

The role of Health professionals in monitoring and implementing the Right to Health in Low- and Middle- Income countries

Maria Fix

Germany

Master of Science in International Health

2023

KIT (Royale Tropical Institute) Amsterdam

VU (Vrije Universiteit) Amsterdam

The role of Health professionals in monitoring and implementing the Right to Health in Low- and Middle-Income countries

A thesis submitted in partial fulfilment of the requirement for the degree of
Master of Science in International Health


by

Maria Fix

Declaration:

Where other people's work has been used (from either a printed or virtual source, or any other source), this has been carefully acknowledged and referenced in accordance with academic requirements.

The thesis "The role of Health of Health professionals in monitoring and implementing the Right to Health in Low- and Middle- Income countries" is my own work.

Signature:..........

Master of Science in International Health (MIH)

12 September 2022 – 1 September 2023

KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

September 2023

Organised by:

KIT (Royal Tropical Institute)

Amsterdam, The Netherlands

In cooperation with:

Vrije Universiteit Amsterdam (VU)

Amsterdam, The Netherlands

Table of contents

Table of contents	i
I. Figures and tables	iii
II. Abbreviations	iii
III. Glossary	iv
IV. Acknowledgments	vi
V. Abstract	vi
VI. Introduction	vii
1. Background	1
1.1. Low-and Middle-Income Countries	1
1.2. The Universal Declaration of Human Rights	2
1.3. International Covenant on Economic, Social and Cultural Rights	2
1.4. General Comment No 14	3
1.5. The role of health professionals	3
1.6. Toolkits	4
2. Problem statement, justification, and study objectives	4
2.1. Problem statement	4
2.2. Justification	5
2.3. Study objectives	6
3. Methodology	6
3.1. Literature Review	6
3.1.1. Search method	6
3.1.2. Inclusion criteria	6
3.1.3. Exclusion criteria	7
3.2. Qualitative data collection	7
3.2.1. Study design	7
3.2.2. Study area and target population	7
3.2.3. Sampling and recruitment	8
3.2.4. Data process and analysis	8
3.3. Analytical framework	8
3.4. Ethical considerations and informed consent	10
3.5. Limitations	10
4. Results	10
4.1. What is the Right to Health or the enjoyment of the highest attainable standard of physical and mental health for health professionals?	11
4.2. The role as a professional	12
4.2.1. Results from Literature	12
4.2.2. Results from qualitative data collection	12
4.3. The as a scholar	13
4.3.1. Results from literature	13
4.3.2. Results from qualitative data collection	14
4.4. The role as a health advocate	14
4.4.1. Results from literature	14
4.4.2. Results from qualitative data collection	15

4.5.	The role as a leader-----	15
4.5.1.	Results from literature-----	15
4.5.2.	Results from qualitative data collection-----	16
4.6.	The role as a collaborator-----	17
4.6.1.	Results from literature-----	17
4.6.2.	Results from qualitative data collection-----	17
4.7.	The role as a communicator-----	18
4.7.1.	Results from literature-----	18
4.7.2.	Results from qualitative data collection-----	18
4.8.	Advantages, facilitating aspects, and barriers for the implementation of a toolkit-----	18
4.8.1.	Advantages for the implementation of a toolkit-----	18
4.8.2.	Facilitating aspects for the implementation of a toolkit-----	19
4.8.3.	Personal barriers-----	20
4.8.4.	Structural barriers-----	21
5.	Discussion-----	22
5.1.	Relevance of the analytical framework-----	24
5.2.	Limitations-----	24
6.	Recommendations-----	25
6.1.	Recommendations for medical education institutes-----	25
6.2.	Recommendations for health facilities and health management-----	25
6.3.	Recommendations for research-----	25
6.4.	Recommendations for IFHHRO-----	25
6.5.	Recommendations for health profession associations-----	25
7.	Conclusion-----	25
	References-----	26
	Annexes-----	32
	Annex 1: Human Rights instruments and monitoring mechanisms-----	32
	Annex 2: List of indicators from ICESCR-----	32
	Annex 3: Interview guide for health professionals-----	33
	Annex 4: Interview guide for key informants-----	34
	Annex 5: Key concepts of the CanMEDs framework-----	35
	Annex 6: Informed consent form key informants-----	38
	Annex 7: Informed consent form health professionals-----	40

I. Figures and tables

Figures

Figure 1: World Bank country classification by income level and regions

Figure 2: The elements of the Right to Health (General Comment No 14)

Figure 3: CanMEDs 2015 Physician competency framework

Tables

Table 1: World Bank classification by GNI per capita

Table 2: Key words and search strategies for literature review

Table 3: Origin of interview participants and key informants

Table 4: CanMEDs framework roles briefly explained

II. Abbreviations

AAAQ	Accessibility, Availability, Acceptability and Quality
ANC	Antenatal care
GDP	Gross domestic product
HIC	High Income country
HIV	Human immunodeficiency virus
HRBA	Human Rights Based Approach
ICESCR	International Covenant of Economic, Social and Cultural Rights
ICN	International Nursing Council
IFHHRO	International Federation of Health and Human Rights Organisations (now called the Medical Human Rights Network)
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and other identities
LMIC	Low- and Middle-Income country
NCD	Non-communicable diseases
NGO	Non-governmental organization
PNC	Postnatal care
SDG	Sustainable development goal
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNIAIDS	Joint United Nations Programme on HIV/ AIDS
WHO	World Health Organization
WMA	World Medical Association

III. Glossary

Duty-bearer: Duty-bearers are entities or individuals having a particular obligation to respect, promote, and realize Human Rights and to abstain from Human Rights violation (1).

Health outcomes: Health outcomes are changes in the health status of the patient. The health outcomes mentioned in this thesis are:

- **Maternal mortality:** “Deaths related to or aggravated by pregnancy or its management during pregnancy and childbirth or within 42 days of termination of pregnancy.”(2)
- **Neonatal mortality:** Deaths of newborns within their first month after birth. (3)
- **HIV:** “Human Immunodeficiency Virus is a virus that attacks the body’s immune system”. It is a communicable disease that is not curable, without treatment it leads to acquired immunodeficiency syndrome (AIDS).(4)
- **Tuberculosis:** Tuberculosis is a communicable disease, that is curable. It affects mostly the lungs and is caused by mycobacteria (5).
- **Communicable diseases:** Communicable diseases is another expression of infectious diseases, which means transmission is possible from human to human.
- **Non-communicable diseases:** “non-communicable diseases are also known as chronic diseases, tend to be of long duration and are the result of a combination of genetic, physiological, environmental and behavioural factors.” They are not transmissible from human to human. (6)

Health professional: As health professionals defined, are all medical and paramedical professions directly involved in health services. In this thesis, the focus will be on health professionals involved in clinical work, such as physicians, nurses, midwives, clinical officers.

Human-Rights Based Approach (HRBA): The HRBA is a concept that is based on international Human Rights law to analyse inequalities in human development (7). It is applied through principles formed by civil and political, as well as economic, social, and cultural rights. Through the HRBA should the right-holder be empowered to claim their rights and to build up the duty-bearers capacity to their obligation to respect, promote, protect, and fulfil Human Rights. The HRBA has a strong focus on accountability towards authorities, including their responsibilities for developing policies and programmes in health care, but also beyond, like improving the access to safe water and sanitation, as part of the underlying determinants of health (8,9). The five principles are:

- **Legality:** “Rights should be legally enforceable.” (10) “Approaches should be in line with the legal rights set out in domestic and international law.” (1)
- **Empowerment:** Right-holders, individuals and communities, need to be informed about their rights, understand them, and be supported in claiming them. (1,10)
- **Equality and non-discrimination:** “All individuals are entitled to their rights without discrimination of any kind. All types of discrimination should be prohibited, prevented and eliminated.” (1)
- **Participation:** “everyone is entitled to active participation in decision-making processes which affect the enjoyment of their rights.” (1)
- **Accountability:** “Duty-bearers are held accountable for failing to fulfil their obligations towards rights-holder.” (1)

Litigation: The process of taking legal action.

Medical Ethics: Medical ethics or bioethics is based on four principles – autonomy, beneficence, non-maleficence, and justice.

- Autonomy is principle of self-governance, which covers, that patients have the freedom of their own choice and consent, it also covers confidential treatment of information about the patient by the health professional and the right to privacy (11).
- Beneficence describes a moral obligation of the health professional to act for the benefit for their patients, it often relates to humanity and kindness, as well as mercy. It also describes an obligation to prevent patients from further harm and to remove anything that causes harm(12).
- The non-maleficence principle stands in short for 'do no harm'. It means that health professionals should never actively use treatment or participate in anything that could cause harm to the patients(13).
- The fourth principle is called justice and obliges health professionals to not make any distinction whether a patient "deserves" care or medical treatment. It refers to fair and equal distribution of services(14).

Patient Rights: Patient Rights are guarantees or entitlements for those receiving health care in health facilities. It often includes the right to information, autonomy and participation in decision-making, free choice and the right to consent (15).

Ratification: The action of signing or giving formal consent to a treaty, contract, or agreement, making it officially valid.

Right-holder: Right-holders are individuals or social groups that have particular entitlements in relation to specific duty-bearers. In general terms, all human beings are right holders under the Universal Declaration of Human Rights (1). (reference)

Universal Health Coverage (UHC): The UHC is defined by WHO as "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship" (16). Many LMICs do not have a health insurance system, as it exists in many High-Income countries, that supports their citizens in case they need medical support. Many people in LMIC have to pay any kind of health services out of their pockets, which leaves them often with selling their little belongings they have, borrow money from relatives or foreigners and use their life savings (16). UHC is a concept that countries use to make sure, that all citizens can afford the health services they need. To monitor UHC two indicators are used (17). One is the coverage of essential health services, Somalia has according to data from WHO the lowest coverage with only 26% of people having access to essential health services (18). The other indicator is measured by the "Proportion of population with large household expenditures on health as a share of total household expenditure or income" (17).

IV. Acknowledgments

I would like to thank my thesis and academic advisor for their support during my whole thesis process. From the beginning you supported me and helped me getting through the challenges I faced on the way.

Thanks to all the interview participants, I really appreciate you took your time answering my questions and that you were so open and made me realize my thesis.

Another big thanks to my friends and fellow students from KIT, listening and motivating me especially at the end of my thesis writing, brought me through the process.

I also thank IFHHRO, for their feedback and helping me find interview participants.

V. Abstract

Background: The Right to Health is defined through the elements of availability, accessibility, acceptability, and good quality of health services as well as the underlying determinants of health. To operationalize the Right to Health, health professionals play a crucial role in promoting and protecting it. As frontline workers, they often are the first ones witnessing violations to the Right to Health. Various toolkits have been used in health care to effectively assess gaps and support improvement plans.

Objective: To explore the role of health professionals in monitoring and implementing the Right to Health and whether a toolkit would be a supportive assessment and implementation instrument for health professionals to monitor and implement the Right to Health.

Methods: A literature review complemented with qualitative data collection among health professionals from Low-and-Middle-income countries and key informants was done using the CanMEDs framework, describing different roles.

Results: Health professionals do not understand the Right to Health well. Though, without understanding it, they actively participate in monitoring and implementing elements of the Right to Health through different roles and responsibilities. There are advantages and disadvantages for a toolkit to be used a supporting mechanism for health professionals.

Recommendations and conclusion: Health professionals need to be more educated in the Right to health to participate in realization the Right to Health. A toolkit, adapted to setting and culture can be an option to support health professionals in monitoring and implementing the Right to Health, but barriers like human commitment can decrease the reliability.

Key Words: Health professional; Right to Health; Human Rights; Monitoring; Implementation; toolkit

Word count: 12,752

VI. Introduction

As a nurse who worked in Germany, I recognised that people were treated very differently depending on where they came from and who they are. I observed discrimination, failing acceptability, constrained access to medication or not informing patients about their health status or respecting patients' decisions. When I started working mostly in humanitarian settings five years ago, I experienced that people were refused to medical treatment by authorities and in other cases medical services were simply not available. My experience on Lesbos, Greece in particular, increased my interest in learning more about Human Rights related to Health, as they were not covered in my nursing education. I became a Human Rights advocate, fighting for the rights of patients with governmental institutions, so my patients, refugees, were able to access medical services.

To understand how global health works and to find solutions for these global injustices, I decided to apply for the master's program in International Health at KIT. At a symposium I was approached by someone working with IFHHRO and they were looking for someone who would be interested in writing their master thesis connected to research that they were working on regarding a monitoring and implementation toolkit for the Right to Health used by health professionals, I thought that is my topic. I am a very passionate nurse, and I would argue that nurses and other health professionals could influence health outcomes significantly more, if they had more responsibilities surrounding the Right to Health. But my personal experience made me realize that only very few health professionals really understand that there is a Right to Health or what it means. This made me decide I want to find out whether this is really the case and how different health professionals actually interpret not only the Right to Health but also how they see their own role. The idea that there could be a toolkit that health professionals could use to monitor and implement the Right to Health motivated to be part of it.

1. Background

Financial availability, physical accessibility to health services, availability of trained health professionals and equipped health facilities, quality of health services or accessibility without discrimination or just the availability of information – all these factors have the potential to change health outcomes in Low- and Middle-Income Countries (LMICs). Besides factors in the health system, many other factors influence health outcomes, including access to healthy and affordable food and access to safe water and sanitation. Health outcomes that are influenced by these factors such as maternal or neonatal deaths or HIV or Tuberculosis (TB) transmission and infections, but also premature deaths because of non-communicable diseases (NCDs). In the United Nations (UN) Sustainable Development Goal Agenda for 2030 many of the factors influencing health outcomes are included in goals and targets (19). However, they are also elements of the Right to Health or the Right to the enjoyment of the highest attainable standard of physical and mental health (20). In this chapter, I will outline the concept of the Right to Health in LMICs.

1.1. Low-and Middle-Income Countries

LMICs are defined by their income level through the World Bank (21). The gross national income (GNI) per capita classifies whether a country is defined as a Low-Income country, Lower-Middle Income country, Upper-Middle Income country or High-Income country (HIC). As illustrated in table 1, a Low-income country is defined with a GNI per capita of less than US\$ 1,085 (21). This thesis will focus on countries classified as Lower-and Middle-Income countries. Figure 1 gives a global overview of the classifications.

GROUP	GNI PER CAPITA IN US\$ (UPDATED 2022)
LOW INCOME	< 1,085
LOWER-MIDDLE INCOME	1,086- 4,255
UPPER-MIDDLE INCOME	4,256- 13,205
HIGH INCOME	>13,205

Table 1: World Bank classification by GNI per capita (21).

