Piloting the Right to Health Monitoring and Implementation Checklist among health professionals to further assess its applicability

A pilot study in three countries: Tanzania, South Africa, and the Netherlands

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

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Abstract

The right to health is a foundational human right, yet its practical implementation in healthcare systems remains inconsistent. To support operationalisation, the International Federation of Health and Human Rights Organisations (IFHHRO) developed the Right to Health Monitoring and Implementation Checklist. This study explored the checklist's perceived potential, challenges, and recommendations for use in diverse healthcare contexts in the Netherlands, Tanzania, and South Africa.

A qualitative, cross-country design was applied, drawing on 20 semi-structured interviews with healthcare professionals, policy experts, and human rights advocates. Interviews were thematically analysed using a coding framework aligned with the Health Equity Framework, enabling examination across four spheres of influence: systems of power, relationships and networks, individual factors, and physiological pathways.

Findings indicate that respondents valued the checklist's potential to raise awareness, promote accountability, and guide rights-based service improvement. However, significant challenges emerged, including limited knowledge of the right to health, resource constraints, competing priorities, and contextual differences between health systems. Recommendations focused on contextual adaptation, integration into existing quality-improvement processes, training, and sustained stakeholder engagement.

This study concludes that the checklist can be a valuable tool to operationalise the right to health if implemented with contextual sensitivity and supported by capacity-building and policy alignment. It contributes to the literature on rights-based approaches in health, offering practical insights for both high- and low-resource settings.

Keywords: Right to Health, Human Rights in Healthcare, Health Equity, Checklist Implementation, Qualitative Research

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II Abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality
HEF	Health Equity Framework
ICESCR	International Covenant on Economic, Social and Cultural Rights
IFHHRO	The Medical Human Rights Network, formerly known as International Federation of Health and Human Rights Organisations
RHMIC	Right to Health Monitoring and Implementation Checklist

III Introduction

During my training as a Medical Doctor in Global Health, I became increasingly aware of the profound health inequities that exist both within and between countries. Working in clinical settings across the Netherlands, Suriname, Greece, and Tanzania has shown me how social, economic, and political structures shape access to healthcare. One of the most formative experiences in this regard was my work in Moria refugee camp on Lesbos, where I provided emergency and primary care in a highly resource-constrained environment. It was there that my passion for improving care for marginalized populations truly took root. I also noticed how many healthcare workers, despite their best intentions, lacked awareness of the right to health and the duties this right implies for health professionals in any setting.

This realization motivated me to focus my second Master's in International Health on policy and human rights. When I was introduced to the newly developed *Right to Health Monitoring and Implementation Checklist* (RHMIC) by the Medical Human Rights Networks, formerly known as the International Federation of Health and Human Rights Organisations (IFHHRO), I immediately recognized its potential and relevance. The idea of a practical tool to help health professionals assess and strengthen their adherence to the right to health strongly aligned with my academic focus and professional values.

In this thesis, I examine the applicability of this checklist across three diverse contexts: the Netherlands, Tanzania, and South Africa. The Netherlands provides near-universal health coverage through a mandatory health insurance system that combines public oversight with private administration. This ensures access to a wide range of services for most residents, financed through premiums and government subsidies(1). However, undocumented migrants face limitations in accessing healthcare, raising concerns about inclusivity and equity(2). Tanzania's efforts to achieve universal health coverage face obstacles such as resource constraints, high disease burdens, and reliance on out-of-pocket payments. These challenges disproportionately impact low-income families, limiting their access to healthcare services(3). Initiatives like deploying community health workers aim to improve access, particularly in rural areas, but substantial investment in health infrastructure and workforce development is necessary to ensure equitable healthcare delivery. South Africa's constitution guarantees the right to health, but profound inequities persist due to historical and systemic disparities. The public healthcare system is overburdened and underfunded, serving the majority population, while a minority benefit from a well-resourced private sector(4). The introduction of the National Health Insurance policy(5) seeks to address these disparities by creating a more unified and equitable healthcare system. However, its implementation faces logistical and financial hurdles.

Despite differences in structure and scale, all three countries face persistent health equity challenges that disproportionately affect marginalized populations. Tools like the RHMIC are therefore essential to help frontline professionals systematically identify, address, and advocate for improvements in service delivery and access. This thesis displays the results of piloting this checklist. I aim to contribute to its refinement and to explore how such a tool can empower health professionals to recognize, assess, and address rights-based barriers to healthcare delivery. With this work, I hope to help bridge the gap between human rights principles and daily clinical practice, ultimately supporting more equitable and just healthcare systems worldwide.

1. Background

1.1 The Right to Health

The right to health is recognized as a fundamental human right in key international legal instruments, most notably the Universal Declaration of Human Rights (1948)(6) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR affirms "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," (7) obligating states to progressively realize this right. The practical interpretation of this right is often structured through the AAAQ framework: *Availability, Accessibility, Acceptability, and Quality*(8). These principles underscore that realizing the right to health not only involves the provision of appropriate healthcare services but also requires attention to underlying determinants such as clean water, adequate nutrition, housing, and a healthy environment. *Figure 1* shows how these different elements are related to each other within the concept of the right to health.

