existing WHO guidelines or widely endorsed documents (e.g., International Conference on Population and Development Programme of Action) serve as the guide in various areas (e.g., universal access to comprehensive HIV prevention, care, treatment, and support, and what this entails; universal sexual and reproductive health services, and what these include)? What role should participatory processes have, possibly feeding into the development of the FCGH or initiated by it (such as by establishing a process that would, within a given period of time, define these interventions or categories of interventions)?

Health system benchmarks: Are there benchmarks for health systems and their components (i.e., human resources for health, health services; medicines, vaccines, and medical technologies; health financing; health information, and; governance and leadership) that the FCGH should

---

[3] "The Committee interprets the right to health…as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels." Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000), at para. 11, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[4] These include, chiefly, clean drinking water and adequate sanitation, sufficient and nutritious food, vector control, injury prevention, tobacco and alcohol control, and healthy built environment. Others key public health functions, such as immunizations and control of communicable diseases, are closely linked to health care.

[5] Taskforce on Innovative Financing for Health Systems Working Group 1, *Constraints to Scaling up and Costs: Working Group 1 Report* (Geneva and Washington, DC: World Health Organization and World Bank, 2009), at 80-81, http://www.who.int/pmnch/media/membernews/2009/htltf_wg1_report_EN.pdf.

incorporate as standards for all health systems? If so, what should these be? How can these be developed in ways that respond to local circumstances (e.g., 5 km is very different in a city with paved roads, sidewalks, and cheap transportation as compared to over mountainous territory; the number of health worker needed varies considerably depending on skills mix, disease burdens, and so forth, and is only one dimension of access to health workers, who also require proper skills, supervision, tools, and motivation)?

Health workers: Should the FCGH specifically address health workers? If so, how? For example, along with issues of migration, it could address obligations around health worker (and patient) safety, distribution, training, knowledge, and support, among other issues? It could also require that countries have rights-based national health workforce strategies.

Underlying determinants of health: What are the underlying determinants of health and public health services to which everyone should be entitled under the FCGH? How do these compare to those included in General Comment 14 (see footnote 3) and major public health areas (see footnote 4)? Should areas covered by one but not the other (e.g., housing) be included in the FCGH? If the FCGH financing framework covers all underlying determinants of health, should cost be a consideration in what the FCGH includes?

Underlying determinants and standard-setting: Can, or how can, the FCGH set binding standards for the more complex underlying determinants of health, such as healthy environments? Would it include standards covering only certain key areas most directly related to health (e.g., indoor and outdoor air pollution levels of the most harmful pollutants)?

Social determinants of health: What social determinants of health (e.g., education, employment, gender equity) should the FCGH specially address among the universal conditions? [NOTE: Question also in Social Determinants section, which also addresses standard-setting for the social determinants.]

Criteria on universal conditions: Are existing international guidelines (e.g., WHO), rights (including their interpretations through General Comments and General Recommendations), and other recognized criteria sufficient for determining standards of the health systems and underlying determinants of health to which everyone is entitled? Or are supplementary methods needed? If so, what might they be?

Health outcomes and universal conditions: Should certain health outcomes have a role in defining the health systems, underlying determinants of health, and broader positive social determinants of health to which everyone is entitled? For example, a certain level of, or increase in, life expectancy or quality-adjusted life years (QALYs), reductions in disability-adjusted life years (DALYs), or levels of or improvements in health equity (across and within nations)? If so, what, and based on what rationale? Or would the requirements for health outcomes be linked to certain key areas (e.g., AIDS, maternal health, cardiovascular disease), and possibly global commitments or targets in these areas, linked to the actions required to achieve these targets?

Participatory processes and universal conditions: What role should participatory processes have, possibly feeding into the development of the FCGH or initiated by it (such as by establishing a process that would, within a given period of time, define these interventions or categories of

interventions of that all health systems should be able to provide, or standards for underlying determinants of health)?