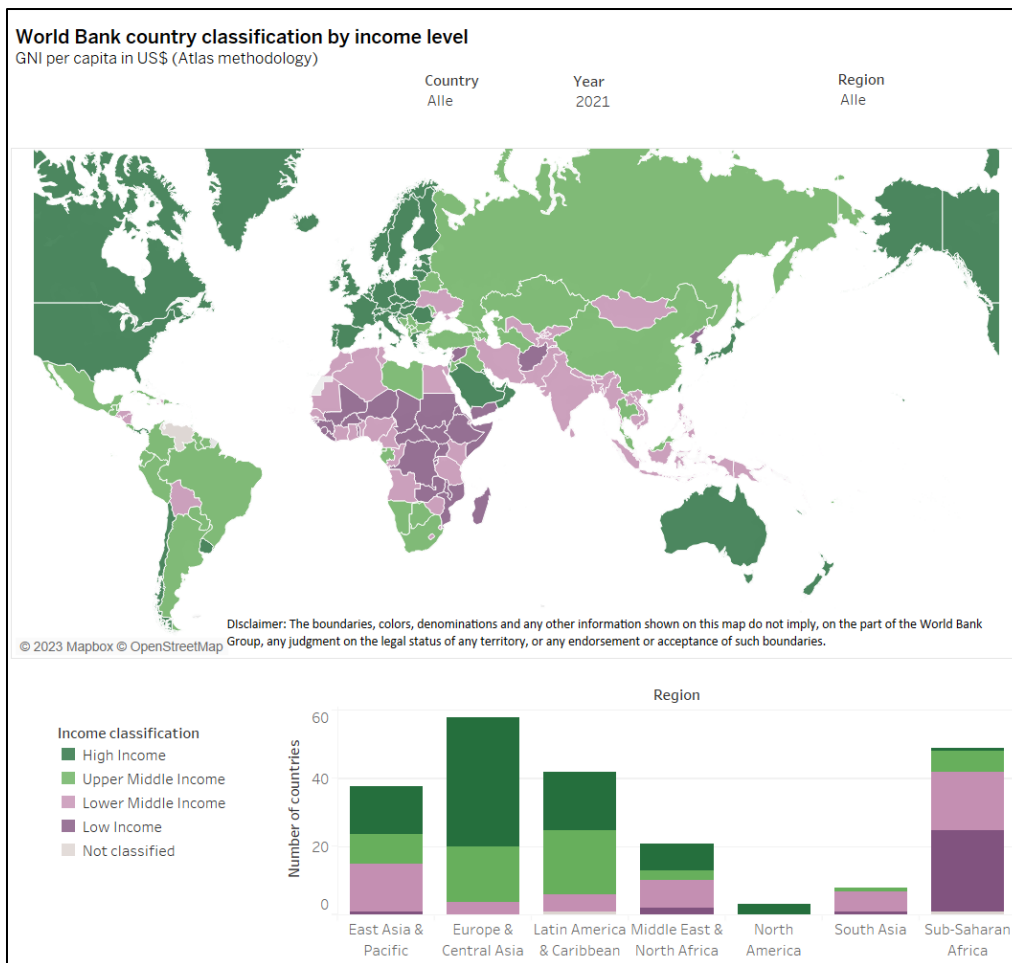


Figure 1: World Bank country classification by income level and regions (21).

1.2. The Universal Declaration of Human Rights

The Right to Health was first mentioned in the Universal declaration of Human Rights (UDHR) in 1948 by the UN. The UDHR was established to enhance a global commitment that the inhumane practices that occurred during World War II could never be allowed to happen again and to protect all peoples and all nations and their fundamental Rights (22). Many articles in the declaration are indirectly connected with Health, like Article 3, the Right to Life. But article 25 describes that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family”(23). In the same year the World Health Organization (WHO) was established and phrased in their preamble “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”(24).

1.3. International Covenant on Economic, Social and Cultural Rights

These words were also used in 1966 when the Human Rights treaty International Covenant on Economic, Social and Cultural Rights (ICESCR) was founded by the UN General Assembly. This treaty defined all Human Rights more detailed, including the Right to Health in article 12 (20,25). Compared to the UDHR, state responsibilities got defined more detailed. States, who ratified the ICESCR are requested to take action to reduce the stillbirth rate and infant mortality, to improve aspects of environmental and industrial hygiene, to prevent, treat and control epidemics and other diseases and to create conditions to give access and treatment to everyone in case they get sick (20). A ratification makes a country accountable to protect, promote, and fulfil these Human Rights. As of the year 2023, 171 UN member states have ratified the ICESCR treaty, while 22 have not (26). The ICESCR along other

mechanisms, mentioned in annex 1, serves to monitor, that states realize Human Rights like the Right to Health through state reports and reports coming from non-governmental organizations, civil society, and international organizations (27). Monitoring is defined by tracking progress on predefined indicators. The indicators used by the ICESCR are shown in annex 2 (28).

1.4. General Comment No 14

To further explain article 12 “the Right to the highest attainable standard of Health” of the ICESCR, the Committee on Social, Economic and Cultural Rights published the General Comment No 14 in 2000. Here, the Right to Health got defined and clarified as a right “not to be understood as a right to be healthy”, but it considers the individuals biological and socio-economic preconditions (29). It further explained that it contains the elements availability, accessibility, acceptability, and quality (AAAQ) as well as the underlying determinants of health including access to safe water, food, housing, and sanitation. Figure 2 illustrates all elements that the Right to Health entitles. The General comment No 14 also explains, that realizing the Right to Health, does not mean a state has to have a full working health system right away, but more that states are obliged to follow a progressive realization with their “maximum available resources” (29). Which differs from country to country. Maximum available resources include for example, using an appropriate amount of the national budget on health. LMIC use between 5% and 7% of their gross domestic product (GDP) (30). WHO estimated that at least 1% more of the GDP per country needs to be invested in health care, otherwise there will still be 5 billion people by 2030 without appropriate access to health care (31).

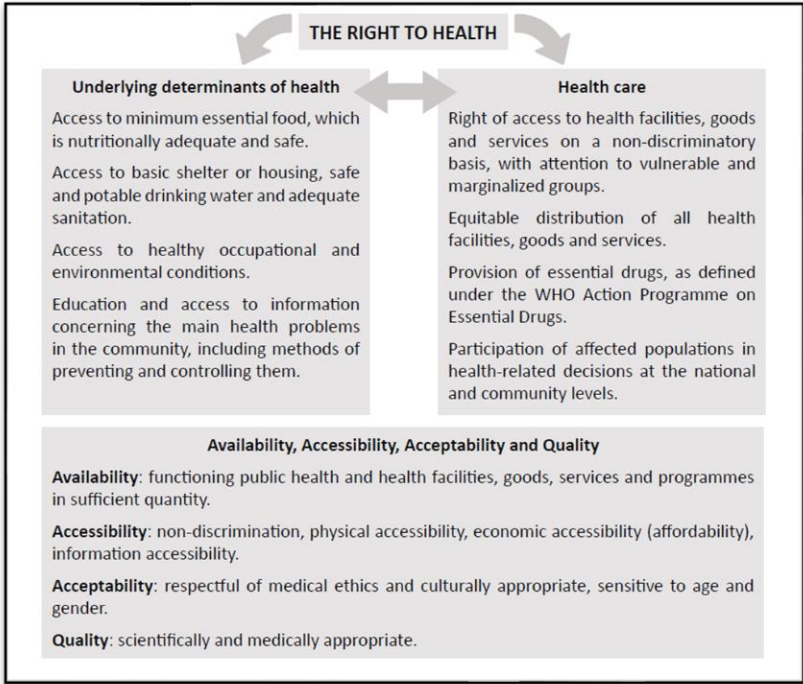


Figure 2.: The elements of the Right to Health (General Comment No 14) (32).

1.5. The role of health professionals

In 2007 the Special Rapporteur on the Right to Health mentioned the importance of health professionals in promoting and protecting the Right to health for the first time in one of their reports to the UN General Assembly. The Special Rapporteur is a monitoring mechanism created by the United Nations. Paul Hunt, the Special Rapporteur at that time phrased it like this: “There is no chance of operationalizing the Right to Health without the active engagement of many health professionals”(33). The health professionals role in the Right to Health is often defined as promoting and protecting the

Human Rights (34). Globally there are more than 65 million health professionals (35), including physicians, nurses, midwives, and other paramedical professions who are often the first ones to recognize violations of human rights, which can come with severe health consequences (34). In promoting Human Rights, they can assure the most positive conditions to the health of the population they are working with. Health professionals played already significant roles in the past in speaking out Human Right violations. In Uganda, in 2011, health professionals together with citizens protested in front of the Constitutional Court in Kampala because of too many women dying of negligence and post-partum haemorrhage in hospitals (36,37). This case brought more attention on the high maternal mortality rate in Uganda. After this protest a lawsuit was filed against the government in this regard. But even before the Court's decision, the government increased the budget for the health sector and recruited more health workers (38). Also, as reported by the Truth and Reconciliation Commission in South Africa, during the apartheid, health professionals have been part of Human Rights violations actively and passively (39–41).

1.6. Toolkits

In healthcare, assessment instruments like toolkits have been used to advise and improve health behaviours and working procedures for health professionals (42). Toolkits can be an effective way to guide users with evidence-based knowledge to improve the services they are working with. In a web-search preceding my research, conducted by the International Federation of Health and Human Rights organizations (IFHHRO), a Medical Human Rights Network several toolkits or assessment instruments could be found that relate to the Right to Health¹.

2. Problem statement, justification, study objectives

2.1. Problem statement

Health outcomes like maternal mortality and neonatal mortality, as well as further transmissions of HIV, TB and other communicable diseases or premature deaths through not the right treatment for NCDs, are often based on lacking accessibility, acceptability, availability, and quality of medical services (2,3,43–45). The deaths of 287 000 women in 2020, most of them in LMICs could have been prevented through better quality of medical services or available services including skilled birth attendants (2). 2.4 million newborns died in 2020, most of them in LMIC. Many of these deaths could have been prevented with available ante- and postnatal care services (ANC and PNC), skilled birth attendants, and food security (3). TB and HIV are two diseases, even though the number of new infections decreased over the last decade, the targets set by the international community through initiatives like the End TB Strategy by the World Health organization (WHO) or the Joint United Nations Programme on HIV/ AIDS (UNAIDS) targets of 90-90-90 until 2020 or 95-95-95 until 2025 won't be reached with the current progress (43,44). HIV might not be curable yet, but preventable and further transmission can be stopped. TB is preventable and curable. Both diseases affect mostly vulnerable groups in LMIC, often facing barriers to medical services because of discrimination and stigma. (45). Beside the communicable diseases, approximately 86% of the 17 million premature deaths caused by NCDs, like cardiac failure and other chronic diseases occur in LMICs (6).

In a recent report, Amnesty International did not only mention specifically the violation of the "Right to Health" in many countries, they also refer to several other Human Rights violations like discrimination against minority groups and refugees, torture and other ill-treatment or violence against women as severe impact on the Right to Health (46). Most of these Human Rights violations are connected to the Right to Health, in regards of accessibility, acceptability, affordability and quality of the services. They also affect the underlying determinants of health and the participation and non-

¹ Web-search document can be presented after request

discriminatory aspect of the Right to Health. Some interesting examples from the report about Right to Health violations in LMICs are from Burundi, Lesotho, and Lebanon. In Burundi prisoners were denied healthcare and food and the government failed to secure fuel, resulting in a breakdown of the public transport system which led to many health professionals not reaching the health facilities. In Lebanon the government failed to implement a social system to provide medication especially for NCDs and make them affordable. More than 60% of the population were relying on health care facilities offering medication free of charge or for little money. In Lesotho many women couldn't reach healthcare facilities due to poor transport systems and roads. In Laos, according to the Amnesty International report, a minority community in the country that fled state violence already since the 1980s, was still suffering from attacks of the military, which influenced their access to food, shelters, safe drinking water, sanitation and health care facilities (46).

Right-holders, who are informed about their rights, can make use of health rights litigations and make their governments accountable when they claim their rights at courts to for example access medical services, which their governments failed to realize (47). Compared to individuals it seems like that health professionals still contribute little to this even though they could play a more significant role as right-holders in achieving better functioning health systems. Even though Human Rights, including the Right to Health, are a subject of states, health professionals and health care providers, including the facilities play a crucial role to support the realization and prevention of negative health outcomes

The 2007 report of the Special Rapporteur on the Right to Health mentioned, that the knowledge about the Right to Health of health professionals in different parts of the world is often non-existent or if they heard of it, they don't really understand what it means (33). Several subsequent studies mentioned the same (36,48,49). This also includes that health professionals are not aware of their potential role in realizing the Right to Health. In a study conducted in Canada, health professionals were asked whether illegal immigrant women and children should have a Right to Health and only 33.6% answered with a clear statement that health is a human right and not a debate of deservingness or a privilege (50).

While SDGs and concepts like UHC, provide a guidance for states to realize equity in health, there is no legal obligation, which means failing these targets has no legal consequences.

2.2. Justification

While several studies and reports describe the lack of education or training in Human Rights, no study could be found that evaluates the understanding of the Right to Health of health professionals and how their role is in regards of monitoring or implementing it (29,51,52). The Right to Health is described often as analysis of the state's health system and health indicators or from a legal perspective, which exist for many LMIC countries. Health professionals are often the first ones to witness violations of the Right to Health, but they are also the ones that can actively implement the elements of the Right to Health.

As of today, monitoring of the Right to Health is mostly done through state reports and monitoring of indicators or benchmarks, if they were set up by the state (53). Which means a head-down approach without often involving the ones most affected, including them to actively participate in decision making. As health professionals are often the first and only ones, they are in most settings not involved in monitoring nor the implementation of policies or programs around the Right to Health.

Knowing the situation of the countries and being aware that many LMIC countries have ratified the ICESCR or implemented the Right to Health in their constitution, there is a state's accountability for improving the situation for their citizens. But what is the role of health professionals working in these countries actively with patients on the frontline to monitor whether there is a violation or is not? And how do health professionals actively participate in the implementation of the Right to Health?

As IFHHRO already found out through their web-search about toolkits for monitoring and implementing the Right to Health, some already exist. But none of these instruments were designed for monitoring and implementing the Right to Health and were focused on being used by health professionals. Can a toolkit help health professionals to fulfil their duty in promoting and protecting the Right to Health?

2.3. Study objectives

Overall Objective: To explore and analyse the health professional's self-perceived and actual role in relation to monitoring and implementing the Right to Health in Low-and Middle-Income countries and whether the use of a toolkit could be a supporting mechanism

Specific objectives:

1. To analyse how health professionals define the Right to Health
2. To analyse the health professionals' role in monitoring and implementing the Right to Health
3. To analyse the self-perceived role of health professionals from Low-and Middle-Income countries in monitoring and implementing the Right to Health
4. To analyse the facilitators and barriers to implement an instrument for health professionals to monitor the right to health and how would such look like
5. To draw recommendations for further research and interventions

3. Methodology

To further understand what the health professionals' part in monitoring but also the implementation of the Right to Health is, this study will conduct a literature review complemented with qualitative data collection. Objective one, three and four will be covered by information gathered via qualitative data collection with health professionals and key informants. For objective two information will be gained through literature review and complemented with information from qualitative data collection. Objective five will be based on information gained through the results of all other objectives.

3.1. Literature Review

3.1.1. Search method

The databases used for the literature research were Google Scholar, PubMed, and the Vrije Universiteit online library. Additionally, the Health and Human Rights Journal was searched. Grey literature was found on UN documents library, WHO, World Bank, Amnesty International, Human Rights Watch, International Nursing Council (ICN), and World Medical association (WMA). For some documents the search engine ecosia was used. Snowballing, reviewing list of references of relevant articles for additional sources, was done for additional identification of literature fitting the inclusion criteria.