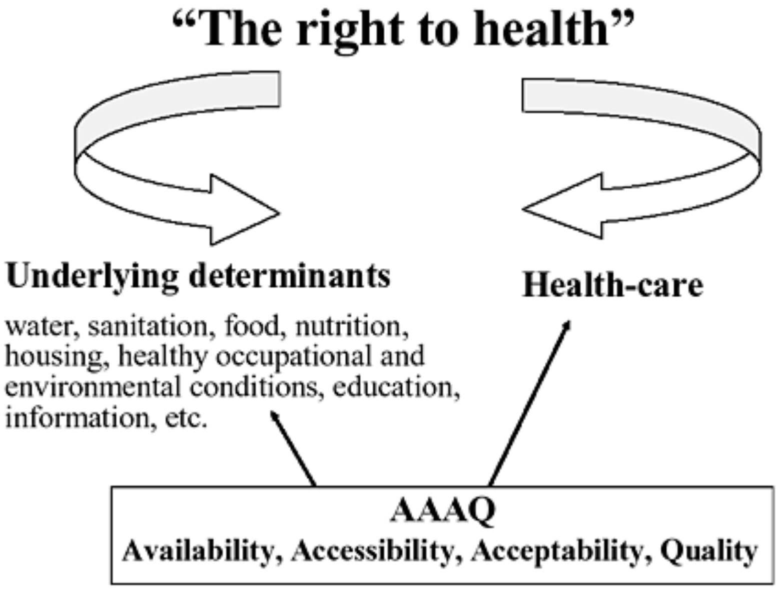

Figure 1 Elements of the right to health (7)

Healthcare professionals, like physicians, nurses, midwives, and others, are vital actors in the realization of this right. Beyond clinical care, they are often the first to witness rights violations and can serve as advocates for systemic change. Integrating human rights principles into professional practice allows them to identify structural barriers, empower patients, and promote equity within health systems(9).

1.2 Global Commitment and the Alma-Ata Declaration

The Alma-Ata Declaration of 1978 marked a pivotal moment in global health by establishing primary healthcare as central to achieving health for all(10). It reaffirmed health as a human right and called for universal access to essential health services through participatory, equitable, and multisectoral approaches(11). Although the declaration laid an important foundation, its implementation has varied significantly across countries, and its vision remains unmet in many low- and middle-income settings(11-13).

1.3 Marginalized Populations and Health Inequity

Despite international legal protections, marginalized populations, including ethnic minorities, migrants, people living in poverty, and individuals with disabilities, continue to face significant barriers in realizing their right to health. Discrimination, language barriers, geographic isolation, and limited financial resources are key determinants that drive unequal access and outcomes(14-16). These inequities persist even in high-resource settings and are often exacerbated by intersecting forms of structural disadvantage(17).

Efforts to improve health equity require policies that address the social determinants of health and actively dismantle exclusionary systems. Proactive measures must go beyond non-discrimination and aim for substantive equality, particularly for historically marginalized groups.

1.4 Right to health in low-resource settings

In low-resource settings, structural deficits such as limited infrastructure, workforce shortages, and underfunded health systems severely impede the realization of the right to health. For example, sub-Saharan Africa accounts for 25% of the global disease burden but has only 3% of the world's health workforce(18). Rural areas are disproportionately affected, with health facilities often located far from communities and plagued by supply and staff shortages (19).

Moreover, high out-of-pocket expenditures remain a significant barrier to access, with catastrophic health costs pushing millions into poverty annually(16, 20). Strengthening health systems through equitable financing, workforce development, and community-based care models is essential for advancing the right to health in these contexts(21) .

1.5 Role of healthcare professionals in addressing the right to health

Healthcare professionals play a pivotal role in protecting and promoting the right to health (22). As front-line providers, they directly influence patients' experiences of availability, accessibility, acceptability, and quality of care. However, research shows that many are unaware of their responsibilities under human rights frameworks(9). Paul Hunt, former UN Special Rapporteur on the right to health, emphasized that most health professionals *"have not even heard of the right to health"* and those who have are often unsure of its operational meaning(15).

Tools such as the *Right to Health Monitoring and Implementation Checklist* aim to address this gap by providing health workers practical guidance to assess and strengthen rights-based service delivery(9). With proper training and supportive institutional frameworks, health professionals can act as agents of change within health systems and become key stakeholders in the progressive realization of health equity.

2. Problem statement, Justification and Objectives

2.1 Problem statement

Despite the right to health is enshrined in international human rights treaties, significant disparities persist in healthcare access and quality, particularly among marginalized populations and people in low-resource settings(23-25). These groups, including ethnic minorities, people living in poverty, and individuals with disabilities, often face substantial barriers in their right to health both in high- and low-resource settings. These barriers include socioeconomic constraints, geographic isolation, discrimination, and lack of awareness about their health rights. This inequitable access is contrary to the principles of human rights and underscores the need for effective mechanisms to monitor and promote the right to health.

The underlying determinants of health, such as socioeconomic conditions, living environments, education, and access to healthcare, are crucial in achieving the right to health for all. These determinants influence the quality and length of life and are essential to ensuring equity in health outcomes. Marmot and Bell(26) emphasize the importance of addressing social determinants to create a fair society and promote healthy lives, arguing that health inequities are primarily shaped by the conditions in which people are born, grow, live, work, and age. This concept aligns with the AAAQ model which is used to assess the fulfillment of the right to health.(8) Ensuring availability means providing sufficient health facilities and services; accessibility involves eliminating barriers to these services; acceptability requires that health services are respectful and culturally appropriate; and quality emphasizes the provision of high-standard health care. Addressing the social determinants of health through the lens of the AAAQ model, can lead to a more equitable and inclusive health system, ultimately ensuring that everyone can achieve their highest possible standard of health(27).