Cost and universal conditions: What role, if any, should cost and cost-effectiveness have in defining the FCGH standards of health systems, underlying determinants of health, and broader positive social determinants of health to which everyone is entitled? Is there a different answer for each of these areas?

National criteria for specific health care and other conditions of health: Should the FCGH include a minimum set of criteria that states should use in adapting FCGH standards on health systems, underlying determinants of health, and the social determinants of health? If so, what should these factors be (e.g., health needs-based, epidemiological trends and national/global burden of disease considerations, input from population's participation, costs, availability of resources)? Would these criteria be expected to vary from one country to the next? If so, how should the FCGH capture these differences?

National processes and FCGH processes: What processes do countries currently use to establish essential health packages (or services to be covered by national health insurance schemes)? What are the technical, participatory, and political bases for these decisions? Are there good practices that the FCGH should promote? How can these inform the process of adapting FCGH standards nationally? Is more guidance needed beyond General Comment 14 of the Committee on Economic, Social and Cultural Rights? (Under General Comment 14, among states' core right to health obligations is: "To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups."[6])

Process of translation FCGH standards to national level: To the extent that the FCGH incorporates requirements on national participatory processes required to tailor standards on the universal conditions of good health in the FCGH to national laws and policies, what should these processes be? How precisely should the FCGH define this process (or should it be limited to providing broad principles, and if so, which?) while also respecting the need for national ownership? How can they ensure that perspectives of marginalized populations are incorporated?

Multiple levels of standards on universal conditions of good health: Should the FCGH have any additional requirements for wealthier countries – beyond those required of all countries – with respect to ensuring effective health systems, underlying determinants of health, and the broader social determinants of health? Should the FCGH have a tiered approach, obliging countries to elevate the standards of the universal conditions of good health once they achieve a given level (e.g., stricter definition of what everyone is entitled to as an improved water source, increased

[6] Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000), at para. 43(f), http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

level of health services guaranteed to all through health systems, additional progress required on addressing particular social determinants of health)? If so, would the FCGH specify these further tiers? Or might it include only factors to take into account but leave the content of these further tiers largely to states to define themselves? Would this be useful in informing specific obligations to progressively achieve the full realization of the right to health?

National health packages and FCGH standards: To the extent that the FCGH provides for the types of health interventions that health systems must ensure for all, what we learn from countries' existing essential health packages (or universal health benefit packages) inform these interventions?

Non-health sector obstacles to health access: How should the FCGH address non-health sector obstacles to access to health services, such as transportation costs and child care and other family responsibilities?

Information for health workers: How should the FCGH address the health information needs of health workers? Should it, for example, establish or reference existing (which?) standards related to health worker knowledge? Should it set benchmarks of health worker knowledge, such as proportion of health workers who adhere to protocols in key health areas? Should the FCGH include or foster standards related to health worker education (pre-service? in-service? both?)?

Health literacy: How should the FCGH address health information requirements of the general population? Should the FCGH encourage or require community health literacy strategies as part of national health strategies? Should it establish benchmarks for such strategies? How else might the FCGH promote health literacy?

Global Governance for Health

(i.e., questions involving the connections between health and other regimes)

Economic policy constraints: How (and how much) do macroeconomic (or other economic, e.g., trade regime) policies constrain national health spending, or otherwise impede health, in developing countries? In practice, what control do developing countries (and other countries seeking support from international financing institutions) themselves (as opposed to international financial institutions) have over these policies? Are there specific changes needed in international financial institution practices that would enable countries to increase health and health-enhancing spending? If so, what, and should the FCGH respond to the need for these changes? Similarly, outside of international financial institutions, such as in the area of trade, are there rules or policies that impede on health and health-enhancing government spending? How should these be changed, and what is the role of the FCGH in these changes? [NOTE: Question also in the funding section.]

Multi-sector and stakeholder collaboration: What is the role of an FCGH in encouraging collaboration within countries among different sectors (e.g., health, education, finance, agriculture, etc.) and stakeholders (e.g., government, civil society, communities, etc.)? How might it do so?