3.1.2. Inclusion criteria

Inclusion criteria were peer-reviewed articles and grey literature written in English language. Literature from 2000 until 2023 was screened. Grey literature was screened for descriptions of the role of health professionals and how it is defined. The year 2000 was chosen as it was the year the General Comment No 14 was released. Key words are illustrated in table 2. As LMICs in general were included, the found literature was screened for the country context.

Key words used		
Human Rights OR Right to Health OR Human Rights Based Approach OR HRBA	AND	Health professional OR Health worker OR Health workforce OR Health staff OR Health personnel OR Physician OR Doctor OR Nurse OR Midwife OR Monitoring OR Implementation OR

Table 2: Key words and search strategies for literature review

3.1.3. Exclusion criteria

Literature in any other language than English was excluded. Literature focused on Human Rights not related to Health excluded. When during the screening of the found literature the country context was solely on a HIC, the literature was excluded.

3.2 Qualitative data collection

3.2.1. Study Design

The study was conducted through semi-structured open-end interviews. For the creation of the interview guide several sources were used (54–56). All these sources were used for previous research to help creating the interview guides. The interview guide (annex 3 and 4) for the health professionals were constructed in three parts. The first part to get a better understanding of the participants professional responsibilities and working environment and training and health education background in regards of Human Rights. The second part was to find out how participants understand the Right to Health and their own role in monitoring it in their working environment. The last part asked participants about possible instruments to be used for future assessing and implementation of the Right to Health. The interview guide for the key informants was built similarly, with a start about their responsibilities and connection to the Right to Health. Followed by more information how they monitor elements of the Right to Health. The final questions were about assessment instruments, like the ones for the health professionals. As the participants were from various countries the interviews took place remotely via (Skype or Zoom or WhatsApp calls.) The interviews were done between June and July 2023.

3.2.2. Study area and target population

The interview participants were all working or are still working with national or international organizations, all of them non-governmental organizations, in LMICs. Health professionals have been defined as staff working in a medical or paramedical profession and work directly with patients. Key informants have been chosen due to their role within an organization, not necessarily medical background but with a function or background in regards of Human Rights or medical coordination. Interview participants and key informants came from various national backgrounds, in details mentioned in table 3.

Country	Interview participant	Key informant
Ghana	1	
India		1
Iraq	1	
Nigeria	1	1
Pakistan	2	
South Sudan	1	

United States of America		1
Australia		1
Brazil		1

Table 3: *Origin of interview participants and key informants.*

3.2.3. Sampling and Recruitment

A total of six health professionals and five key informants have been interviewed. Key informants have been approached at an international workshop on military medical ethics in Switzerland, with a focus on medical neutrality in theory and practice. The six health professionals have been sampled through personal connections or through previous working or studying colleagues of myself. The professional background of the interview participants was one medical doctor, two nurses, one midwife, one clinical officer, and one health officer. Four of the health professional interviewees have been working with an NGO in the past, two are still working with an NGO at the time of the interview. The working experience with an NGO was between eight months and six years. As health professionals the interview participants worked between 3 years and more than 25 years. The key informants were one law professor with background in health and Human Rights, one NGO director and medical specialist, one medical specialist, one advisor for access to health. The fifth key informant interview was conducted with two persons, working within the research unit of their organization.

3.2.4. Data process and analysis

Nine of the eleven interviews have been recorded through Zoom, Teams, or voice recorder. One participant objected the recording, and with another one the recording didn't work, in both case notes were taken. Afterwards the audio files were uploaded in the MAXQDA software and transcribed. The interviews have been saved anonymously and will be deleted after the finalization of the thesis.

The transcripts were coded and analysed in a deductive approach for objective two. An inductive approach was used for objectives three and four. Together with the interview guide and the results from the interviews, codes were made to define the categorise of the different results.

3.3. Analytical Framework

To analyse the results the CanMEDs 2015 Physician Competency framework was used (57). This framework, established by the Royal College of Physicians and Surgeons of Canada in 2015, has been defined as one "that identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve" (58). The framework outlines seven roles of a physician. With every role come several key-concepts or responsibilities that further define this role. The key concepts for every role are further listed in annex 5 and table 4 gives a brief explanation of each role. In this thesis, the framework, even though created for physicians will be used for health professionals in general. The results of how the role of health professionals is in monitoring and implementing the aspects of the Right to Health will be explained with the roles illustrated in the framework in figure 3, the Professional role, the communicator role, the collaborator role, the leader role, the health advocate role, and the scholar role. The medical expert role is a combination of all the other roles and will there for not be used. Some of the predefined key-concepts of the roles are overlapping and are part of several roles.

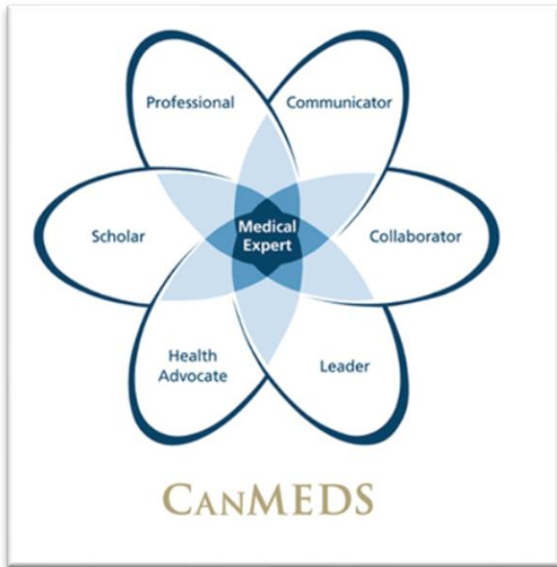


Figure 3: CanMEDs 2015 Physician competency framework (57,58).

Role	Explanation
Professional	“As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health.”(57)
Scholar	“As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.”(57)
Health advocate	“As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.”(57)
Leader	“As Leaders, physicians engage with others to contribute to a vision of a high-quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers.”(57)
Communicator	“As Communicators, physicians form relationships with patients and their families* that facilitate the gathering and sharing of essential information for effective health care.”(57)

Collaborator	“As Collaborators, physicians work effectively with other health care professionals to provide safe, high-quality, patient-centred care.”(57)
Medical Expert	“As Medical Experts, physicians integrate all of the CanMEDs Roles, applying medical knowledge, clinical skills, and professional values in their provision of high-quality and safe patient-centred care. Medical Expert is the central physician Role in the CanMEDs Framework and defines the physician’s clinical scope of practice.”(57)

Table 4: *CanMEDs framework roles briefly explained*

3.4. Ethical considerations and informed consent

Through the KIT Research Ethics committee, a waiver exempted the further studies. A waiver was possible in this case, as the focus was solely on professional opinions and experiences. After participants were informed and before they participated in the interviews, they read and signed the informed consent forms. The informed consent forms can be found in annex 6 and 7. One participant objected recording, without further explanation.

3.5. Limitations

The limitations are particularly on the qualitative data collection part of the study. Through limited access to health professionals a selection bias needs to be noted. All interview participants were reached through personal contacts and conveniently sampled. Key informants were reached while they visited a workshop. The number of interview participants is rather small with six health professionals and five key informants and not intended to be representative of all health professionals. As such, this research should be seen as a start to get into the topic. While creating the interview guide, I kept in mind the possibility that interview participants would not know what the Right to Health means according to Human Rights Law, but still wanted to get to know how they understand the words, without giving them the feeling to not know something they should know. This opened the possibility for answers that might not be directly related to Right to Health.

4. Results

The results of the research will start with how health professionals defined the Right to Health in the interviews. It follows by presenting the role of health professionals in monitoring and implementing the Right to Health through the CanMEDs framework. Every role will be presented first with the information gathered through literature review, followed by the information coming from health professionals during the interviews. The third part of the results will present barriers, advantages, and facilitators of a toolkit.

The Right to Health is defined through article 25 of the UDHR. It was further defined in the ICESCR in article 12 and with the General Comment No 14, the elements of accessibility, availability, acceptability, and quality as well as the underlying determinants of health were first mentioned to give a detailed description of what the Right to Health entitles. It means that every citizen, as a right-holder has the right to access healthcare facilities, without physical or financial obstruction. It means that every citizen has a right that information and health care facilities are available for their needs and cultural acceptable. Everyone has the right to health services of good quality, which means scientifically approved and through skilled and trained health professionals. Right-holder also have the right to access safe water and sanitation, access food and have shelter as some parts of the underlying determinants of health. All countries who ratified the ICESCR have a legal obligation to promote,

protect and fulfil the Human Rights, including the Right to Health that were listed in this document. Health professionals have a responsibility to promote and protect the Right to Health.

4.1. What is the Right to Health or the enjoyment of the highest attainable standard of physical and mental health for health professionals?

As stated in the UN document from the Special Rapporteur, many health professionals do not understand the concept of the Right to Health and especially the idea, that it is not based solely on litigation, but the possibility to operationalize with responsibilities of their daily work. Their involvement can influence policies and programs to make them more “equitable, effective, evidence-based, robust, participatory, inclusive and meaningful”(33). This was confirmed by the interviews as only one of the health professionals, could say with confidence, that they understand the Right to Health and what it stands for. Some said they heard of it before but couldn’t define it.

“Yeah, they told us also about that one. I have just forgot it.” (Interviewee 2)

“I hear but I didn't focus about this.” (Interviewee 4)

The elements of the Right to Health used most to define it, were non-discrimination and accessibility. Accessibility was mentioned in regards of physical and financial accessibility.

“Every folk have rights to access their health regardless their race, regardless their tribes and regardless their religions. So of course, in the right to health there is not a discrimination.” (Interviewee 2)

“For me it means access to health without obstructions, like restrictions of security for example.” (Interviewee 1)

“People shouldn't be discriminated. Based on where they are coming from based on their colours their ethnic group. Their pockets or whatever. The quality for everyone.” (Interviewee 5)

One of the interview participants mentioned that their knowledge changed since their health education, but only through postgraduate education and explained what they understood with it in the past and what they understood at the time of the interview.

“That was when I was in college like giving everybody their needed help health care that they need they should be given. That was in nursing college. Do what you're supposed to do for the patient the patient is always right. By now I know that everybody no matter the status or whatever is entitled to quality health care. Whether they can afford it or not. they are entitled to it is their right. Like the right to live the right to health.” (Interviewee 5)

While some of the interviewed health professionals defined the Right to Health with some of its elements, others defined the Right to Health as rights that health professionals have.

“That health professionals have their rights.” (Interviewee 1)

“Like when you're working as a health professional what are your rights for health I think so. Like if you're becoming sick what right they should give you if you had any problem like health-related issues. So, what kind facilities or leaves they can provide you. I think it's about this.” (Interviewee 6)

The underlying determinants of health were not mentioned once. And elements like availability and acceptability weren’t defined by any of the interview participants but one, who mentioned medical ethics. During the interviews some of the health professionals replied to the questions more in regards of patient rights. Patient rights are not the same as the Right to Health but overlap in several elements. There could be no connection seen between understanding the Right to Health better with more working experience, the position, or the profession.

4.2. The role as a professional

4.2.1. Results from Literature

A key concept of the professional role is quality improvement. According to literature, health professionals can monitor several aspects that involve the Right to Health element Quality, which defines that medical services “must be scientifically and medically appropriate and of good quality” (59). According to a study done by Kruk et al, where they analysed amenable deaths in 137 countries, in LMICs poor quality resulted in more deaths than not accessing and utilising health services (60). Health professionals can monitor quality with the use of medication and other medical equipment, that it is evidence-based and according to national guidelines (61). This also involves the monitoring of expired drugs and the stock of essential medicines, but also the rational and appropriate prescription of antibiotics and other medications (62). Implementing medical guidelines and ensuring that health professionals are trained in those appropriately can prevent violations of the Right to Health such as refusing medication in case of pain management for people who inject drugs (63). Through their clinical skills they recognize diseases and injuries related to violations of the Right to Health, that otherwise wouldn't be seen (64,65).

Another key concept of the professional role is the commitment to medical ethics and the ethical codes set up by their professionals associations (66–68). Through committing and following those, they implement the important aspect of acceptability. Health professionals can create health services, like in the case of people living with HIV, that they do not stigmatize, discriminate, or exclude them from their facilities. Discrimination and exclusion from receiving medical services, keeps people living with HIV away from health facilities and therefor also from prevention (63,69). Being professional also involves assessing their own values and behaviour especially in regards to gender, ethnic background, religion and sexual orientation or gender identity (70). An example might be screaming women in labour. Depending on the health professionals' own background the level of care and quality might differ, if they do not focus on their professionalism (71). Negative experiences for the patient in cases like this can influence future health seeking behaviour. Thompson describes the impact a health professional can have beyond the health facility when a culturally acceptable environment is created as, “if girls and women are truly valued as human beings, the way they are treated by others will promote their health and well-being and not intentionally harm them”(71).

In many LMICs, there are ethnic, religious, and cultural aspects that influence health seeking behaviour and access to health services. Health professionals should be sensitive to these, and recognize barriers, so they can be eliminated (53,72). Through moral and ethical behaviour, health needs of marginalized and vulnerable groups can be identified and through appropriate treatment plans, preventive and promotive actions, they can be supported to stay healthy (65,73–76).

4.2.2. Results from Qualitative data collection

One of the health professionals interviewed described their role as to monitor cultural sensitivity. They described the situation when patient's that are members of a minority religious group, in this case the Jehovah's witnesses, need a different professional and medical approach for a blood donation treatment.

“So, I monitor it like this, [...] which religions the patient has. So, the way how I monitor is that I tell this the nurses because the nurses are the ones who are caring most of the time for the patients. So, it ensures that any patient that used to come to the facility where I am offer equal services for him or to her. [...] Of course, there was a case scenario the same religion which I was talking about which is Jehovah witness. As a girl was brought, she was thirteen years old, and she had severe malaria and she had anaemia due to malaria. And the plan for us as a health personnel was to give this blood for her

life procedure health because she was very anaemic and fatigue. With all that. But her parents the parents of the lady didn't agree to give blood.” (Interviewee 2)

Providing medical services on behalf of medical ethics is another key concept, involving the accessibility with no discrimination for everyone, that health professionals defined as their role in monitoring the Right to Health.

“According to what I am seeing like in generals we as the health workers we shall do monitor our mandate is about ethics which I will mostly emphasize on it. As we are health workers duty is most on our ethics. Who work with the person, and you are not there to discriminate, and the person is and the different religions, so I understand this condition for this is all over in the world.” (Interviewee 5)

Monitoring correct treatment, referrals and that the patient is followed up if necessary was described as one of the more clinical responsibilities a health professional has in regards of the Right to Health.

“They need the monitoring. Like we were sending our patients to PHCUs [local abbreviation for their hospital] for the follow up. We were giving them one week treatment same patients and then for follow up to got to PHCU hospital. And we were monitoring them are they taking medicine are they going to hospital or not. We were asking from the hospital nutrition assistant or also doctors. That we have send five ten whatever patients are they coming? We had some numbers and contacts. We were calling them are you going or not? If you are going you are taking medicine from the hospital or not?” (Interviewee 3)

On the other side, especially key informants argued that health professionals need to be clinicians. To monitor and implement the Right to Health other professions should be responsible, like judicial professions and colleagues in management positions or more focused on public health.