Notwithstanding the pivotal role of healthcare professionals in asserting the right to health, research conducted by IFHHRO revealed that many healthcare professionals are unaware of their role in implementing the right to health(28). This finding is in line with observations made by Paul Hunt, UN Special Rapporteur on the right to the highest attainable standard of health (2002-2008). During the UN General Assembly in 2007, he stated:

"To be blunt, most health professionals whom the Special Rapporteur meets have not even heard of the right to health. If they have heard of it, they usually have no idea what it means, either conceptually or operationally. If they have heard of it, they are likely to be worried that it is something that will get them into trouble"(15)

This lack of awareness hinders the health professionals' ability to advocate effectively for patients' rights and to report and address violations when they occur. Healthcare professionals are frequently the first to witness violations of the right to health, whether through inadequate access to healthcare services due to systemic barriers or insufficient services, discrimination in healthcare delivery(29). Furthermore, during the training of health professionals by IFHHRO on health and human rights it regularly came up that they would like a simple assessment tool for assessing their own adherence to the right to health and that of their context(28). That is why this thesis aims to research to what extent the Right to Health Monitoring and Implementation Checklist is applicable in healthcare institutions in different settings, and how its implementation might empower healthcare professionals to more effectively identify and address right to health violations, thereby contributing to improved patient care and reduced health disparities.

2.2 Justification

The 'Dignity by the Bedside' project, initiated by IFHHRO, aims to address this gap by equipping healthcare professionals with the necessary tools and knowledge to uphold human rights in healthcare settings(9). The project recognizes that healthcare professionals often confront complex decisions regarding the availability, affordability, and acceptability of healthcare services, which directly impact the realization of the right to health.

To explore if there was not already an existing assessment toolkit regarding the right to health for health professionals, IFHHRO conducted an extensive web-search of existing right to health toolkits. This web-search showed twenty monitoring and implementation instruments of which none met all four predefined selection criteria. The selection criteria were that the instrument focuses solely on the right to health, has health professionals as its target group, is designed for use all over the world, and for all types of clinical settings. The study therefore concluded that currently a Right to Health Monitoring and Implementation Checklist for health professionals does not exist(30). The same study showed that most health professionals have inadequate knowledge of the right to health, need more training and education, and are unaware of mechanisms to report human right violations. In this context, IFHHRO has developed the Right to Health Monitoring and Implementation Checklist(31). This checklist aims to assist health professionals in assessing and monitoring the implementation of the right to health within their practice settings. The checklist provides a structured approach to evaluate various aspects of healthcare delivery, including the availability, accessibility, acceptability, and quality of health services, ensuring they align with human rights standards. However, the effectiveness and applicability of this checklist need to be piloted and evaluated in real-world settings to ensure it meets the needs of healthcare professionals and contributes to better health outcomes for patients, in particular marginalized populations and in low-resource settings. By doing so, it can be refined to better serve its purpose and ultimately contribute to the progressive realization of the right to health.

Previous research underscores the potential of such tools in enhancing the capacity of healthcare providers to uphold human rights. Middelburg's *"A Roadmap to Realizing the Right to Health"*(30) emphasizes the importance of practical toolkits in translating human rights principles into actionable policies and practices within healthcare settings. Equipping healthcare professionals with the knowledge and tools to advocate for health rights empowers them to systematically address gaps in health service delivery and push for necessary reforms. This approach can lead to significant progress in reducing health disparities by promoting adherence to the right to health and improving access to quality care for everyone.

2.3 Study Objectives

2.3.1 General objective

This thesis will assess the applicability and make recommendations for the improvement and implementation of the Right to Health Monitoring and Implementation Checklist developed by IFHHRO in healthcare institutions in the Netherlands, Tanzania, and South Africa. The ultimate goal of this checklist is to support and empower health professionals working in low-resource settings or with marginalized populations in high-resource settings to systematically address violations to the right to health and advocate for necessary reforms, thereby contributing to improved patient care and reduced health disparities.

2.3.2 Specific Objectives

1. To explore the potential of the Right to Health Monitoring and Implementation Checklist.
2. To explore possible challenges which can be encountered during the implementation of the Right to Health Monitoring and Implementation Checklist.
3. To provide recommendations for improvement of the Right to Health Monitoring and Implementation Checklist, including but not limited to the safety and security of the patient, as well as that of the health professional and their professional confidentiality.

3. Methods

3.1 Qualitative Research

A qualitative research approach was chosen to gain in-depth insights into the experiences and perspectives of healthcare professionals regarding the RHMIC. This approach was particularly suited for exploring complex issues, understanding contextual factors, and capturing the nuances of professional experiences. The right to health is exemplary of this complexity: it has a broad definition and scope, encompassing both direct healthcare and its underlying determinants. Furthermore, resource constraints remain a significant barrier to the realization of the right to health. Low- and middle-income countries, in particular, face challenges in allocating sufficient resources to health services and infrastructure, while even high-income countries experience disparities in resource distribution and access to care(27). Although the right to health is enshrined in international treaties and national constitutions, translating these legal commitments into effective policies and practices is challenging. Different countries interpret and implement the right to health differently, leading to inconsistencies and gaps in protection(32). A qualitative approach allowed for these contextual differences to be fully considered when evaluating the checklist's applicability and identifying potential implementation challenges.