Elevating status of health and right to health in other international regimes: How should the FCGH elevate health in international legal regimes outside the health sector, particularly ones that can come into conflict with health? How can international law best be shaped through the FCGH to elevate health? What exactly should state responsibilities be in these other regimes? To respect and protect the right to health? What about more affirmative obligations with respect to fulfilling the right to health?

Specific ways to address health and other international regimes: Are these other international regimes (e.g., trade, intellectual property, agriculture) that the FCGH should specifically address? Which ones? Should the FCGH include specific requirements in these areas? If so, which areas, and what requirements (e.g., informing adaptation measures that will reduce the health impact of climate change, ensuring that intellectual property agreements and laws do not interfere with public health [such as agreement on ensuring TRIPS/Doha Declaration flexibilities in bilateral and regional agreements?], and regulating “land grabs” [the large-scale foreign purchase of land in developing countries, which can threaten food security])? Would FCGH protocols likely address more detailed requirements in these areas?

Respecting right to health abroad: Should the FCGH specify responsibilities countries have to prevent other transnational activities from harming health abroad, such as international health worker recruitment, transnational pollution, and the impact of climate change? What are existing responsibilities in these areas (e.g., the Global Code of Practice on the International Recruitment of Health Personnel), what could the FCGH add to them? To what degree of precision should the FCGH prescribe ways in specific areas for states to prevent harming the right to health in other countries?

Global Health Governance

(i.e., questions addressing health-related institutions and structures)

Relationship between FCGH and other international health law: How, if at all, should the FCGH relate to existing binding global health law (the International Health Regulations, the Framework Convention on Tobacco Control)? Should it apply any of its compliance and enforcement mechanisms to these other legal instruments? And how should the FCGH relate to non-binding global health law (e.g., codes of practice, World Health Assembly resolutions, WHO global strategies). Should the FCGH incorporate key elements of these? If so, which? Should the FCGH incorporate any of these indirectly, such as having WHO strategies in particular health areas form the standards for aspects of the universal conditions of good health to which everyone would be entitled under the FCGH?

Regional health responsibilities: Should the FCGH include any regional health responsibilities? What regional responsibilities and mechanisms can enhance regional health solidarity for reducing inequities within regions?

World Health Organization: What is needed for WHO to achieve its constitutional role as the coordinating authority on international health work? What role should the FCGH have in supporting WHO, including with respect to ensuring it sufficient and flexible funds?

Global health coordination: What are the main obstacles to global health coordination? What are the most effective ways to improve global health coordination, cooperation, and collaboration, and how could these be incorporated into the FCGH?

Innovation: What are new and emerging mechanisms and models through which the FCGH could address innovation, access to medical products, access to knowledge and information, and other ways of improving health?

Joint Assessments of National Strategies: What role might the Joint Assessment of National Strategies (JANS) or comparable process have in future global health governance structures?

States in conflict or upheaval: How, if at all, should the FCGH address special needs to best ensure essential health services and other conditions required for good health for people who live in conflict areas over which the state lacks authority, as well as in post-conflict states? What about states experiencing other political, social, or economic upheaval that disrupts health and social systems?

NGO regulations: Should the FCGH include responsibilities or guidelines for NGOs, particularly international NGOs, such as on transparency (e.g., of overhead costs, how they are using their money, how many local compared to international staff they employ)? Should it have a mechanism for coordinating NGOs in response to natural disasters and humanitarian crises to reduce competition for funds (and thus improve efficiency)? If so, would these responsibilities come in the form of state regulation of their NGOs? What dangers would that create of using the

FCGH to suppress NGOs that are critical of the government?

Transnational corporations and other transnational non-state actors: How could the FCGH exert control over transnational corporations (and other transnational non-state actors)? Upon which states should the obligations to regulate these corporations fall (e.g., where corporation is incorporated?)? What regulatory mechanisms should states employ? [Note question also in the right to health section.]