“Actually, I think to what end, why would we want that to happen for frontline staff and the Right to Health, social determinants, it's in the domain of public health. And there is a space where of course there's a spectrum, clinical health, public health, but clinicians need to get on and be clinicians.” (Key informant 4)

4.3. The role as a scholar

4.3.1. Results from Literature

In the role of a scholar, health professionals can influence the Right to Health in several ways, but the two key concepts of the role focused here are the aspect of their continuous learning about the Right to Health and Human Rights and the teaching and informing of patients and colleagues. Thompson argued in her article that *“Increasing the knowledge and understanding of human rights empowers healthcare professionals to protect human rights and uses interactive and participatory methodology to develop attitudes of respect for human rights, develop skills needed to defend human rights, integrate the principles of human rights into everyday practice and encourage respect and tolerance”* (77). Better understanding gives health professionals the skills to implement monitoring mechanisms to protect the Right to Health of their patients and their own (52,63,77–79). A.J. Vranes et al represented in a study in 2014 in Serbia, that only 6.7% of the study participants, health professionals with several years of working experience, were familiar with the topics around Human Rights taught in continuing medical education courses (77). Through qualitative data collection, McKinnon et al concluded as well that training in human rights-based approach for health professionals is missing (74). In the same research key informants acknowledged that they and their staff had “no idea” or “not much” knowledge about human-rights-based approaches. Educating health professionals and

educating other colleagues in Human Rights can improve their attitudes towards marginalized and stigmatised groups, like prisoners and sex workers and can create acceptability through health professionals in the health facilities (74,80,81). To guarantee a sustainable protection and implementation of the Right to Health, continuous education and trainings are necessary (82). To avoid human rights violations through health professionals by the authorities, health professionals need to be educated, be able to identify the situation as such and know about resources to monitor and report (75). The experience health professionals gained through working with poverty and marginalized groups need to be shared with future health workers (83). The earlier in their career or even during their education that they work or interact with more disadvantaged groups in the population and understand the idea of the Right to Health the more likely they turn into advocates and use their knowledge accordingly (84). Focused education on Human Rights can increase critical thinking of health professionals (85).

4.3.2. Results from Qualitative Data collection

None of the interviewed health professionals said with confidence they were appropriately trained and educated on the Right to Health. They emphasised that more training and education in regards of the Right to Health is necessary. Key informants questioned whether every health professional needs to be trained or to focus on training people in key positions.

“There is training in bioethics in medical school and some patient rights, but not on particular the Right to Health or much about human rights.” (Key informant 1)

“There has been no specific education in the Right to Health or Human Rights.” (Key informant 1)

“It should be more. At that time we had a lot of subjects that was a minor subject so we didn't consider more or they didn't give more time. But we need more.” (Interviewee 3)

“I'd be quite selective in who I thought would value, who could benefit from it.” (Key informant 4)

During the interviews health professionals pointed out the importance of educating their patients about their rights. Through the implementation of sharing information and rights education, patients would be more aware of medical services and supports they can ask for.

“If the patient knows about their rights, they will ask for it. They don't know they just accept whatever we give to them.” (Interviewee 5)

Information about the diseases and health consequences are part of the Right to Health element availability. Through health education, health professionals mentioned they could prevent further complications, as in the case of pregnancies.

“And to give them education about antenatal and postnatal this is the only way that I could change. Because once they enter into the hospital then if they are in complication or if they are in some other problem, I cannot change I can treat at that time, but it's already done.” (Interviewee 6)

4.4. The role as a health advocate

4.4.1. Results from the literature

An important role of the health professional is the health advocate, which goes beyond the most common description of health professionals being only focused on clinical procedures (53,75,86). Putting into practice the Right to Health and overarching Human Rights principles amplifies the efficiency of public health strategies (63). In many LMICs, it is difficult for citizens to speak out and advocate for their rights, often through restrictions in the freedom of speech or lack of education. Instead, health professionals who are often highly educated in the same countries can use their

professional knowledge to advocate that elements of the Right to Health are implemented or to raise awareness of health outcomes that might occur when those are not respected and fulfilled (87,88). This, however, has the risk of negative consequences for health professionals, as in Venezuela. There, health professionals feared reprisals and dismissals because they monitored an increase of infant and maternal mortality through lack of essential medicines (87,89). An important key concept of the role as a health advocate is the monitoring of the underlying determinants of health which can influence the health outcome of patients. Through the direct contact and communication with the patient and their relatives, health professionals often get information beyond the physical and mental complaints that the patient presented for. They hear about food insecurity or difficulties to access safe water, they hear about neighbours and friends having similar symptoms or the immediate working conditions that maybe caused the complaint that prompted them to visit a health facility (90). Health professionals might be the only ones that can monitor whether the population they are working with have enough access to food, by not only treating the undernourishment health outcomes, but also through documenting and advocating for better access to food for the same. Health professionals might not only treat and report the increase of diarrhoeal diseases in a specific area, but also advocate for interventions regarding the water accessibility and quality in the same area (83). As Shuftan et al argued in their article, “health professionals must stop avoiding conflicts with authorities to reach the possibility of dialogues” (88).

4.4.2. Results from qualitative data collection

While health professionals described more the key concept health promotion of the health advocate role, key informants responded more with the argument, that health professionals need to urge for more changes in policies and programs to implement the Right to Health. They also argue that advocacy should be the preferred method to implement the Right to Health instead of reporting violations.

“So, then I called sometimes to their mother-in-law and tell them that she is sick that she had stitches, or she had the right to stay at home to take some rest after the baby. To eat some healthy fruit or to give them meat. Like this kind of things, you should take care of her.” (Interviewee 6)

“I think in regard to the right to health there needs to be more done in regards of policies.” (Key informant 1)

“I think the idea is in cooperate in to or advocate in cooperation in policies and programs. For example, the right protection against discrimination. So, it seems to me that health professionals should urge policies and practices that say that there would be no discrimination based on race gender origin ethnic background whatever is in health care. So that’s an informative position rather than recording violations.” (Key informant 3)

4.5. The role as a leader

4.5.1. Results from literature

Key concepts of the health professional’s role as a leader include, managing health human resources, management of personnel and leadership skills. An important criterion to fulfil the Right to Health is the availability and the good quality of medical services through trained health workers. The role of a leader involves that vacancies are filled, and that the working environment attracts the human resources necessary. Often this cannot be solved via legislation, absenteeism especially in rural areas of LMICs is a common challenge that is difficult to overcome (82,91). Information about practicing health professionals need to be documented and shared to ensure future coverage of skilled health workers. In Chad for example this kind of management is not working, which makes it difficult to predict the future coverage of midwives in the country (92). Skilled management can reduce workload on health professionals in the team, which deprioritizes monitoring the needs of the population (64). In

the role of a leader, health professionals can be actively participating in developing monitoring and quality improvement mechanism for their teams and their health facilities (74,83,85). They can also function as role models that show younger colleagues how to implement Right to Health elements into their clinical and professionals' practice. On the contrary ignoring it might be interpreted as not their responsibility or not a priority (74,93). Within the key concept organizing and budgeting, leading health professionals need to monitor that medical services stay free of costs where they should be and preventing corruptive behaviours of team members (41). In the role as a leader they can also implement conditions for a healthy working environment, as an underlying determinant of health (15). Violations of their work environment can range from "unsafe working conditions, sanctions for providing evidence-based health care, limits on their freedom of associations, [to] denial of due process when patients make complaints against them"(15). Health professionals cannot guarantee quality of care unless their working conditions are safe (15).

According to several sources, the lack of health professionals is a major challenge to realize the Right to Health (41,52,72). The so called "skills drain" or "brain drain" refers to health professionals migrating because of various reasons, particularly from LMIC to HIC. It's also their Human Right to migrate, but it leaves the country of origin with a huge financial and access burden. They invest money in the education of health professionals and lose highly skilled health professionals they need (94,95). In a study in Kenya, they estimated the loss of a physician, educated in Kenya, who migrated after graduation, results in a financial loss of more than US\$ 500,000, and for one nurse more than US\$ 330,000 (94). The migration of health professionals increases the workload on the health professionals left and reduces the possibility to participate in any responsibility that goes beyond immediate and emergency interventions (94). In many cases the migrating health professionals are in supervisory positions, therefore the loss is not only of a skilled health professional but also the capacity of leadership and management is interrupted and weakens the system (94).

4.5.2. Results from qualitative data collection

Health professionals can within the role of a leader initiate change, with several interview participants answering that they can influence their direct working environment to change something if they see the need for it. One of them described their initiative that recognized lacking accessibility and availability in a community.

"So, I was like ah is these people are not here we don't have people here who are coming. So, I suggested let's go to them let's start a community clinic. [...] They say we don't have money for transportation we don't have money for this. We didn't get a car whatever. So, we started a community clinic like where we move from community to community to organise clinics for those patients and those then don't need to come to the hospital afterwards. So, what we saw is that after we started this in the community the number of patients that we saw went high why because they realised, they felt they've been accepted." (Interviewee 5)

Another interview respondent raised the importance of supervising mechanisms, that serve to improve and maintain specific standards within the health facility. They raised the example of infection control committees, that didn't work well without adequate supervision during the COVID-19 pandemic.

"Actually, that can exist on paper, theoretically like we forget the infection control committee we forget that we are part of infection control committee. So, we just have meetings yearly maybe few times but no proper action of the monitoring of the committee happens." (Key informant 2)

Strong leadership was also mentioned in regard to reporting mechanisms for health professionals.

"But one problem is that managers and directors of health facilities people value political connections more than Human Rights. They don't want to disclose Human Rights violations." (Key informant 1)

In case they monitor violations of the Right to Health or to support initiating implementations, many interview respondents could not identify a specific person, position, or way to report. Two of the health professionals said that violations of the Right to Health would be reported to the police.

“There is no place to report in local hospitals here.” (Interviewee 1)

“Yes, we used to go to the police.” (Interviewee 2)

4.6. The role as a collaborator

4.6.1. Results from literature

As MacNaughton and McGill argue, “only with interdisciplinary collaboration between scholars and practitioners in a wide range of social sciences can we mainstream the Right to Health into policies, planning institutions, management practices, programs, projects, and operations”(49). They further wrote this interdisciplinary collaboration includes health professionals and those working with Human Rights, like lawyers and social workers (53,96). Interdisciplinary collaboration also means that physicians, nurses, midwives, and others involved in patient management communicate with each other and respect the other one’s work. In many health facilities globally, the hierarchy within the health professions is a reason why the patients’ Right to Health cannot be fully protected (93).

Beside collaborating with other medical and paramedical professions, as well as other professions not related to the medical field, collaboration with the community is necessary. Health professionals can participate and organise outreach programs for disadvantaged groups, to increase availability and accessibility for the same (53,72). As experienced under the apartheid in South Africa, health professionals need to gain trust through active participation with the community so they can realize the Right to Health but also to implement and to monitor it (75,76). Health professionals are often seen as very respected personalities in their communities, through the collaboration with them, they can adapt parts of the health services to the needs of the community and monitor that those are functioning (88).

A barrier that keeps health professionals from actively monitoring and implementing elements of the Right to Health appropriately is the so called “dual loyalty”. It has been described as the challenge of health professionals mostly working in the public sector in authoritarian structures, when the loyalty of the health professionals does not only belong to the patient, but they also must stay loyal to their employer (15,64,93). While this was mostly reported through the South African apartheid time, South Africa was not and is not the only place. In many prisons and detention centres, health professionals cannot fulfil their duty towards the patients because of their obligations towards their employer (40,97).

4.6.2. Results from qualitative data collection

Interview participants highlighted the importance of team work to be able to realize any elements of the Right to Health. Even high workload should not be seen as a barrier, one of them argued.

“If we have a good team it doesn't matter. We don't care about the workload. We should care about our patients like we have worked in emergency. [...] All responsibilities just with your patients. You give one hundred percent for whatever they are.” (Interviewee 3)

Interviewee 2 argued that the teamwork means sharing knowledge and reminding colleagues of their professional objectives, which include protecting the Right to Health.

“When you are trained as a fresh health worker you are the one who has the current knowledge now. So, it needs you to go and empower your fellow colleagues. They were having the same knowledge

before, but the problem is they have forgotten it because they are no longer practicing it.” (Interviewee 2)

4.7. The role as a communicator

4.7.1. Results from literature

In many places, the health professionals at the frontline are the only ones that can inform patients about their rights and medical options. To be able to participate in the decision-making regarding their own treatments, options, and improvements of their living conditions to stay healthy, they need the communicated information from the health professionals (77,98). Health illiteracy and illiteracy in general are still very common in many LMICs, especially in remote areas, more predominantly women are illiterate when compared to men, and health professionals play a crucial role informing their patients about rights but also how to prevent diseases, or complications of diseases. This information might help especially vulnerable groups in the population, suffering of discrimination and stigma to participate more actively in changing their circumstances (77). Through active communication health professionals can investigate patient’s needs, like physical access to health facilities, whether they can afford the healthcare and transportation (74,83). States and duty-bearers need to have information on the indicators and benchmarks to realize the Right to Health and need the health professionals documentation and information gathered (53). Duty-bearers can only be made accountable if reports and information are being shared, health professionals are responsible for documenting and monitoring the health outcomes or indicators in their facilities. This shared information can be sufficiently used to improve services (99).

4.7.2. Results from qualitative data collection

Active communication with community members, relatives and patients can reduce barriers of accessibility and acceptability, that are made through prejudices of the health facilities, interview participants described themselves as the one communicating between their own community and the health facility they are working with.

“We can look at whether these are according to our community or not like sometimes people when they use to come to our hospital, they mostly were complaining that somebody had told them that there are hidden cameras here and they used to record. So, I used to tell them no look there are no cameras we are also living in this community like if they're going to record you, so I will also be in the camera.” (Interviewee 6)

4.8. Advantages, facilitating aspects and barriers for the implementation of a toolkit.

Beside understanding how the role of health professionals in monitoring and implementing the Right to Health is described in literature and by health professionals themselves, I additionally analysed through the interviews whether a toolkit could be a supporting mechanism. While all participants in the interviews agreed that easy-to-use instruments could support health professionals to assess the Right to Health situation within their work environment, some barriers, advantages, and facilitating aspects were mentioned that seem to be important considering when creating and implementing such a toolkit. In the chapter advantages for the implementation, aspects will be explained that such a toolkit could improve for the health professionals. Facilitating aspects will define how such a toolkit could look like the best, according to the health professionals and key informants interviewed. Barriers will be categorized into personal and structural barriers.

4.8.1. Advantages of implementation of a toolkit

One of the advantages mentioned was, a toolkit or any assessment instrument could strengthen the health professionals, give them more responsibility and an active part in participating to change something.

“It would strengthening the health workers.” (Interviewee 2)

Health professionals could ensure with the support of the toolkit as guidance that patients are informed and educated about their rights. A toolkit as a way of guidance could help health professionals to know how things should be and what they could do to change it.

“It will guide you what to do, where to do it, and how to do it.” (Interviewee 5)

“This tool could help the patient [to know] that they have also rights.” (Interviewee 2)

When health professionals are trained appropriately in the Right to Health a toolkit could help them recognize violations immediately as they are often the first ones, the patients see in a health facility and learn about the patients’ living situations and determinants of health.