3.2 Semi-Structured Interviews

Data were collected through semi-structured interviews, which provided the flexibility to explore respondents' views in depth while ensuring that key topics were consistently covered across interviews. This method allowed respondents to elaborate on their experiences, perceptions, and contextual realities, while also enabling the researcher to probe for clarification or further detail when relevant. The interview guide (see Annex 1) was based on the Health Equity Framework (HEF) and the study objectives. Questions were designed to explore the four HEF domains, systems of power, relationships and networks, individual factors, and physiological pathways, in relation to respondents' experiences with the RHMIC. Semi-structured interviewing was selected because it allowed for a balance between structured comparability across respondents and the flexibility to capture unanticipated but relevant insights.

3.3 Sampling Strategy

A non-probability sampling method was used, employing purposive sampling and snowball sampling through the researcher's professional and personal networks. Potential respondents were identified during informal meetings, at conferences, or through direct email contact. Recommendations from key informants were also followed up, and those prospective respondents were contacted by email, phone, or in person. This strategy ensured the inclusion of respondents with relevant experience and knowledge, thereby enhancing the depth and relevance of the data collected.

3.4 Inclusion Criteria

Inclusion criteria for participation in the study included being a healthcare professional either directly involved in clinical care or holding a senior position within an organisation providing such care. Respondents had to be currently working with marginalized populations in the Netherlands, Tanzania, or South Africa, or have previous experience in low-resource settings or with marginalized groups. In addition, respondents were required to have at least three years of relevant work experience in these contexts. This ensured that respondents could provide informed and reflective feedback on the RHMIC.

3.5 Data Collection

The data collection tool, a semi-structured interview guide (see Annex 1) based on the HEF and research objectives, was developed Charissa Rahmee. The SAGE Handbook of Interview Research(33), with further input from Qualitative Methods for Health Research by Green & Thorogood(34) and Qualitative Interview Questions: Guidance for Novice Researchers by Roberts(35) was used to develop the interview guide.

The three countries, the Netherlands, Tanzania, and South Africa, were intentionally selected to reflect diverse healthcare contexts and to provide feedback from both high-income and low-/middle-income settings.

The Netherlands

As the researcher's country of residence, most professional contacts were based here, and the researcher had direct clinical working experience, including with marginalized populations such as undocumented migrants and refugees. While the Netherlands is a high-income country, it still faces challenges in serving marginalized groups, making it a relevant setting for assessing the applicability of the RHMIC in addressing gaps within an otherwise well-resourced system.

Tanzania

The researcher had lived and worked in Tanzania as a global health medical doctor and had developed an extensive professional network. Tanzania, a lower-middle-income country, encompasses diverse cultural, religious, and tribal backgrounds and faces significant health inequities affecting a range of marginalized groups. This diversity provided an important testing ground for how the checklist might be applied in contexts with different systemic and sociocultural challenges.

South Africa

The researcher had some working experience in South Africa, a country with both high-income characteristics in certain regions and low-/middle-income characteristics in others. Profound disparities exist in the quality and accessibility of care based on geography, socioeconomic status, and the resources of healthcare facilities. This made South Africa a particularly valuable context for exploring how the RHMIC performs in an environment where access and quality vary dramatically.

Including these three countries enabled cross-contextual comparison and provided insights into how the RHMIC might function across different health system structures, resource levels, and cultural contexts. This approach aligned with IFHHRO's aim for the checklist to be applicable across varied global healthcare settings.

3.6 Interview Process

In total, 20 semi-structured interviews were conducted: 17 were carried out face-to-face, while 3 interviews with one respondent from each of the three countries were conducted via online video conferencing platform Zoom. The interview process consisted of two parts. First, the researcher presented the RHMIC to the respondent and walked through it together. Second, the semi-structured interview was conducted to gather the respondent's feedback on the checklist's applicability, clarity, and potential challenges. This two-step approach ensured that respondents' reflections were grounded in an actual review of the tool while also allowing space for broader discussion about rights-based care in their respective contexts.

3.7 Data Analysis

All interviews were audio-recorded, either using the iPhone 13 voice recorder for in-person interviews or the recording function in Zoom for online interviews, and transcribed verbatim. Data were analysed using inductive thematic analysis(36, 37), supported by NVivo software for data management. Coding was iterative: initial open codes were created during the first readings of the transcripts, and new codes were added as further transcripts were reviewed. These open codes were then grouped into subcategories and broader categories. The coding framework was refined by integrating the four HEF domains and key right-to-health concepts. This hybrid approach allowed for both inductive theme generation and deductive mapping to the analytical framework.

3.8 Ethical Considerations

An ethical waiver was obtained from the KIT Royal Tropical Institute's Research Ethics Committee on 19 July 2024, as the study involved only professional, non-sensitive questions related to respondents' work. Ethical considerations were strictly adhered to throughout the research. All respondents gave informed consent prior to participation and were reminded that they could withdraw at any time without consequence. No personal or identifying information was collected; all data were anonymised by assigning codes to respondents and removing identifiable details from transcripts. Recordings and transcripts were securely stored and deleted after completion of the study. Given the potentially sensitive nature of some discussions, such as institutional shortcomings or discriminatory practices, special attention was paid to maintaining confidentiality, both during and after data collection.