Obligations of non-state actors: Should the FCGH create direct obligations on corporations (and other non-state actors), as opposed only through states as the intermediaries, with requirements to regulate non-state actors? If so, how would the FCGH create these direct obligations, particularly assuming that non-state actors are not direct parties to the FCGH? [Note question also in the right to health section.]

Equity

Domestic health equity principles: Should the FCGH include principles related to domestic health equity? If so, what should they be?

Domestic health equity strategies: Should the FCGH require that countries develop national health equity strategies? If so, what guidance should it provide? Should the FCGH specify that these strategies should address the particular circumstances and needs of each identified marginalized or vulnerable population?

Domestic health equity targets: Should the FCGH include targets on domestic health equity? If so, what should the targets be? Should they address health system inputs (e.g., distribution of health workers, marginalized populations with access to sanitation), outputs (e.g., health services delivery and marginalized populations), and outcomes (improved health of marginalized populations)? To what degree should there be globally agreed deadlines, and to what degree should these be determined nationally?

Right to health for marginalized populations: What special measures should governments take to ensure the right to health of marginalized and vulnerable populations, and how should the FCGH incorporate these measures?

Defining marginalized populations: As part of its requirements on addressing marginalized populations, such as through a national strategy and specific measures the FCGH may require, to what degree should the FCGH specify marginalized populations, and to what degree should this be left for countries to determine? Should the FCGH include a minimum set of populations to be considered with respect to any treaty stipulations on marginalized populations, and if so, which groups? What are such groups presently included in international instruments (e.g., General Comment 14, international declarations on HIV/AIDS)? Should the FCGH establish or provide guidelines for a national process to identify these groups? Or should the FCGH simply refer to such groups in broad terms (e.g., disadvantaged, marginalized, and vulnerable populations), without further specification? Does this last approach pose the risk that certain marginalized or

disfavored groups would be left out from national definitions and measures to support (and reduce discrimination against and other mistreatment of) these populations?

Non-health discriminatory laws and policies: Should the FCGH address discrimination against marginalized populations that affects health but is rooted in laws and practices outside the health sector (e.g., criminalization of homosexual acts)?

Equitable distribution of health facilities, goods, and services: What measures should the FCGH include to achieve the equitable distribution of health facilities, goods, and services, including the equitable distribution of health workers? Should the FCGH require that this goal should be part of national health strategies and plans of action?

Global equity in vaccine and medicine distribution: Should the FCGH address equitable distribution of vaccines and medicines in the face of public health emergencies? If so, how should it build upon existing global health law in this area, namely the Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits?[7]

Social Determinants of Health

Social determinants and universal conditions of good health: What positive social determinants of health (e.g., education, employment, gender equity) should the FCGH specially address among the universal conditions to be ensured for all people? [NOTE: Question also in the section on Ensuring for All Universal Conditions of Good Health.]

Standards and social determinants: How should the FCGH address guarantees for the social determinants of health? Should it set certain standards for each social determinant included, or measures that states should or are required to take to address them? If so, what should the standards or measures be for each social determinants of health that the FCGH includes (e.g., education, stress, employment, violence against women and degree of women's empowerment, social status)?

Comprehensive public health strategies: Should the FCGH require comprehensive public health strategies that address these social determinants? Would these replace or supplement standards for a defined set of social determinants?

Health in All Policies (Domestic) and right to health assessments: What measures could the FCGH include to ensure that policy-making in non-health spheres duly accounts for and does not negatively impact on the right to health and state obligations under the right? What might be the

[7] Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits, World Health Assembly A64/8 (May 5, 2011), http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_8-en.pdf.

role of health (or right to health) assessments, and what would trigger a requirement for such an assessment? Should such assessments include not only initial but also periodic/ongoing assessments of certain non-health sector interventions? How prescriptive should be the FCGH be in terms of how the state uses the result of that assessment (e.g., prohibiting any activities that would negatively impact the right to health? – what impact would that have for climate change?)?