“Because we, the doctors, or the medical staff they can recognize it properly. Sometimes the patient doesn’t even know that his or her rights have been violated, so that we can recognize the medical staffs or the doctors.” (Key informant 2)

With a functioning toolkit, a good data collection for monitoring has also been mentioned as an advantage. The data can be assessed regularly and be used for improvement in areas with missed opportunities.

“We can write all these things and then by collecting the data monthly of all the patient. Then they can work on it and after they could try to change it.” (Interviewee 6)

4.8.2. Facilitating aspects for the implementation of a toolkit

Interview participants also came up with some characteristics how such an easy-to-use instrument could look like. Whether it should be electronical or in paper form, doesn’t define any clear preference, but will be further elaborated with the barriers. Both have advantages and disadvantages coming with their use, relying on human commitment or electricity and internet. What might be concluding this argumentation was the mentioning of flexibility in regards of culture and settings.

“So that is the more likely when they are suffering from particular rights violations. Then I think it becomes so that is the greater the degree of protection component in a programme then I think that the more that it becomes useful.” (Key informant 4)

“I think it would depend what those medical programmes are doing.” (Key informant 4)

Beside the flexibility of such an instrument, several interview participants mentioned the best way would be a checklist.

“Just a checklist would be really good. Because we would ask everything one by one.” (Interviewee 3)

“The best way is a checklist.” (Interviewee 4)

Such a checklist could then also be integrated in the patient file already, which would give the assessment instrument a place where it is attached to the medical records that are monitored asked already.

Beside some practical information how they could best work with it, some external aspects are also important to mention that would facilitate the use of such an assessment instrument. It should be as objective and independent as possible, especially connected with the barrier aspect of missing human commitment.

“I think it should be an independent monitoring not within the hospital.” (Interviewee 1)

“Yes, it is possible, but it needs to be objective, and they should take it seriously.” (Key informant 1)

To support the argument of independence, some mentioned the best way such an assessment instrument could work is with NGOs, as many, especially bigger international NGOs receive a rather good perception from the citizens of the country and are known for their principles. Beside NGOs, that could use such an instrument to report situations their health professionals have witnessed, a backup through the national medical associations might be an important characteristic. Through the national medical associations or nursing associations, an assessment instrument could get support through their own community and not from external. Additionally, such an instrument could already come with recommendations and further steps when assessing the results.

“Which would happen to carry the most weight that with the national medical association got behind it they would give attention to it much more than if civil society. [...] And I think it's more powerful coming from their own community than from outside.” (Key informant 3)

“You already get some recommendations or what could be done so it could go beyond data collection, and it could already be pointing to action.” (Key informant 5)

An argument raised by some of the interview participants and key informants, whether a health professional might be the right person to use such a toolkit. They argued that maybe someone in a managerial position would be the better person to use such an assessment instrument and have the position and knowledge to use the results.

“But I think for example, a manager of a Primary Health care centre, you know or you know a local like a health authority, you know that that oversees a couple of Primary Health care centres and. They could benefit from that lot also.” (Key informant 5)

4.8.3. Personal barriers

Beside describing advantages and how such a toolkit could look like, interview participants mentioned some barriers, that could create difficulties for the implementation. Most of the interview participants and key informants mentioned that one of the barriers to use a toolkit or anything similar would be the lack of human resources in the health facilities and the high workload on the staff that is working.

“Patient to healthcare ratio is very high. Imagine, I'm going to the hospital and see at work, at shift a hundred patients. So, you can imagine how can I fill this tool? It is not possible.” (Interviewee 5)

“And it increases the workload on the human resources, and as said before, the health workforce is leaving the country.” (Key informant 1)

Another argument is the increased workload in many health facilities prevents health professionals from being able to do additional tasks beside the necessary medical treatment. Some key informants also mentioned that the main scope of work responsibilities does not involve those kinds of assessments, especially health professionals working on the frontline in direct patient contact, who very much focus on the medical part of their work.

“But most of the doctors, they don't have time and the [health] system will not work properly.” (Key informant 2)

The priority setting, because of time, workload and the lack of human resources seem to be the main barriers for most of the interview participants.

“Getting people to pay attention when they have a lot of other stuff going on and this is not necessary priority.” (Key informant 3)

But as key informant 3 and one other interview participant mentioned, the workload shouldn't always be used as an excuse. Health professionals often have the expectation, even during their education, that the profession is associated with high workload. Interviewee 6 explained, if health professionals are going to work with an organization, they are signing a contract and accept the workload with it.

"There is no time, it's a common [reason] [...] that's all true, but yet it's not an excuse, it shouldn't be an excuse." (Key informant 3)

Another argument mentioned as a barrier for a toolkit, to be used by health professionals is the human element. If it is missing commitment to follow some guidance or just laziness.

"There is no commitment to guidelines, especially the doctors [...] we can't discuss with the doctor about what is the right or what is the wrong." (Interviewee 4)

"But because she [the midwife] is lazy she don't want to implement." (Interviewee 6)

Another key informant used different words but argues as much that the human element by itself would be barrier.

"I think human involvement should be as little as possible. Due to corruption and abuse possibilities." (Key informant 1)

Other barriers that haven't been mentioned by some were health literacy even within health professionals and language. Many countries, especially LMICs, have many different languages within the country and not all health professionals are fluent in the national language and due to education, their health literacy may not be advanced.

4.8.4. Structural barriers

Beside the personal barriers, interview participants also mentioned some barriers, that can be categorized as structural, as they are resulting from the system or the circumstances of the country, they have been working in.

Examples are the lack of training of health professionals, or the investment in time and resources for health professionals to be trained in using such a toolkit. Also, with a missing definition in job responsibilities, health professionals might not see, as mentioned before the assessment as part of their professional responsibilities.

"Because that is not being implemented or the system itself has not developed that kind of system that doctors been given that [assessing] responsibility." (Key informant 2)

"I mean I think tools alone are not efficient you have to [at] least [try to] urge people to learn the concept." (Key informant 3)

On top of the training barrier, the system itself may not be supportive to use a toolkit, while one participant mentioned it wouldn't work within public hospitals. Another questions the safety of the health professionals when they assess the Right to Health and might recognize violations. They used the situation of Uganda as an example, where the criminalization of LGBTQIA+ community members just reached a new level of discrimination (100). They worried that, if health professionals would report the discrimination of LGBTQIA+ as a violation of the Right to Health, they might risk being arrested themselves.

"They would probably be reluctant to say anything. Because they could be punished in some way." (Key informant 3)

Another aspect of the system is, when health professionals being more part of assessing the Right to Health situation within their scope of work, they need support from their supervisors and the management system. They want the information they assessed to be used. But without a system starting with their supervisors, that will use the information to actively change something, they don't see why they should do it. Whether authorities would accept such a report through international organizations was mentioned as questionable. Besides a regulation of Human Right violations reporting, in many countries there is also a missing regulatory system for medical ethics and the application of these.

"I will record but it's just written. It's finished it will change nothing." (Interviewee 6)

"Production of tools are necessary but not sufficient without any kind of back up from some people with influence." (Key informant 3)

"Another missing link of this chain is the fact that many, many countries don't have established a body that regulates, for example, medical ethics and application of certain standards in care." (Key informant 5)

Especially for LMICs the aspects of costs and available electricity or internet have been mentioned by several participants. In remote areas of the countries, a toolkit that relies on electricity, technology, or internet might be difficult to implement as there is no guarantee and people rely on solar systems often.

"Electricity is not available in Pakistan in remote areas." (Interviewee 3)

5. Discussion

With my research I wanted to explore and analyse the actual and self-perceived role of health professionals in monitoring and implementing the Right to Health and whether a toolkit would be an assessment instrument that could and would be used by health professionals in LMICs.

Most of the interviewed health professionals did not know what the Human Right to Health is. But it did not mean that they did not understand elements of the Right to Health. Health professionals were aware that medical services should be available, acceptable, and accessible, and of good quality. They were aware that through medical ethics, medical procedures should be causing no harm and be created for the benefit of the patient. Through the interviews I could understand that medical ethics and patient's Rights are more familiar to most of the health professionals than the Right to Health. While both are related to the Human Right to Health, they are not the same. When talking about Human Rights, it seemed that health professionals associate more civil and political Human Rights than economic, social, or cultural Human Rights, which confirms what MacNaughton et al mentioned in their article (49). But to take the step from institutionalizing to operationalising the Right to Health as was mentioned by Special Rapporteurs and in official reports from the UN, it is necessary that health professionals understand the same.

Health professionals have an active role in monitoring and implementing elements of the Right to Health. Be it monitoring the prescriptions of the appropriate medication or monitoring who of their patients have better access to services than others. Through following medical ethics and their professional objectives, they already realize elements of the Right to Health, even though they might not be aware of the definition of the Right to Health.

The different role of health professionals could not be directly associated with a specific element of the Right to Health but overlap in many cases and interlink with each other. Quality can be realized through the role as a professional, following connected objectives and using the clinical knowledge they must

guarantee medical services of good quality. Accessibility can be reached through the role of a leader, finding initiatives to reach those from the community that do not visit the health facility, but also through the role as collaborator who finds ways through interdisciplinary collaboration to create access to health facilities. Availability can be realized through health professionals who use their role as communicators, to inform the communities they interact with about the services and their health concerns. Acceptability can be accomplished through professional commitments to medical ethics and through the role of health advocate in promoting non-discrimination and equity. The underlying determinants of health can be monitored and assessed through the role of the health advocate, by going beyond the clinical part of their work.

Health professionals but also key informants complemented the information gathered through literature, that more education and training in Human Rights, including the Right to Health is necessary. But they also raised the importance of existing structures, that give them support when they use their knowledge, when they want to report violations but also for acknowledged ways of implementations. It means giving them opportunities to implement for accessible, acceptable, available, and of good quality health care services. In many LMICs, people cannot reach health care facilities, as they can't afford transportation or simple because there is no transportation service. Health professionals would not only need money to implement accessibility, but authority and power of decision. They can assess it, document it, and report it to their supervisors, they can even inform civil society organizations, but they have their limitations. To motivate health professionals to monitor the Right to Health there needs to be use of the information they have documented and reported.

As scholars, health professionals have a responsibility to not only educate themselves, but also their patients. Informing patients not only about their rights but also about their health situation is crucial for the health outcome of the patient, and according to interview participants is missing in many settings. Especially as illiteracy is in many LMIC still very high, especially on the poorer people in the communities, health professionals are often the only ones that can transfer the needed knowledge appropriately to the patients. While workload might be one reason, why patients often get less information than they need, commitment to this responsibility was another reason mentioned during the interviews. Monitoring their own attitudes and values and those of their colleagues has been described as necessary to realize that patients do not only get the information, they have a right to have but also that the medical services are created in a cultural acceptable way. This is also means that health professionals need to understand the Right to Health, so argumentations like someone "deserves" a specific medical service more than another one disappear.

WHO estimates that by 2030 10 million health workers will be missing globally (35). According to interview participants these missing health professionals influence whether they can take more responsibility on them beside focusing on immediate and emergency care. In literature and the qualitative data collection, the workload has been used as a reason why health professionals could not be involved in more additional responsibilities. Lacking human resources increases workload on the individual, as they need to compensate for the not filled positions. But recognizing the different roles and responsibilities health professionals have and how they already implement and monitor elements of the Right to Health without understanding it completely shows, it's already part of their professional objectives. To avoid that the inequality of migrating health professionals from LMICs to HICs increases, and mostly LMICs suffer from the financial loss among other losses, HIC need to find ways to compensate LMICs.

Prevention of diseases or negative health outcomes is a major part of the work of health professionals. Through the role as a medical expert, in the example of decreasing maternal mortality, they can monitor whether pregnant women are coming to ANC and PNC consultations. To influence prevention

even more, health advocates are needed to implement ways to reach out to the communities, so they are aware of the importance of ANC and PNC visits to decrease maternal mortality.

In which role the health professionals can be part of monitoring and implementing the Right to health also depends on the setting they are operating in. In many settings, security and political oppression make it difficult for them to advocate and speak out. Dual loyalty brings them in situation where they must decide a side, which might not be going along their professional objectives.

With the interviews I also tried to elaborate whether a toolkit would be a good instrument that health professionals could use to monitor the Right to Health within their working environment. Key informants and health professionals argued that an instrument would be a good idea, but only with the connected usage of the results that this instrument would bring. It needs to be avoided to be another tool that is a responsibility for the individual health professional, but that it would or could not be used further. Barriers, often depending on the settings, need to be possible to overcome with flexibility and adaptability to the specific context it is used. Such a toolkit needs to be integrated through training the users, with appropriate management and by respecting the results. Key informants overall seemed to be more sceptical that such an instrument would be used by them, even though they thought it would be useful. It became clear that simply using a toolkit and relying on human commitment might not be as efficient, but with educating and training health professionals in the Right to Health and Human Rights law in general it might be more efficient. However, with a toolkit health professionals could have something in their hands that could help them understanding what needs to be improved and implemented but also to act before violations of the Right to Health occur.

5.1. Relevance of the analytical framework

The CanMEDs framework is originally focused on physicians. While many responsibilities within the different roles can be projected on health professionals in general, this does not count for all of them. In the framework roles and responsibilities, the so-called key concepts bring already explanations that helped to sort the information gathered in context. Some of those key-concepts were not mentioned, as some might have been too focused on physicians and no information could be found on these key-concepts. All roles have been elaborated with the collected data. As many roles of the framework have overlapping key-concepts, it was difficult to fit the gathered information in the appropriate role. Some of the information was also difficult to identify with a specific role, as they might be fitting in different roles or in none perfectly.

5.2. Limitations

Originally this research was planned to be a qualitative data collection without the literature review method. I expected to get a broader view of the self-perceived role the health professionals see themselves in monitoring and implementing the Right to Health. It was also planned on focusing on two LMIC specifically, but due to not getting interview participants from these two countries and the general problem in finding interview participants, the method changed. With a clearer focus on two specific countries, I could have been able to get a little more precisely into their roles in a specific context. Another limitation is that the research is done by only one person, including the conduction of interviews and coding of the data. The research is mostly focused on the AAAQ elements of the Right to Health, while these are not the only ones, less focus has been put on the underlying determinants of health, as it would have exceeded the limitation through word count of this thesis.

6. Recommendations

6.1. Recommendations for medical education institutes

Medical and nursing schools and other health education institutes should give more space in their curricula for Human Right and Right to Health education. The subject on Human Rights should not only be on postgraduate studies.

6.2. Recommendations for health facilities and health management

Health facilities should build structures within their system, so health professional can participate more in realizing the Right to Health. Including mechanisms to report violations and improvement plans to implement elements of the Right to Health. This also means that such a system can be secure for people to report without getting into dual loyalty situations or being punished for it.

6.3. Recommendations for research

- As my research was originally planned to focus on specific countries instead of generalising to LMIC, I would suggest doing more research involving health professionals' opinion and experiences and connect it with the opportunities it could change the Right to Health situation in their country.
- Many articles called for more Human Rights education but during my literature review I could not recognise it has really changed over the last decades. I would suggest more research why is there no change? What are the barriers to it?