Participating in this study did not bear any physical, psychological and/or socio-economical risk or discomfort. The researcher traveled to the respondent or made sure data collection from a distance was possible. There was no need for socio-economical input from respondents and the respondents were not put into a situation where they could potentially be at socio-economical risk. During the data collection there were no inquiries regarding personal details of the respondent but it focused on the professional opinion regarding the right to health.

4. Analytical Framework

4.1 Health Equity Framework

This study used the Health Equity Framework (HEF)(38) as the primary analytical lens to assess the applicability, potential, and implementation challenges of the RHMIC. The HEF was chosen because it provides a comprehensive, justice-oriented approach to understanding and addressing the multifactorial drivers of health inequities, and is therefore well suited to examining a rights-based tool whose explicit aim is to promote equitable healthcare. The framework moves beyond narrow biomedical or behavioural explanations for health disparities, focusing instead on the social determinants of health and the structural and relational contexts in which healthcare occurs(14).

The right to health, as articulated in international human rights law, is not limited to access to medical services but also encompasses the conditions necessary for achieving the highest attainable standard of health. The HEF operationalises this principle by identifying and examining four interacting spheres of influence: systems of power, relationships and networks, individual factors, and physiological pathways. Together, they shape health outcomes over the life course. These spheres help to locate the right to health within a practical analytical structure, enabling systematic examination of both structural barriers and protective factors that influence how the RHMIC might function in different contexts.

4.2 Why the HEF is appropriate for this study

The HEF was selected for this study because it closely aligns with the principles underlining the right to health, particularly those reflected in the AAAQ framework. Both emphasise justice, equity, and the role of social determinants, prioritising systemic change over individual blame and recognising that health inequities often stem from structural disadvantage. In addition, the HEF's capacity to integrate multiple levels of influence enables a balanced analysis of how rights-based tools function within complex, real-world healthcare environments. Finally, its provision of a shared conceptual language facilitates meaningful cross-contextual comparison of how the RHMIC is understood and applied in both high-resource and low-resource settings, while maintaining sensitivity to the unique dynamics of each context.

4.3 The four spheres of the HEF in relation to the right to health

See *Figure 2* for the four interacting spheres of influence identified in the HEF: systems of power, relationships and networks, individual factors, and physiological pathways. These spheres represent categories of risk and protective factors for health outcomes and offer strategies to address these factors, which can be used in improving the RHMIC.

Relationships and Networks

Connections with family, friends, partners, community, school and workplaces that:

+ Promote health equity through support systems that encourage health-promoting choices

- Intensify health inequities through social networks that enable health-harming behaviors

Individual Factors

A person's response to social, economic and environmental conditions that:

+ Promotes health equity through attitudes, skills and behaviors that enable their personal and community's health

- Intensify health inequities through attitudes, skills or behaviors that cause harm to their personal or community's health

Systems of Power

Policies, processes, practices that:

+ Promote health equity through fair access to resources and opportunities that enable healthy lives

- Intensify health inequities by allowing unfair social, economic or environmental advantages for some groups over others

Physiological Pathways

Factors that:

+ Promote health equity when a person's physical, cognitive and psychological abilities are maximized

- Intensify health inequities when a person's environment or experiences has impaired their physical, cognitive or psychological functions

Figure 2 ETR's Health Equity Framework showing that health and education outcomes are influenced by complex interactions between people and their environment (38)

4.3.1 Systems of Power

Encompasses political, economic, legal, and institutional structures that shape health opportunities and outcomes. In relation to the right to health, this includes laws, policies, funding mechanisms, and institutional accountability systems that determine whether rights commitments are translated into practice. In this study, the systems of power sphere was used to examine how policy environments, governance structures, and institutional priorities enable or constrain the RHMIC's uptake.

4.2.2 Relationships and Networks

Refers to the formal and informal connections between individuals, groups, and organisations that influence health behaviours and access to resources. For the right to health, this includes the role of trust, professional culture, interdisciplinary collaboration, and community engagement in enabling rights-based care. In this study, this sphere was applied to assess how interpersonal and interprofessional dynamics, such as hierarchy, collegial support, and team culture, affect checklist implementation.

4.2.3 Individual Factors

Captures the knowledge, attitudes, skills, and lived experiences of individuals that influence how they engage with health systems. In the right to health context, this involves professionals' understanding of rights concepts, confidence in advocating for patients, and capacity to identify violations. In this study, this sphere was used to analyse how healthcare workers' awareness, motivation, and perceived agency shape their use of the RHMIC.

4.2.4 Physiological Pathways

Refers to the biological and psychological processes through which social and environmental conditions influence health. In the right to health, this sphere is relevant because structural inequities and chronic stress can directly impact both providers' and patients' wellbeing, affecting care quality and equity. In this study, this sphere was applied to explore how workload, emotional strain, and moral distress among health professionals influence their capacity to engage with and benefit from the checklist.

4.3 Application of the HEF in this study

The HEF was applied at multiple stages of this research. During data collection, the interview guide was informed by the HEF, ensuring that questions address structural, relational, individual, and physiological dimensions of checklist use. In the analysis phase, responses were coded inductively and refined by integrating the four HEF spheres, allowing for systematic comparison within and across country contexts. Furthermore, the study findings were organised around the HEF domains, enabling clear linkage between empirical evidence, theoretical insights, and the study's objectives. Finally, for the interpretation the HEF helped interpret how different factors interact to facilitate or hinder the RHMIC's implementation, providing a holistic understanding of its potential to advance the right to health.