Capacity Building

Health capacity building: How should the FCGH promote capacity building for health workers, civil society organizations, media, government officials and institutions, universities, and others working on health? What are international responsibilities on health-related capacity building that the FCGH should include? Should it include any stipulations related to using and supporting local sources of technical support? Should the FCGH include any funding-related provisions on (e.g., encouraging) capacity building (e.g., professional education, research capacity, leadership)? If the FCGH addresses responsibilities for building national capacity, how should it do so, and in what areas? Should the FCGH outline broad areas of capacity building that should be included in national health strategies?

Non-health sectors: How should the FCGH promote health capacity building outside the health sector, to facilitate a Health in All Policies approach, policy coherence for health, and increased support throughout government on health priorities, including for funding?

Right to health capacity fund: Should the FCGH develop a special right to health capacity building funding channel? If so, what should it cover (e.g., right to health education of the population and authorities, national right to health infrastructure such as units within health ministries, right to health ombudspeople and commissions, community and civil society organizations addressing the right to health, local health accountabilities mechanisms)? Should it include funding for both non-state actors (civil society, media, academic institutions) and governments? Should institutions in high-income countries (only non-state institutions, or governments as well?) be eligible? How should such a funding channel be structured and funded? Should it be an independent fund? Or should the funding channel(s) be incorporated into or otherwise linked to other health (or human rights) funding streams? Should the capacity fund's funding be encompassed within the overall funding framework of the FCGH? How should the funding channel(s) relate to or be incorporated into other health (or human rights) funding streams? [Note question also in the right to health section.]

Population-Specific

Women: What specific provisions should the FCGH include to improve the health of women and girls? What strategies can the FCGH draw upon from existing national efforts in this regard? What about from international strategies (e.g., the Global Fund's Gender Equality Strategy, http://www.theglobalfund.org/documents/core/strategies/Core_GenderEquality_Strategy_en/; the U.S. Global Health Initiative Supplemental Guidance on Women, Girls, and Gender Equality

Principle, http://www.ghi.gov/documents/organization/162100.pdf; WHO's report on women's health (http://www.who.int/gender/documents/9789241563857/en/index.html, and; CEDAW General Recommendation 24, http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24)?

Violence against women: Should the FCGH address violence against women and gender-based violence more generally? If so, how?

Non-citizens (migrants): Are special FCGH provisions required to address non-citizens including refugees, internally displaced people, stateless people, non-citizen permanent residents, non-citizen temporary residents (including migratory/foreign workers), and undocumented immigrants? If so, what provisions?

People with disabilities: Are special FCGH provisions required to address mental health and the rights and needs of people with physical and mental disabilities? Should the FCGH specifically require that national health strategies address physical and mental disabilities, and measures to increase access of people with disabilities to health services? Are there areas in the Convention on the Rights of Persons with Disabilities (http://www.un.org/disabilities/convention/conventionfull.shtml) that the FCGH should build upon? What about WHO's Comprehensive Mental Health Action Plan 2013-2013 (http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf)?

Other marginalized populations: Are there other populations not described here for whom the FCGH should include special measures to protect or otherwise meet their needs? If so, what populations, and what measures?

Disease-Specific

(i.e., how, if at all, should the FCGH include provisions pertaining to specific diseases, categories of disease, or health conditions)

NCD-related regulation: Should the FCGH regulate food production and processing, beverages, or other factors that affect non-communicable diseases (NCDs)? How? Are there elements of the Political Declaration on NCDs (http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1) or subsequent Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 (http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R10-en.pdf) that the FCGH should incorporate or build upon?

Antibiotic resistance: Should the FCGH address antibiotic resistance, given the growing harm and global dimensions of this challenge? If so, how? Research and development of new antibiotics? Measures to improve the rational use of and compliance with antibiotic prescriptions? The use of antibiotics in livestock?

Health Lessons

IHP+: What has been the experience of IHP+ of trying to improve coordination and country-led approaches? What can be learned of its successes and shortcomings in terms of how an FCGH could improve coordination and support country-led approaches?

Universal health coverage: What developing countries are most effectively providing universal health coverage and what lessons can be learned from their experiences? Are there certain features of universal health coverage strategies and systems, in particularly to ensure that movement towards universal health coverage is consistent with and prioritizes health equity, that are critical to securing universal health coverage that might factor in some way into the FCGH?