6.4. Recommendations for IFHHRO

Whether such a toolkit is going to be used, will very much depend on whether it has options to fit into different settings and cultures. I recommend that such a toolkit is translated in various languages and available in different forms so it can be used not inclusively for some but for everyone where it is used. I also recommend that such a toolkit is only offered with a connected training in the Right to Health and Human Rights law in general.

6.5. Recommendations for health profession associations

International and national medical, nursing, and midwifery associations need to involve themselves more, instruments such as toolkits can best work when regulated through the supporting associations. They also need to not only advocate for more Human Rights education, but actively get into action to change the health education system in their countries. They also need to use their position within a country to advocate for more implementation mechanisms of the Right to Health.

7. Conclusion

Health professionals play a crucial role in promoting and protecting Human Rights, including the Right to Health. As I can conclude from this study the knowledge about the Right to Health among health professionals was little. But I can also conclude without understanding the Right to Health fully, health professionals actively participate in monitoring and implementing the Right to Health through their different roles and the responsibilities coming with it. The elements accessibility, availability, acceptability, and quality are actively monitored and implemented by health professionals. However, to say someone is monitoring whether a violation of the Right to Health exists, a better understanding is necessary. To involve health professionals more effectively into monitoring mechanism of the Right to Health, it is important that they are trained and educated in it. To implement elements of the Right to Health that goes beyond the health facilities, to realize the Right to Health of the people visiting them, it is again important that they understand what the Right to Health means and entitles.

But even with having more health professionals understanding the Right to Health, without a system and structures, that support the realization of the Right to Health, their efforts have limitations. Management and authorities need to recognize when health professionals report violations. They need to give them tools and opportunities to implement the Right to Health. They should not fear reprisal or dismissals. A toolkit may be a good supporting mechanism for health professionals to guide them where implementation of elements of the Right to Health are necessary and to provide them with a monitoring mechanism, they can use to initiate change and report further. But for the toolkit as well structure and a functioning system behind it, is needed.

In many LMICs, a progressive realization of the Right to Health is a solution to reduce the health inequities with the countries. But beside the authorities, there needs to be more awareness about it. Those having the possibilities, such as health professionals, to actively initiate change through monitoring and implementing the Right to Health, need to be part of it.

References

1. European Network of National Human Rights Institutions. Human Rights-Based Approach [Internet]. 2023 [cited 2023 Aug 1]. Available from: <https://ennhri.org/about-nhris/human-rights-based-approach/>
2. World Health Organization. Maternal mortality [Internet]. 2023 [cited 2023 Jul 23]. Available from: <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>
3. World Health Organization. Newborn mortality [Internet]. 2022 [cited 2023 Jul 23]. Available from: <https://www.who.int/news-room/fact-sheets/detail/levels-and-trends-in-child-mortality-report-2021>
4. World Health Organization. HIV/ AIDS [Internet]. 2023 [cited 2023 Jul 26]. Available from: <https://www.who.int/news-room/fact-sheets/detail/hiv-aids>
5. World Health Organization. Tuberculosis [Internet]. 2023 [cited 2023 Jul 26]. Available from: <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>
6. World Health Organization. Noncommunicable diseases [Internet]. 2022 [cited 2023 Aug 1]. Available from: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>
7. UN Sustainable Development group. Human Rights-Based Approach [Internet]. 2023 [cited 2023 Aug 1]. Available from: <https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach>
8. London L. What is Human Rights- Based Approach to Health and does it matter? 2008;(1):65–80.
9. Villar Uribe M, Escobar ML, Ruano AL, Iunes RF. Realizing the right to health in Latin America, equitably. *Int J Equity Health*. 2021;20(1):1–6.
10. Human Rights Careers. What is a Human Rights-Based Approach? [Internet]. 2023 [cited 2023 Aug 1]. Available from: <https://www.humanrightscareers.com/issues/what-is-a-human-rights-based-approach/>
11. Beauchamp TL. Respect for autonomy. In: *Principles of biomedical ethics*. 5th ed. OXFORD UNIVERSITY PRESS; 2001. p. 57–68.
12. Beauchamp TL. The Concept of Beneficence. In: *Principles of biomedical ethics*. 5th ed. OXFORD UNIVERSITY PRESS; 2001. p. 166.

13. Beauchamp TL. The Concept of Nonmaleficence. In: Principles of biomedical ethics. 5th ed. OXFORD UNIVERSITY PRESS; 2001. p. 114–7.
14. Beauchamp TL. The concept of Justice. In: Principles of biomedical ethics. 5th ed. OXFORD UNIVERSITY PRESS; 2001. p. 226–9.
15. Cohen J, Ezer T. HUMAN RIGHTS IN PATIENT CARE: A THEORETICAL AND PRACTICAL FRAMEWORK. *Health Hum Rights*. 2013;15(2):7–19.
16. World Health Organization. Universal Health Coverage [Internet]. 2023 [cited 2023 Aug 1]. Available from: [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))
17. United Nations. SDG Goal 3: Ensure healthy lives and promote well-being for all at all ages [Internet]. [cited 2023 Jul 26]. Available from: <https://sdgs.un.org/goals/goal3>
18. World Health Organization. UHC service coverage index (SDG3.8.1) [Internet]. 2023 [cited 2023 Aug 1]. Available from: [https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/uhc-service-coverage-index-\(sdg-3.8.1\)](https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/uhc-service-coverage-index-(sdg-3.8.1))
19. United Nations. Sustainable development goals - the 17 goals [Internet]. 2023 [cited 2023 Jul 29]. Available from: <https://sdgs.un.org/goals>
20. United Nations. International Covenant on Economic, Social and Cultural Rights. 1966;
21. Hamadeh N, Rompaey C van, Metreau E, Eapen SG. New World Bank country classification by income level: 2022-2023 [Internet]. *World Bank Blogs*. 2022 [cited 2023 Aug 5]. Available from: <https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023>
22. United Nations. Universal Declaration of Human Rights - History of the declaration [Internet]. [cited 2023 Jul 25]. Available from: <https://www.un.org/en/about-us/udhr/history-of-the-declaration>
23. United Nations. The “Universal” Declaration of Human Rights. 1948; Available from: <https://www.un.org/sites/un2.un.org/files/2021/03/udhr.pdf>
24. WHO. Basic Documents: 49th edition [Internet]. 2020. 1–244 p. Available from: <https://apps.who.int/gb/bd/>
25. Meier BM, De Milliano M, Chakrabarti A, Kim Y. Accountability for the human right to health through treaty monitoring: Human rights treaty bodies and the influence of concluding observations. *Glob Public Health* [Internet]. 2018;13(11):1558–76. Available from: <https://doi.org/10.1080/17441692.2017.1394480>
26. Office of the High Commissioner for Human Rights. United Nations Human Rights Treaty Bodies database [Internet]. 2023 [cited 2023 Jul 30]. Available from: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?Treaty=CESCR
27. United Nations Human Rights office of the High Commissioner. Instruments and mechanisms [Internet]. 2023 [cited 2023 Aug 2]. Available from: <https://www.ohchr.org/en/instruments-and-mechanisms>
28. United Nations. Report on Indicators for Monitoring Compliance with International Human Rights Instruments. Vol. 41960. 2006.
29. Office of the High Commissioner for Human Rights. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Adopt Twenty-second Sess Comm Econ Soc Cult Rights, 11 August 2000 (Contained Doc E/C12/2000/4) [Internet].

- 2000;2000(14):1–21. Available from:
<https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf>
30. World Health Organization. Global Health Expenditure database [Internet]. 2023 [cited 2023 Aug 6]. Available from: <https://apps.who.int/nha/database/Home/Index/en>
 31. Lindmeier C. Countries must invest at least 1% more of GDP on primary health care to eliminate glaring coverage gaps [Internet]. World Health Organization. 2019 [cited 2023 Aug 2]. Available from: <https://www.who.int/news/item/22-09-2019-countries-must-invest-at-least-1-more-of-gdp-on-primary-health-care-to-eliminate-glaring-coverage-gaps>
 32. International Organization for Migration. International Migration, Health and Human rights. Int Migr Heal Hum rights [Internet]. 2013;1–64. Available from: www.iom.int
 33. United Nations. IMPLEMENTATION OF GENERAL ASSEMBLY RESOLUTION 60/251 OF 15 MARCH 2006 ENTITLED “HUMAN RIGHTS COUNCIL”- A/HRC/4/28. 2007.
 34. S. Sirkin, V. Iacopino, M. Grodin YD. The Role of Health Professionals in Protecting and Promoting Human Rights: A Paradigm for Professional Responsibility. In: The Universal Declaration of HUMAN Rights: Fifty years and beyond. 1st Editio. Routledge; 2018. p. 355–69.
 35. Boniol M, Kunjumen T, Nair TS, Siyam A, Campbell J, Diallo K. The global health workforce stock and distribution in 2020 and 2030: A threat to equity and “universal” health coverage? *BMJ Glob Heal*. 2022;7(6):1–8.
 36. Ray S, Madzimbamuto F, Fonn S. Activism: Working to reduce maternal mortality through civil society and health professional alliances in sub-Saharan Africa. *Reprod Health Matters*. 2012;20(39):40–9.
 37. Edwards J. Landmark case in Uganda on maternal deaths [Internet]. Thomas Reuters Foundation. 2011 [cited 2023 Jul 25]. Available from: <https://news.trust.org/item/20110902023200-1wzfp>
 38. Mulumba M. How the death of two Ugandan mothers is helping entrench the right to health care [Internet]. The Conversation. 2016 [cited 2023 Jul 25]. Available from: <https://theconversation.com/how-the-death-of-two-ugandan-mothers-is-helping-entrench-the-right-to-health-care-54703>
 39. London L, Baldwin-Ragaven L. Human rights and health: challenges for training nurses in South Africa. *Curationis*. 2008;31(1):5–18.
 40. Truth and Reconciliation Commission of South Africa. Volume four Ch1-10. Rep Hum Rights Viol Comm [Internet]. 1998;4. Available from: <http://www.justice.gov.za/trc/report/>
 41. United Nations. Commission on Human Rights 59th session E/CN.4/2003/58. 2003.
 42. Barac R, Stein S, Bruce B, Barwick M. Scoping review of toolkits as a knowledge translation strategy in health. *BMC Med Inform Decis Mak*. 2014;14(1):1–9.
 43. UNAIDS. 90–90–90: good progress, but the world is off-track for hitting the 2020 targets [Internet]. 2019 [cited 2023 Aug 1]. Available from: <https://www.unaids.org/en/90-90-90>
 44. World Health Organization. Global Tuberculosis programme - The End TB strategy [Internet]. 2023 [cited 2023 Aug 1]. Available from: <https://www.who.int/teams/global-tuberculosis-programme/the-end-tb-strategy>
 45. FAO, IFAD, UNICEF, WFP, WHO. The Food security and nutrition in the world 2023. FAO Rome. 2023.

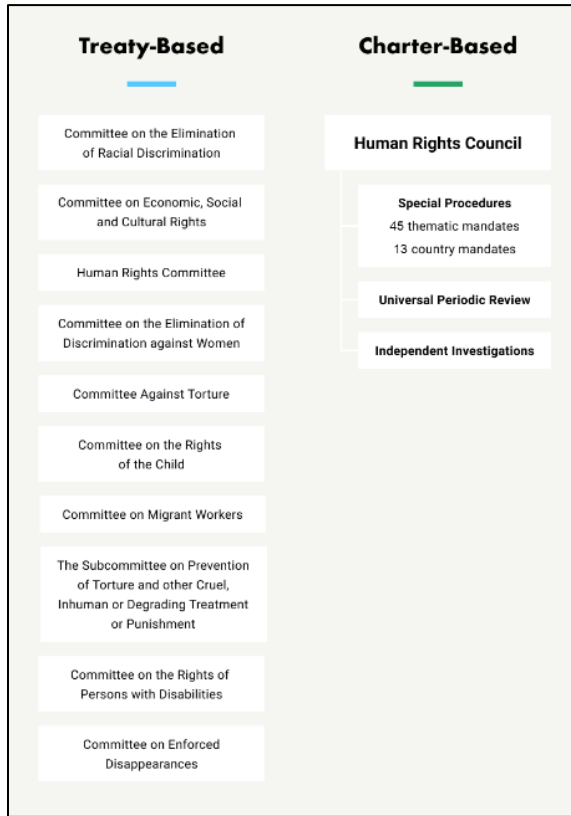
46. Amnesty International. Amnesty International Report 2022/23. 2022.
47. Yamin AE. Promoting Equity in Health. *Health Hum Rights*. 2014;16:1–9.
48. Kiyancicek Z, Dedeli O, Yildiz E, Senakin G. A Survey: Health Professionals' Attitude towards Patient Rights and Patient Safety. *Asian J Pharmacy, Nurs Med Sci* [Internet]. 2014;02(01):2321–3639. Available from: www.ajouronline.com
49. Macnaughton G, McGill M. The challenge of interdisciplinarity in operationalizing the right to health. *Health Hum Rights*. 2019;21(2):251–62.
50. Vanthuyne K, Meloni F, Ruiz-Casares M, Rousseau C, Ricard-Guay A. Health workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege? *Soc Sci Med*. 2013;93:78–85.
51. Ezer T, Overall J. Advancing Human Rights in Patient Care through Higher Education in Eastern Europe and Central Asia. In: *Health and Human Rights*. HeinOnline; 2013. p. 54–68.
52. United Nations. General Assembly A/60/348: Report of the Special Rapporteur on the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2005.
53. Hunt P, Backman G. Health Systems and the Right to the highest attainable Standard of Health. *Health Hum Rights*. 2008;10:81–92.
54. Wang AJ, Yan Y. The SAGE handbook of interview research: the complexity of the craft. *Choice Rev Online*. 2012;49(12):49-6645-49–6645.
55. Duevel C. SAGE Research Methods. *Charlest Advis*. 2019;19(4):38–41.
56. Roberts RE. Qualitative interview questions: Guidance for novice researchers. *Qual Rep*. 2020;25(9):3185–203.
57. The Royal College of Physicians and Surgeons of Canada. CanMEDS 2015 Timeline. *Evol CanMEDS Framew* [Internet]. 2015; Available from: <http://www.royalcollege.ca/portal/page/portal/rc/canmeds/canmeds2015/overview>
58. The Royal College of Physicians and Surgeons of Canada. CanMEDS: Better standards, better physicians, better care [Internet]. 2015 [cited 2023 Jul 25]. Available from: <https://royalcollege.ca/rcsite/canmeds/canmeds-framework-e>
59. Office of the United Nations High Commissioner for Human Rights, World Health Organization. Factsheet No. 31: The right to health. 2003.
60. Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. *Lancet*. 2018;392(10160):2203–12.
61. Abbas N, Hasan SS, Curley L, Babar ZUD. Access to medicines - a systematic review of the literature. *Res Soc Adm Pharm* [Internet]. 2020;16(9):1166–76. Available from: <https://doi.org/10.1016/j.sapharm.2019.12.009>
62. WHO. World Health Organization. Promoting rational use of medicines: core components. *WHO Policy Perspect Med*. 2002;1–6.
63. Gruskin S, Mills EJ, Tarantola D. History, principles, and practices of health and human rights. *Lancet*. 2007;370:449–255.
64. Amnesty International. Prescription for change - Health professionals and the exposure of human rights violations. 1996.