By grounding the analysis in the HEF, this study could systematically relate the empirical findings to broader equity and human rights principles. This approach not only supported rigorous analysis but also ensured that recommendations for the RHMIC's refinement and scaling were sensitive to the multi-level realities in which health rights are realised , or denied.

5. Findings

This section presents the key findings of the study, drawn from 20 semi-structured interviews with healthcare professionals working in South Africa, Tanzania, and the Netherlands. The results are organized around the study's main thematic areas: respondents' knowledge of the right to health, the perceived potential of the RHMIC, challenges to its implementation, and respondents' recommendations for improvement of the RHMIC.

5.1 Respondent sociodemographics

Table 1 provides a summary of respondent characteristics. The sample (N = 20) included professionals from diverse clinical and non-clinical backgrounds, representing a wide range of healthcare roles, geographic regions, and marginalized populations.

Table 1 Respondent sociodemographics

Characteristics	Number of respondents The Netherlands (7)	Number of respondents Tanzania (9)	Number of respondents South Africa (4)
Age			
30-35	3	1	1
36-40	2	6	1
41-45	2	1	1
		1	1
Gender			
Female	5	3	1
Male	2	6	3
Profession			
Clinical	2	8	2
Non-clinical	6*	3*	2

* Three respondents (4, 5, 13) have both clinical and non-clinical tasks

Respondents reported work experience in a combined total of 21 countries, in both high- and low-resource settings, reflecting a highly international professional background. This cross-country exposure provides insight into healthcare delivery across different systems and sociopolitical contexts.

There were notable differences in education levels between countries. Among those currently employed in Tanzania (n = 9), 9 respondents held a master's degree, with one also reporting an undergraduate degree. In South Africa (n = 4), there was a more diverse educational mix: 2 respondents held a master's degree, 2 had undergraduate degrees, of which 1 reported an honours-level qualification. In The Netherlands (n = 7), 8 master's degrees were reported (including dual degrees by some respondents), with no respondents listing undergraduate or honours degrees as their highest level of education. These differences in academic background provide important context for how respondents engage with and interpret the right to health and the checklist's practical value.

5.2 Knowledge of the Right to Health

5.2.1 Familiarity with the Concept

Across all three countries, respondents reported some familiarity with the right to health, though depth, framing, and perceived relevance varied according to education, professional role, and institutional setting. Awareness of the right to health varied considerably across the three contexts, reflecting differences in professional roles, education, and system orientation. In the Netherlands, the concept was well recognised yet often remained abstract; while NGO and policy professionals engaged with it as part of their routine work, most clinicians encountered it primarily during academic training and rarely applied it explicitly in daily practice. In Tanzania, understanding was most often grounded in medical or public health education, typically framed as an entitlement to basic care within community health modules. This perspective tended to be more limited than the broader human rights framework, with little emphasis on structural determinants or accountability mechanisms. In South Africa, levels of familiarity ranged widely, from strong constitutional awareness embedded in professional identity to minimal exposure, even among trained healthcare providers.

Across contexts, the gap between conceptual recognition and practical application was consistent, pointing to the need for systematic integration of rights-based principles into professional education, workplace norms, and clinical decision-making.

Quote #1

“Yes, when we are in medical school, that's what we learn, especially when we learn what we call community health in the medical school. So we usually learn this health, health, health to all, universal health coverage, treaties, Alma Alma”

Tanzania, respondent 3 – General surgeon at a Regional Refferal Hospital

5.2.2 Practical Application in Clinical Settings

Respondents described applying right-to-health principles through ethics, equity, and advocacy rather than formal rights-based frameworks. Application of the right to health took distinct forms across contexts, shaped by local priorities and systemic realities. In the Netherlands, engagement was typically implicit, with professionals addressing the needs of undocumented migrants, asylum seekers, and other marginalised groups without explicitly invoking rights-based or legal terminology. In Tanzania, practitioners connected the concept more directly to daily ethical decision-making, frequently navigating cultural norms and logistical constraints to secure access to care. In South Africa, application was more overtly multidimensional, combining patient advocacy with institutional and policy-level initiatives aimed at improving services for underserved populations and embedding rights-based principles into system planning.

Quote #2

"I think what we do is fill the gaps, I guess. So there's the idea of right to health, healthcare and the application. I guess we are sort of more concerned with the application. So we try to offer some forms of basic healthcare or to mediate in finding proper healthcare for people who are deprived of that.."

The Netherlands, respondent 1 – Regional coordinator at NGO

In all three settings, the right to health functioned as an ethical compass adapted to local realities and systemic constraints, even when not expressed in formal legal terms.

Quote #3

"… it's not just clinical care. It's it's the politics. It's the policies. It's the the socioeconomic element, and it's the human rights, right to health, uhm that all that all comes together in in this global health intersection."

South Africa, respondent 20 – Global Health specialist and general physician in anesthesia

5.2.3 Education and Training

Structured training on the right to health was limited in all contexts, with most respondents citing informal learning, postgraduate study, or workplace experience as the primary source of knowledge. Exposure to the right to health varied markedly across contexts. In the Netherlands, it was seldom integrated into core curricula and, when addressed, was typically confined to brief coverage within electives or postgraduate programmes. In South Africa, the concept was more consistently embedded, albeit often indirectly, through professional development, health systems, ethics, and public policy modules. In Tanzania, exposure was uneven, with some respondents recalling discussions during community health rotations or in relation to the Alma-Ata Declaration, while others encountered the concept only in specialist training or professional practice.