Health equity: What have been the most successful strategies in improving health equity domestically, across income groups and for marginalized populations? How can the FCGH learn from these experiences?

Domestic health budgeting: What factors have led some countries to achieve the Abuja target of countries spending at least 15% of their government budgets on the health sector? How might the FCGH facilitate these factors?

International health budgeting: What factors have enabled countries that consistently provide high levels of international health assistance to maintain such investments? How might the FCGH facilitate these factors?

Ministerial Leadership Initiative: What lessons do the Ministerial Leadership Initiative (http://www.ministerial-leadership.org/), which strengthened government ability to develop health systems that are more capable of delivering on the right to health, hold for an FCGH?

Targets, Timelines, and Indicators

Target areas: What areas covered by the FCGH require targets? For example, along with funding, targets areas might cover gains in health equity, improvements in health indicators, coverage of health care and the underlying determinants of health, and progress along the various right to health elements included in the FCGH.

Targets and timeframes: In areas for which the FCGH sets targets, what should the targets be? What about benchmarks and timeframes for achieving them? What are appropriate indicators? Would the FCGH itself include indicators, or charge WHO, the FCGH Secretariat, or another institution with developing indicators?

Process for developing targets and timeframes: Should targets be defined in the FCGH itself or in protocols, or some of each? What is the appropriate level of specificity for these targets and timelines at the international level? Should the FCGH outline target areas, and possibly general

guidance on targets and timelines, with these being further developed at regional or national level? Should the FCGH outline these processes (e.g., inclusive, participatory), and if so, and to what level of detail? Should the FCGH include a mix of specific global, regional and national targets?

Target dates: How should target dates (e.g., achieving a certain requirement under the FCGH within a given number of years after ratification) be structured? What is the proper balance between creating global-level accountability and standards, with specific target dates for progress incorporated directly into the FCGH, compared to tailoring timing to country differences by having timelines determined primarily at the national level? Should the FCGH itself establish target dates, but with a recognized process for countries justifying later target dates (or holding itself to more ambitious timeframes)? Should the FCGH include a common set of timeframes for different groups of countries (based, e.g., on income or current levels of achievement in target areas) to achieve various targets, or should it aim to catalyze ambitious yet achievable timelines that differ for each country, developed nationally through participatory processes, with the FCGH providing guidance including areas that target dates should cover? Should the FCGH incorporate a process to revise timelines based on the level of progress, or would that undermine accountability?

Historical bests as target timeframes: Should targets be based on the fastest that countries have historically scaled up certain health services, or universal health coverage more generally? What are the best achievements in this respect? Would there be a way to adjust such best achievements for factors that will affect pace of achievement (e.g., current nature of health workforce, geography affecting the number and proportion of the population living in hard-to-reach areas)? Should historical bests set the default targets in the FCGH, with states required to report on whether these will be their national targets, or if they will vary from these targets, explaining and justifying these variations, with the variations developed through and affirmed in inclusive national processes?

Timelines and funding: Should the FCGH include timelines for achieving funding targets, or pace of required scale-up?

FCGH implementation strategy: Should the FCGH require countries to develop FCGH implementation strategies, which would include targets, benchmarks, timelines, and indicators? Would the FCGH then include a review process for these strategies? What sort of process? A few review by the FCGH Secretariat? A special multi-stakeholder body that the FCGH could establish for this review process? Some form of peer review by other countries? A process similar to the Joint Assessment of National Health Strategies, where the countries stakeholders involved in developing the national health strategies, along with and individuals and institutions not involved in the planning process (e.g., local consultants, international agencies, regional partners), jointly review national health strategies? Should there also be an ongoing review of progress on implementing these strategies? [Note this question also in the accountability and compliance section.]

Scope of the FCGH

Roads: Should an FCGH address factors outside health and related sectors that nonetheless significantly impact health (such as infrastructure, e.g., rural roads)? If so, how?