65. Fitchett JR. The right to health in practice. *Int J Clin Pract.* 2011;65(3):245–8.
66. International Council of Nurses. Council of Nurses THE ICN CODE OF ETHICS FOR NURSES [Internet]. 2021. Available from: https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf
67. World Medical Association. Medical ethics manual. 2015.
68. International confederation of midwives. International Code of Ethics for Midwives. 2014.
69. Mann J, Tarantola D. Responding to HIV/ AIDS: A historical perspective. *Heal Hum Rights J.* 1998;4:5–8.
70. Sundler AJ, Darcy L, Råberus A, Holmström IK. Unmet health-care needs and human rights—A qualitative analysis of patients’ complaints in light of the right to health and health care. *Heal Expect.* 2020;23(3):614–21.
71. Thompson JB. A human rights framework for midwifery care. *J Midwifery Women’s Heal.* 2004;49(3):175–81.
72. Backman G, Hunt P, Khosla R, Jaramillo-Strouss C, Fikre BM, Rumble C, et al. Health systems and the right to health: an assessment of 194 countries. *Lancet.* 2008;372(9655):2047–85.
73. World Health Organization. Human Rights and Health [Internet]. 2022 [cited 2023 Jul 29]. Available from: <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>
74. McKinnon I, Lor A, Evans DP. An assessment of human rights-based approaches to health knowledge, attitudes, and practices among centers for disease control and prevention locally employed staff. *Health Hum Rights.* 2019;21(1):33–44.
75. Baldwin-Ragaven L, London L, De Gruchy J. Learning from our apartheid past: Human rights challenges for health professionals in contemporary South Africa. *Ethn Heal.* 2000;5(3–4):227–41.
76. Hunt P. The human right to the highest attainable standard of health: new opportunities and challenges. *Trans R Soc Trop Med Hyg.* 2006;100(7):603–7.
77. Vranes AJ, Mikanovic VB, Vukovic D, Djikanovic B, Babic M. Education on human rights and healthcare: Evidence from Serbia. *Health Promot Int.* 2015;30(1):101–4.
78. Rashid A. Human rights and education. OSI Education Conference 2005: “Education and Open Society: A Critical Look at New Perspectives and Demands.” 2005.
79. World Medical Association. WMA Resolution on the inclusion on medical ethics and human rights in the curriculum of medical schools world-wide [Internet]. 2022. Available from: <https://www.wma.net/policies-post/wma-resolution-on-the-inclusion-of-medical-ethics-and-human-rights-in-the-curriculum-of-medical-schools-world-wide/>
80. Glowa-Kollisch S, Graves J, Dickey N, Macdonald R, Rosner Z, Waters A, et al. Data-driven human rights: Using dual loyalty trainings to promote the care of vulnerable patients in jail. *Health Hum Rights.* 2015;17(1):124–35.
81. Maher L, Dixon TC, Phlong P, Mooney-Somers J, Stein ES, Page K. Conflicting rights: How the prohibition of human trafficking and sexual exploitation infringes the right to health of female sex workers in Phnom Penh, Cambodia. *Health Hum Rights.* 2015;17(1):102–13.
82. Maru D, Farmer PE. Human Rights and Health systems development: confronting the politics of exclusion and the economics of inequality. *Health Hum Rights.* 2012;14(2):1–9.
83. Braveman P, Gruskin S. Poverty, equity, human rights and health. *Bull World Health Organ.*

- 2003;81(7):539–45.
84. Bakshi S, James A, Hennelly MO, Karani R, Palermo AG, Jakubowski A, et al. The Human Rights and Social Justice Scholars Program: A Collaborative Model for Preclinical Training in Social Medicine. *Ann Glob Heal* [Internet]. 2015;81(2):290–7. Available from: <http://dx.doi.org/10.1016/j.aogh.2015.04.001>
 85. Ventura CAA, Mendes IAC, De Godoy S, Fumincelli L, Souza MC, Souza Junior VD. Perceptions of brazilian nursing faculty members regarding literacy of human rights related to health in nursing undergraduate programs. *BMC Int Health Hum Rights*. 2019;19(1):1–7.
 86. World Health Organization. People-Centred Health Care A Policy Framework. *World Heal Organ*. 2007;13–4.
 87. Lohman D. Retreat from human rights and adverse consequences for health. *JAMA - J Am Med Assoc*. 2018;319(9):861–2.
 88. Schuftan C. Nurses, Public Health, and Human Rights: Their Role as Claim Holders, Duty Bearers, and Promoters of Social Change. *Creat Nurs*. 2021;27(3):163–6.
 89. United Nations. UN Security Council. Letter dated 18 August 2016 from the Secretary-General addressed to the President of the Security Council. 2016.
 90. McKenzie KC, Mishori R, Ferdowsian H. Twelve tips for incorporating the study of human rights into medical education. *Med Teach* [Internet]. 2020;42(8):871–9. Available from: <https://doi.org/10.1080/0142159X.2019.1623384>
 91. Chaudhury N, Hammer JS. Ghost doctors: Absenteeism in rural Bangladeshi health facilities. *World Bank Econ Rev*. 2004;18(3):423–41.
 92. Azétsop J, Ochieng M. The right to health, health systems development and public health policy challenges in Chad. *Philos Ethics, Humanit Med*. 2015;10(1):1–14.
 93. London L, Baldwin-Ragaven L, Kalebi A, Maart S, Petersen L, Kasolo J. Developing human rights competencies for South African health professional graduates. *South African Med J*. 2007;97(12 I):1269–70.
 94. Kirigia JM, Gbary AR, Muthuri LK, Nyoni J, Seddoh A. The cost of health professionals’ brain drain in Kenya. *BMC Health Serv Res*. 2006;6:1–10.
 95. Physicians for Human Rights. An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa A Report by Physicians for Human Rights. *Heal Action Aids* [Internet]. 2004;1–129. Available from: <https://allafrica.com/download/resource/main/main/idatcs/00010242:21e6b22646882263f8b7aa73a71c810c.pdf>
 96. Hunt P. Configuring the UN human rights system in the “Era of implementation”: Mainland and archipelago. *Hum Rights Q*. 2017;39(3):489–538.
 97. Allhoff F, editor. *Physicians at War*. Springer. 2008.
 98. Peel M. Human rights and medical ethics. *J R Soc Med*. 2005;98(4):171–3.
 99. Pérez-Molina A, Sánchez-Pérez HJ, Yanes-Pérez M, Arana-Cedeño M. Tuberculosis care in Mexico’s Chiapas highlands region: A right to health analysis. *Health Hum Rights*. 2020;22(1):305–16.
 100. Atuhaire P. Uganda Anti-Homosexuality bill: Life in prison for saying you’re gay [Internet]. *BBC News Kampala*. 2023 [cited 2023 Jul 30]. Available from: <https://www.bbc.com/news/world->

Annexes

Annex 1: Human Rights instruments and monitoring mechanisms



Source: Office of the High Commissioner of Human Rights (27)

Annex 2: List of indicators from the ICESCR

	Reproductive health	Child mortality and health care	Natural and occupational environment	Prevention, treatment and control of diseases	Accessibility to health facilities and essential medicines
Structural indicators	<ul style="list-style-type: none"> International human rights instruments, relevant to the right to health, ratified by the State Period of application and coverage of the right to health in supreme law/Constitution/bill of rights Period of application and coverage of domestic laws relevant to the implementation of the right to health Number of registered civil society organizations involved in the promotion and protection of the right to health Estimated proportion of births, deaths and marriages recorded through vital registration system 	<ul style="list-style-type: none"> Period of application and coverage of national policy on child health and nutrition 	<ul style="list-style-type: none"> Period of application and coverage of national health policy Period of application and coverage of national policy for mentally challenged and disabled Period of application and coverage of national drug policy, including on generic drugs 		
Process indicators	<ul style="list-style-type: none"> Number of complaints concerning the right to health, received, investigated and adjudicated by the national human rights institution/human rights ombudsperson/specialized institution and other administrative mechanisms (created to protect the interest of specific population groups) in the specified period Net official development assistance for health sector received/provided as proportion of public expenditure on health/gross national income (GNI) Proportion of births attended by skilled health personnel* Proportion of women receiving pre- and post-natal care Percentage of women of child-bearing age using contraception or whose partner is using contraception (CPR) Medical terminations of pregnancy as a proportion of live births Total and adolescent fertility rates Reported cases of genital mutilation, rape and other violence restricting women's sexual and reproductive freedom 	<ul style="list-style-type: none"> Proportion of school-going children educated on health issues Proportion of children having regular medical check-up Proportion of children covered under nutrition supplement programmes Proportion of one-year-olds immunized against vaccine-preventable diseases (e.g. measles*) 	<ul style="list-style-type: none"> Proportion of population with sustainable access to an improved water source* Proportion of population with access to improved sanitation* Proportion of population using solid fuels* Number of cases of deterioration of water sources brought to justice Proportion of population living/working in hazardous conditions 	<ul style="list-style-type: none"> Proportion of population covered under awareness-raising programmes on transmission of diseases (e.g. HIV/AIDS*) Proportion of population (above age one) immunized against vaccine-preventable diseases Proportion of population applying effective preventive measures (e.g. against HIV/AIDS, malaria*) 	<ul style="list-style-type: none"> Per capita government expenditure on primary health care Density of medical and paramedical personnel, hospital beds Proportion of population with access to affordable essential drugs on a sustainable basis* Proportion of people covered by health insurance Proportion of people covered under indigenous/alternative systems of health care

	Reproductive health	Child mortality and health care	Natural and occupational environment	Prevention, treatment and control of diseases	Accessibility to health facilities and essential medicines
				<ul style="list-style-type: none"> • Proportion of disease cases detected and cured (e.g. tuberculosis*) • Incidence of substance abuse (e.g. drug, alcohol, chemical and psychoactive substance) 	<ul style="list-style-type: none"> • Proportion of disabled and mentally challenged persons accessing public/social institutional services • Share of public expenditure on essential medicines met through international aid
Outcome indicators	<ul style="list-style-type: none"> • Proportion of live births with low birth-weight • Perinatal mortality rate • Maternal mortality ratio* 	<ul style="list-style-type: none"> • Infant and under-five mortality rates* • Proportion of underweight children under five years of age* 	<ul style="list-style-type: none"> • Incidence of deaths/diseases/injuries caused by unsafe natural and occupational environment 	<ul style="list-style-type: none"> • Prevalence and death rates associated with communicable and non-communicable diseases (e.g. HIV/AIDS, malaria, tuberculosis*) • Prevalence of disability/proportion of mentally challenged persons • Life expectancy at birth/age one/health-adjusted life expectancy • Suicide rates 	

Source: (28)

Annex 3: Interview guide for health professionals

Professional background

- Would you mind telling me a little more about what your position is?
 - How long have you been working in this position?
 - Have you been working all the time at the same place? Same country?
 - If not: Which kind of health care services/ facilities have you been working with? (Primary Health Care/ Secondary, Private/governmental/ non-profit)
 - And what kind of responsibilities are coming with your position? How does the structure of your organization look like?
- When you think back to your time at school and health education, what do you remember about how the right to health was mentioned within your curriculum?
 - Have there been any other Human Rights been mentioned?
 - Since you graduated what kind of trainings that involved human rights have been offered or did you attend?
 - How sufficient would you describe your education and training in Human Rights? What would you change? Would you suggest more or less trainings?

Perspective on the Right to Health

- Have you ever heard about the Human Right “Right to Health” or the enjoyment of the highest attainable standard of physical and mental health?
 - If yes: Can you tell me what your understanding is?
 - What does Right to Health mean to you as a Nurse/ Physician/ Midwife?
- When you think about the highest attainable standard of physical and mental health for your patients, how would that look like?
 - What is missing for your patients to attain this?
 - And what do you think could improve that?

The role of the health professional

- When you think about your patients, what kind of role do you have as a nurse/physician/midwife to obtain your patients’ rights?
- How would you describe your role in monitoring the right to health as a nurse/ physician/ midwife in regards of availability, accessibility, acceptability, and quality? And what aspects need to be addressed to perform such a monitoring role?
- Have you within your position ever experienced Human Rights (Right to Health) violations? Or a situation which you could think of that might have been one?
 - Would you mind describing what you’ve witnessed?
 - Why did you think it’s a violation?
 - What did you do?

- Would you know who to approach within your health care facility? Are you aware of any guidelines in place within your organization or health facility?
 - If yes: Can you describe the approach you'd take?
 - If no: How do you think it could/ should be?

Improvement in future assessment and implementation of the Right to Health

- What do you think how you as a nurse/ physician/ midwife could participate more in assessing the Right to Health within your profession? What could be your role/ responsibility in assessing the Right to Health under ideal circumstances?
- Do you consider yourself having influence to change something?
 - If yes what are elements that make you feel being able to act?
 - If no, why not?
- What would you think about using an easy-to-use assessment instrument (a toolkit) to apply the Right to Health?
 - How could such a toolkit look like that you'd feel comfortable using it?
 - Who do you think should be involved in it?
 - What would you see as advantages for such?
 - What would be barriers in your work environment to use such instrument?

[Annex 4: Interview guide for key informants](#)

Professional Background

- Would you mind sharing with me what your position is?
- What are your main responsibilities?
- How is your position connected with implementing Human Rights within your organization?

The connection to the Right to Health

- How do you assess the Right to Health within your organization and the health care facilities you are working with?
- How do you implement the Right to Health within your organization and the health care facilities you are working with?
 - Are you using any tools?
- How would you describe the organizations' role regarding the availability, accessibility, acceptability, and quality of medical services for the population you are working with?
 - What kind of steps could you do within your organization to get those realized?
 - What kind of steps could you do beyond your organization to get those realized?
- How would you describe the organizations' role regarding monitoring underlying determinants of health, like access to safe water and sanitation, food security, and housing?
 - What are the steps your organization is able to do, when the population you are working with recognizes lacking or not existing of those?
- Are you training health professionals in aspects of the Right to Health?
 - If yes: How do they get trained?
- What would you say are the responsibilities of health professionals regarding the Right to Health?
- What do you expect from them?
- Is there anything that can be improved?

- If yes could you specify?
- When Health professionals recognize a human rights (Right to Health) violation, what could or should they do?
- What do you think is necessary to reach a human rights-based approach in health?
 - Within your own organization?
 - Beyond your organization?
- How could you emphasize a way of assessing and/ or implementing the Right to Health for the Health professionals working frontline in your organization?
- Would you see a need to have an easy-to-use instrument (a toolkit) to apply the right to health?
 - How could such tool(kit) look like to work best for your organization? (E.g. digital, paper, questionnaire or checklist?)
 - How could you think of using it? Who should be involved?
 - Would your organization use it if it is available?
 - What could be barriers to overcome for the use of such a tool?