Quote #4

"… it's embedded in the education and because I did this, I did a master's subject 'Ethics, Human Rights and Health'. But prior to that, no, not in the specialization (i.e. Global Health), not sufficiently or not in this way, in medical school, definitely not… "

The Netherlands, respondent 13 – MD Global Health and Sexual, Reproductive Health & Rights specialist at NGO

Respondents in all countries called for earlier, more structured, and practical integration of the right to health in professional education to enable confident application in everyday practice.

5.2.4 Most Valued Components

Accessibility emerged as the most consistently valued component, but its meaning varied by context. In the Netherlands, the right to health was often discussed in terms of practical barriers faced by marginalised groups, despite their formal legal entitlements, with concerns extending to the quality, affordability, and acceptability of services. In Tanzania, access emerged as an urgent challenge, closely linked to affordability and availability, with respondents describing ethical dilemmas in which lifesaving care was withheld due to inability to pay. In South Africa, concerns over affordability and systemic inequities were intertwined with issues of dignity, safety, and persistent disparities between the public and private health sectors.

> *Quote #5*
>
> *“Access and the actual access people have, are two completely different things.”*
>
> The Netherlands, respondent 14 – MD Global Health and Manager Domestic Programs at NGO

Across contexts, respondents agreed that the right to health is meaningful only when access is equitable, dignified, and supported by enabling social and economic conditions.

5.2.5 Perceived Professional Role

Professionals in all settings described responsibilities beyond technical care, including advocacy, patient empowerment, and engagement with systemic issues. In the Netherlands, advocacy often centred on navigating complex systems to secure care for excluded patients, with some questioning whether such representation should be the primary responsibility of healthcare professionals.

> *Quote #5*
>
> *"Our mission is right to health for all, but in practice, many groups are unable to access care."*
>
> The Netherlands, respondent 19 – Manager and Advocacy lead at NGO

In Tanzania, advocacy was embedded in routine practice, involving direct interventions to secure access and inform patients of their entitlements. In South Africa, it encompassed both inclusive clinical practice and action on broader determinants of health, such as nutrition, alongside systems-level influence through leadership roles.

Approaches differed, but all reflected a strong sense of professional agency adapted to local system realities.

5.2.6 Awareness of Reporting Mechanisms

Reporting channels existed in all three contexts but were rarely framed in explicit rights-based terms. In the Netherlands, reporting was largely informal, relying on team culture and interpersonal networks rather than dedicated human rights channels. In Tanzania, formal escalation pathways ran through hospital management to district or regional health authorities, though responsiveness was inconsistent. In South Africa, multi-tiered routes to higher authorities existed, but perceptions of ineffectiveness and the absence of independent oversight limited their use.

A shared limitation was the absence of transparent, trusted mechanisms tied specifically to the right to health, leaving concerns vulnerable to underreporting or insufficient follow-up.

5.3 Potential of the Checklist

5.3.1 Applicability in Professional Settings

Respondents across all three countries agreed that the Right to Health Monitoring and Implementation Checklist is relevant to their professional contexts, though its impact depends on contextual adaptation and follow-up. In the Netherlands, it was valued as a reflective and ethical compass, stimulating awareness and team dialogue in NGO and primary care settings. Those in humanitarian contexts stressed the need for tailoring to specific operational realities. In Tanzania, it was seen as a diagnostic tool for mapping practices, identifying service gaps, and addressing issues of inclusion and accountability. Suggested adaptations included simplified language, translation into Swahili, and phased roll-out to enable broad engagement. In South Africa, respondents highlighted its ability to unite clinical and non-clinical staff around shared commitments to patient rights and quality care, adaptable across all levels of care and departments.

While Dutch respondents emphasised ethical reflection, Tanzanian and South African respondents prioritised practical applications such as identifying resource gaps and guiding service improvements. Consensus across contexts was that adaptation to frontline realities and strong follow-up mechanisms are essential.

5.3.2 Raising Awareness

The checklist was widely recognised as a tool for surfacing inequities, blind spots, and overlooked groups, encouraging both personal reflection and institutional dialogue. In the Netherlands, it challenged assumptions in high-resource settings, prompting structured self-assessment and questioning of whether existing services meet all patients' needs.

> *Quote #6*
>
> *"I answered some of the questions about disabilities with 'no'… and immediately thought, we actually don't have a toilet accessible for someone using a wheelchair or walking stick… It made me realise this needs to be addressed."*
>
> The Netherlands, respondent 14 – MD Global Health and Manager Domestic Programs at NGO

In Tanzania, it reframed routine challenges in rights-based terms, helping staff think beyond operational constraints and examine their work through broader ethical and social lenses.

In South Africa, it was described as “eye-opening,” linking institutional values with the principles of the right to health and making these principles more actionable.

Quote #7

"For me, it was a bit of an eye-opener, because now I feel like there are certain things that I was not actually looking into. So I'm going to have to go look more into the human rights for the patients to right charter and sort of go through those kind of policies. We need to remind ourselves as employees, as government employees or service providers, that this is the level of quality of the services that we need to be rendering. We need to remind ourselves of what we need to do.”

South Africa, respondent 16 – Clinical dietician at a District hospital

Across contexts, its strength lay less in compliance assessment and more in stimulating critical reflection: an entry point for rights-based dialogue and institutional learning in both high- and low-resource environments.