Research: What role does the FCGH have in addressing health research and development (R&D)? Should it include as a protocol the treaty envisioned by the Consultative Expert Working Group on Research and Development (http://www.who.int/entity/phi/CEWG_Report_5_April_2012.pdf)? Should the FCGH address medical research outside of any protocol (e.g., commitments on research and development for unmet need, particularly among poorer populations; coordination and information sharing; establishing a process to address situations where market incentives are insufficient to incentivize R&D for unmet health needs)? Should the FCGH address R&D critical to health but outside the health sector, such as genetically modifying crops to improve their nutritional value? How should the FCGH address health systems and operational research, including ways to improve access and accountability?

Implications of increasing clarity on the right to health: How should the FCGH approach questions/issues implicating ESCR generally, such as explanations of overall elements of the right to health (e.g., maximum available resources): in a health-specific way, or cutting across all ESCR (or even all human rights)?

Traditional medicine: Should the FCGH address traditional/alternative medicines? If so, how?

Additional areas: Are there additional issues not adequately covered above that the FCGH should address. If so, how?

Regional Perspectives

Regional priorities: What are health priorities in different regions of the world, and how can the FCGH best meet these priorities? Are there any region-specific health issues that the FCGH should address? Are any of these priorities or issues missing from the Framework for an FCGH (http://www.jalihealth.org/documents/Framework.pdf)?

Regional organizations: How should the FCGH incorporate regional and sub-regional organizations (e.g., PAHO and other WHO regions, the African Union, the East, Central and Southern Africa Health Community [ECSA])? Should they have a role in monitoring and evaluation, or other forms of compliance? In coordinating target-setting or standards on the universal conditions required for good health? In helping to periodically update these standards? Should the FCGH include a provision on educating regional and sub-regional human rights and other relevant mechanisms (e.g., courts and commissions) on the standards of and obligations under the FCGH?

II. Process of Developing the FCGH

Process of Developing and Structure of the FCGH

Forum for FCGH: What is the best forum for an FCGH? WHO? The UN General Assembly? The UN Human Rights Council? A separate process (as for the treaty banning landmines)? What are the advantages and disadvantages of each?

Non-binding predecessor: Should we aim for a non-binding version of an FCGH before the treaty? Why or why not?

FCGH Advocacy and Social Movements

Politically effective arguments: What are the most politically effective arguments (for different countries) for why wealthier countries should accept their responsibilities with respect to global health, including through increased and longer term health assistance? What are the most effective arguments to convince less wealthy countries support the FCGH?

Lessons from AIDS movement: What lessons and knowledge can be gained from the AIDS movements and its success?

Lessons from global health movements: Why have previous efforts to mobilize a global health movement not been more successful? Where there mistakes towards the effort to achieve a research and development treaty to learn from and avoid? What are lessons from other successful health movements, such as for the Framework Convention on Tobacco Control?

Post-MDG agenda: What are JALI opportunities for engaging the post-MDG agenda, both to influence the post-MDG agenda itself and to more directly advance the FCGH (e.g., through explicit recognition as part of post-2015 agenda, or high-levels calls for the FCGH as part of the post-2015 process)?

Political mapping of FCGH supporters and opponents: Who are the actors (e.g., within the UN system, among governments) that will oppose an FCGH, that could be persuaded to support it, and that will be champions? What is the position of different states? How to mobilize those actors that do not yet support an FCGH, and change the positions of those opposed? What are ministers' and diplomats' true positions (what they say at home versus what they say around the negotiating table)?

FCGH champions: FCGH champions could be states, ex-leaders, famous people, and civil society leaders. What would empower those that support an FCGH to be even greater champions?

Key opportunities and movements: What are the processes and actors – political opportunities, social movements to involve, key events, allies, key people – that FCGH supporters should engage to build broad support for an FCGH?

Evidence for Assertions in FCGH Documents

Evidence: What assertions in FCGH material (e.g., the Manifesto) require research to back them up? What is the evidence?