Annex 5: Key concepts of the CanMEDs framework

Source: (57)

The Role as a professional	
<p>KEY CONCEPTS</p> <p>Professional identity: 1.1, 4.1, 4.2</p> <p>Commitment to patients</p> <p>Altruism: 1.1</p> <p>Bioethical principles and theories: 1.3</p> <p>Commitment to excellence in clinical practice and mastery of the discipline: 1.2</p> <p>Compassion and caring: 1.1</p> <p>Confidentiality and its limits: 1.1, 1.5</p> <p>Disclosure of physician limitations that affect care: 1.1</p> <p>Insight: 1.1, 1.3, 1.4, 2.1</p> <p>Integrity and honesty: 1.1</p> <p>Moral and ethical behaviour: 1.1, 1.3</p> <p>Professional boundaries: 1.1</p> <p>Respect for diversity: 1.1</p> <p>Commitment to society</p> <p>Commitment to the promotion of the public good in health care: 2.1, 2.2</p>	<p>Social accountability: 2.1, 2.2</p> <p>Social contract in health care: 2.1, 2.2</p> <p>Societal expectations of physicians and the profession: 2.1, 2.2</p> <p>Commitment to the profession</p> <p>Accountability to professional regulatory authorities: 3.1</p> <p>Codes of ethics: 3.1</p> <p>Commitment to patient safety and quality improvement: 2.1, 4.1</p> <p>Commitment to professional standards: 3.1</p> <p>Conflicts of interest (personal, financial, administrative, etc.): 1.4</p> <p>Medico-legal frameworks governing practice: 3.1, 3.3</p> <p>Responsibility to the profession, including obligations of peer assessment, mentorship, collegiality, and support: 3.2, 3.3, 4.3</p>
The Role as a scholar	

KEY CONCEPTS**Lifelong learning**

Collaborative learning: 1.3
 Communities of practice: 1.3
 Patient safety: 1.3
 Performance assessment: 1.2
 Personal learning plan: 1.1
 Quality improvement: 1.1, 1.2, 1.3
 Reflection on practice: 1.2
 Seeking feedback: 1.2
 Self-improvement: 1.1, 1.2, 1.3

Teacher

Faculty, rotation, and program evaluation: 2.5, 2.6
 Formal and informal curricula: 2.1
 Hidden curriculum: 2.1
 Learner assessment: 2.5, 2.6
 Learning outcomes: 2.4, 2.5, 2.6
 Mentoring: 2.2, 2.5
 Needs assessment: 2.4
 Optimization of the learning environment: 2.2
 Principles of assessment: 2.6
 Providing feedback: 2.5, 2.6
 Role-modelling: 2.1, 2.5
 Supervision and graded responsibility: 2.3
 Teaching and learning: 2.2, 2.4, 2.5

Evidence-informed decision-making

Effect size: 3.3, 3.4
 Evidence-based medicine: 3.1, 3.2, 3.3, 3.4
 Evidence synthesis: 3.2, 3.3
 External validity: 3.3
 Generalizability: 3.3
 Information literacy: 3.2
 Internal validity: 3.3
 Knowledge gaps: 3.1
 Knowledge translation: 3.3, 3.4
 Quality-appraised evidence-alerting services: 3.2, 3.4
 Recognizing bias in research: 3.3
 Structured critical appraisal: 3.3
 Uncertainty in practice: 3.1

Research

Conflict of interest: 4.2, 4.5
 Confidentiality: 4.1, 4.2
 Informed consent: 4.1
 Research: 4.1, 4.2, 4.3, 4.5
 Research ethics: 4.2
 Research methods: 4.4
 Scholarly inquiry: 4.1, 4.2, 4.4, 4.5
 Scholarship: 4.1, 4.2
 Scientific principles: 4.1

The Role as a health advocate**KEY CONCEPTS**

Adapting practice to respond to the needs of patients, communities, or populations served: 2.1, 2.2

Advocacy in partnership with patients, communities, and populations served: 1.1, 1.2, 2.1, 2.2, 2.3

Continuous quality improvement: 2.2, 2.3

Determinants of health, including psychological, biological, social, cultural, environmental, educational, and economic determinants, as well as health care system factors: 1.1, 1.3, 2.2

Disease prevention: 1.3, 2.1

Fiduciary duty: 1.1, 2.2, 2.3

Health equity: 2.2

Health promotion: 1.1, 1.2, 1.3, 2.1

Health protection: 1.3

Health system literacy: 1.1, 2.1

Mobilizing resources as needed: 1.1, 1.2, 1.3

Principles of health policy and its implications: 2.2

Potential for competing health interests of the individuals, communities, or populations served: 2.3

Responsible use of position and influence: 2.1, 2.3

Social accountability of physicians: 2.1, 2.3

The role as a leader

KEY CONCEPTS

Administration: 4.1, 4.2
Career development: 4.2
Complexity of systems: 1.1
Consideration of justice, efficiency, and effectiveness in the allocation of health care resources: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2
Effective committee participation: 3.2
Health human resources: 2.1, 4.2
Information technology for health care: 1.4
Leading change: 1.1, 1.2, 1.3, 1.4, 2.2, 3.2
Management of personnel: 4.2
Negotiation: 3.1
Organizing, structuring, budgeting, and financing: 2.1, 2.2, 4.1, 4.2, 4.3
Personal leadership skills: 3.1, 4.1
Physician remuneration: 4.2
Physician roles and responsibilities in the health care system: 1.1, 1.2, 1.3, 1.4, 2.2, 3.2
Physicians as active participant-architects within the health care system: 1.1, 1.2, 1.3, 1.4, 3.2
Practice management to maintain a sustainable practice and physician health: 4.1, 4.2, 4.3
Priority-setting: 2.1, 3.2, 4.1
Quality improvement: 1.1, 1.2, 1.3, 1.4, 2.2, 3.2, 4.3
Stewardship: 2.1, 2.2
Supervising others: 4.2
Systems thinking: 1.1, 1.2, 1.3, 1.4, 2.1, 2.2
Time management: 4.1, 4.2

The Role as a collaborator

KEY CONCEPTS

Collaboration with community providers: 1.1, 1.2, 1.3
Communities of practice: 1.3, 3.2
Conflict resolution, management, and prevention: 2.2
Constructive negotiation: 2.2
Effective consultation and referral: 1.2, 1.3, 3.1, 3.2
Effective health care teams: all enabling competencies
Handover: 3.1, 3.2
Interprofessional (i.e. among health care professionals) health care: all enabling competencies
Intraprofessional (i.e. among physician colleagues) health care: all enabling competencies
Recognizing one's own roles and limits: 1.2, 3.1
Relationship-centred care: all enabling competencies
Respect for other physicians and members of the health care team: 2.1, 2.2
Respecting and valuing diversity: 1.2, 2.1, 2.2
Shared decision-making: 1.3
Sharing of knowledge and information: 1.3, 3.1, 3.2
Situational awareness: 1.1, 1.2, 2.2, 3.1, 3.2
Team dynamics: 1.1, 2.2, 3.1
Transitions of care: 3.1, 3.2

The Role as a communicator	The Role as a Medical Expert
<p>KEY CONCEPTS</p> <p>Accuracy: 2.1, 3.1, 4.2, 5.1</p> <p>Active listening: 1.1, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 4.1, 4.3</p> <p>Appropriate documentation: 2.1, 5.1, 5.2, 5.3</p> <p>Attention to the psychosocial aspects of illness: 1.6, 2.1, 2.2, 4.1</p> <p>Breaking bad news: 1.5, 3.1</p> <p>Concordance of goals and expectations: 1.6, 2.2, 3.1, 4.3</p> <p>Disclosure of harmful patient safety incidents: 3.2</p> <p>Effective oral and written information for patient care across different media: 5.1, 5.2, 5.3</p> <p>Efficiency: 2.3, 4.2, 5.2</p> <p>Eliciting and synthesizing information for patient care: 2.1, 2.2, 2.3</p> <p>Empathy: 1.1, 1.2, 1.3</p> <p>Ethics in the physician–patient encounter: 3.2, 5.1</p> <p>Expert verbal and non-verbal communication: 1.1, 1.4</p> <p>Informed consent: 2.2</p> <p>Mutual understanding: 1.6, 3.1, 4.1</p> <p>Patient-centred approach to communication: 1.1, 1.6, 2.1, 3.1</p> <p>Privacy and confidentiality: 1.2, 5.1</p> <p>Rapport: 1.4</p> <p>Relational competence in interactions: 1.5</p> <p>Respect for diversity: 1.1, 1.6, 2.2, 4.1</p> <p>Shared decision-making: 1.6, 4.1, 4.3</p> <p>Therapeutic relationships with patients and their families: 1.2, 1.3, 1.4, 1.5, 1.6</p> <p>Transition in care: 5.1, 5.2, 5.3</p> <p>Trust in the physician–patient relationship: 1.1, 5.2, 5.3</p>	<p>KEY CONCEPTS</p> <p>Agreed-upon goals of care: 2.1, 2.3, 2.4, 3.2, 4.1</p> <p>Application of core clinical and biomedical sciences: 1.3</p> <p>Clinical decision-making: 1.4, 1.6, 2.2</p> <p>Clinical reasoning: 1.3, 1.4, 2.1, 3.1</p> <p>Compassion: 1.1</p> <p>Complexity, uncertainty, and ambiguity in clinical decision-making: 1.6, 2.2, 2.4, 3.2, 3.3, 3.4</p> <p>Consent: 3.2</p> <p>Continuity of care: 2.4, 4.1</p> <p>Duty of care: 1.1, 1.5, 2.4</p> <p>Integration of CanMEDS Intrinsic Roles: 1.2</p> <p>Interpreting diagnostic tests: 2.2</p> <p>Medical expertise: all enabling competencies</p> <p>Patient-centred clinical assessment and management: 1.4, 2.2, 2.4, 3.1, 3.3, 3.4, 4.1, 5.2</p> <p>Patient safety: 1.5, 3.4, 5.1, 5.2</p> <p>Prioritization of professional responsibilities: 1.4, 1.5, 2.1, 3.3, 5.1</p> <p>Procedural skill proficiency: 3.1, 3.3, 3.4</p> <p>Quality improvement: 5.1, 5.2</p> <p>Self-awareness of limits of expertise: 1.4, 3.4</p> <p>Timely follow-up: 1.4, 2.2, 4.1</p> <p>Working within the health care team: 1.3, 1.4, 2.1, 2.4, 3.3, 4.1, 5.1</p>

Annex 6: Informed consent form key informants

Informed consent form for key informants

Hello, my name is Maria Fix, and I am a master student at KIT Royal Tropical Institute. For my Master thesis I am working on a study on the role of Health professionals in monitoring and implementing the Right to Health. If you agree to participate, I hope that the information you provide will help not only my thesis but also helping to create recommendations for further studies regarding this topic. The study takes place between May and July 2023.

Procedures including confidentiality

If you agree to participate in this study, you will be interviewed about your position and responsibilities within your organization and regarding the Right to Health, how you see the role of health professionals within your organization regarding the same and what could be done to improve the current situation. You can express your honest opinion freely in this interview. The questions are designed to give you the possibility to openly share your perspectives, but also give you and me both the possibility to ask more detailed questions if anything is unclear.

The interview will take place remotely via Zoom or Teams, will only have yourself and myself as the interviewer participating and will last about 30 minutes.

To ensure data collection, the answers you provide will be audio recorded with your consent. If you don't consent to audio recording, written notes will be taken. Everything that will be said and written down will be kept strictly confidential. Your name will not be recorded or written down; no personal identifying information will be collected. All anonymous information will be kept in a secured locked cabinet and only myself and my tutors will have access to the anonymous information. The recorded files will be transcribed, and the original audio recording deleted after. All the data collected will be analysed and deleted six months after completion of the study.

In publications, the findings will focus on the role of health professionals in general and not on your particular answers, to ensure confidentiality.

Risk, discomforts and right to withdraw

After having agreed to participate in the interview, you are still free to refuse to answer any question that makes you uncomfortable and it will not have any consequences on you or your organization. You can also withdraw from this study at any time.

Benefits

This study may not help you directly, but the results will help future studies to improve the assessment and implementation of the Right to Health in various healthcare settings. They are no reimbursements or compensations for participating in this study.

Sharing the results

After the study is completed, I will share the result in my completed thesis, the IFHHRO (a medical human rights network) and at a global Health congress in the Netherlands at the European Congress on Tropical Medicine and International Health (ECTMIH 2023). If you would like to receive a copy of the report, please let me know and I will make this possible.

Consent and contact

Do you have any questions that you would like to ask?

Are there any things you would like me to explain again or say more about?

Do you agree to participate in the interview?

DECLARATION: TO BE SIGNED BY THE RESPONDENT

Agreement respondent

The purpose of the interview was explained to me and I agree to be interviewed
(name of person).

Signed _____ Date _____

WITNESS SIGNATURE

Signed _____ Date _____

If you have any questions or want to file a complaint about the research you may contact:

Contact information organization	Contact for Ethics Committee
----------------------------------	------------------------------

m.fix@student.kit.nl	Sandra Alba s.alba@kit.nl
----------------------------------------------------------------	------------------------------

Annex 7: Informed consent form health professionals

Informed consent form for health professionals

Hello, my name is Maria Fix, and I am a master student at KIT Royal Tropical Institute. For my Master thesis I am working on a study on the role of Health professionals in monitoring and implementing the Right to Health. If you agree to participate, I hope that the information you provide will help not only my thesis but also helping to create recommendations for further studies regarding this topic. The study takes place between May and July 2023.

Procedures including confidentiality

If you agree to participate in this study, you will be interviewed about your position and responsibilities within your organization and regarding the Right to Health, how you see the role of health professionals within your organization regarding the same and what could be done to improve the current situation. You can express your honest opinion freely in this interview. The questions are designed to give you the possibility to openly share your perspectives, but also give you and me both the possibility to ask more detailed questions if anything is unclear.

The interview will take place remotely via Zoom or Teams, will only have yourself and myself as the interviewer participating and will last about 30 to 45 minutes.

To ensure data collection, the answers you provide will be audio recorded with your consent. If you don't consent to audio recording, written notes will be taken. Everything that will be said and written down will be kept strictly confidential. Your name will not be recorded or written down; no personal identifying information will be collected. All anonymous information will be kept in a secured locked cabinet and only myself and my tutors will have access to the anonymous information. The recorded files will be transcribed, and the original audio recording deleted after. All the data collected will be analysed and deleted six months after completion of the study.

In publications, the findings will focus on the role of health professionals in general and not on your particular answers, to ensure confidentiality.

Risk, discomforts and right to withdraw

After having agreed to participate in the interview, you are still free to refuse to answer any question that makes you uncomfortable and it will not have any consequences on you or your organization. You can also withdraw from this study at any time.

Benefits

This study may not help you directly, but the results will help future studies to improve the assessment and implementation of the Right to Health in various healthcare settings. They are no reimbursements or compensations for participating in this study.

Sharing the results

After the study is completed, I will share the result in my completed thesis, the IFHHRO (a medical human rights network) and at a global Health congress in the Netherlands at the European Congress on Tropical Medicine and International Health (ECTMIH 2023). If you would like to receive a copy of the report, please let me know and I will make this possible.

Consent and contact

Do you have any questions that you would like to ask?

Are there any things you would like me to explain again or say more about?
Do you agree to participate in the interview?

DECLARATION: TO BE SIGNED BY THE RESPONDENT

Agreement respondent

The purpose of the interview was explained to me and I agree to be interviewed
(name of person).

Signed

Date

WITNESS SIGNATURE

Signed

Date

If you have any questions or want to file a complaint about the research you may contact:

Contact information organization m.fix@student.kit.nl mariafix29@gmail.com	Contact for Ethics Committee Sandra Alba s.alba@kit.nl
----------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------