5.3.3 Empowering Healthcare Professionals

Respondents saw the checklist as a means of affirming healthcare professionals’ roles in rights-based care while offering a structured framework for reflection, advocacy, and improvement. In South Africa, it was seen as a confidence-builder for patient advocacy and as filling a gap in quality improvement initiatives that empower frontline staff.

Quote #8

"It presents an opportunity for leadership to educate their workforce to say, actually, these things are available. The pamphlets are just in the wrong place. Let's work that out. And there's an opportunity for accountability for that hospital to look at themselves and go, actually, we need to be improving this."

South Africa, respondent 20 – Global Health specialist and general physician in anesthesia

In Tanzania, it validated ethical responsibilities and offered language to articulate concerns in ways that could influence decision-making and strengthen accountability. In the Netherlands, empowerment was discussed more implicitly, with the checklist providing a shared language and structure for aligning work with collective principles.

Across contexts, empowerment came from the dual role of the checklist as an ethical anchor and a navigational aid in complex or constrained settings.

5.3.4 Patient Empowerment

Mentioned explicitly only in Tanzania, the checklist was seen as a tool to educate patients about care standards and their rights, enabling them to recognise shortcomings and hold providers accountable. This vision positioned patients as active stakeholders in improving services. Its absence in Dutch and South African perspectives may reflect different system cultures or assumptions about patient roles, suggesting future adaptations could strengthen community and patient engagement, particularly where health literacy is uneven.

5.3.5 Policy Reform, Evaluation, and Identifying Room for Improvement

Respondents across contexts saw the checklist as more than a compliance tool, a means of connecting frontline realities with institutional and policy-level change. In the Netherlands, it was valued for generating evidence to support structured advocacy, inform service design, and organise policy discussions. Within organisations, it was a flexible tool for critical reflection and identifying structural barriers. In Tanzania, it fit naturally into planning and quality improvement systems, with low scores seen as diagnostic indicators for resource allocation and service planning. Respondents emphasised the need for leadership commitment to act on findings. In South Africa, it clarified responsibilities between staff and authorities, supporting advocacy for equitable service provision and serving as a mechanism for continuous improvement through progress tracking.

While Dutch respondents stressed internal learning, Tanzanian and South African respondents linked it to formal monitoring cycles. In all contexts, it was understood as a developmental, not punitive, instrument that bridges awareness and action.

5.3.6 Improving Service Delivery

The checklist was seen as a valuable tool for enhancing healthcare delivery, though approaches differed. In the Netherlands, it facilitated structured feedback, incremental quality improvement, and evidence-based service refinement. In Tanzania, it guided targeted interventions to address inefficiencies and infrastructure gaps, boosting staff motivation and patient trust. In South Africa, it was envisioned as part of routine professional practice to strengthen clinical consistency and patient-centred care.

Differences reflect broader system variations: Dutch respondents leaned toward organisational learning, Tanzanians toward operational planning, and South Africans toward embedding the tool in daily practice.

5.3.7 Impacting Safety

Safety benefits were recognised across settings but framed differently. In Tanzania, the checklist drew attention to threats to dignity, privacy, and environmental safety, influencing professional behaviour and accountability. In South Africa, it highlighted facility hazards and prompted corrective action, supporting risk management processes. In the Netherlands, safety was viewed through inclusivity and psychological security, with the checklist uncovering hidden policy-level risks.

In all contexts, it was seen as a preventive tool for fostering safer, more equitable environments for patients and staff.

5.3.8 Improving Equity

Equity and inclusivity were most clearly addressed in Tanzania, where the checklist encouraged identification of underserved populations, challenged provider assumptions, and documented patterns of discrimination to inform improvements. In the Netherlands, it served as a reflective tool to assess whether diversity in organisations translated into genuine inclusion. In South Africa, while not explicitly discussed as a standalone theme, related concerns such as LGBTQ+ inclusion and equitable access indicated underlying alignment with the checklist's equity goals. Across contexts, it was recognised as a catalyst for expanding the equity lens in practice and policy, though its potential was most fully articulated in Tanzania.

5.4 Challenges of the Checklist

5.4.1 Accountability, Trust, and Perceptions of Risk

Across all three countries, respondents identified a lack of clarity around accountability as a central challenge to the effective use of the Right to Health Monitoring and Implementation Checklist. While the specifics differed by setting, a common pattern emerged: unclear responsibility for acting on checklist findings, compounded by mistrust and fears about how results might be used.

In the Netherlands, accountability gaps were linked to relatively flat organisational structures and informal reporting mechanisms. While team discussions, managerial check-ins, and planning retreats were common, respondents felt these lacked authority to enforce follow-up. Some described the personal discomfort of identifying gaps without the institutional power or mandate to address them, which risked eroding confidence in the tool's usefulness. These concerns were closely tied to fears that findings could be misinterpreted or used to judge individual performance, discouraging staff from engaging fully.

In Tanzania, accountability followed formal hierarchical lines from departmental supervisors to hospital boards and, in some cases, up to government authorities. However, respondents questioned whether these channels consistently translated into action. They described a tendency for blame-shifting in the absence of strong leadership and noted that raising critical issues could carry reputational or professional risks. Despite this, some expressed faith in the potential for multi-level accountability, particularly if communities and patients played an active role in holding institutions responsible.

In South Africa, accountability was seen as even more diffuse. Respondents described uncertainty over whether responsibility lay with clinical managers, executives, or district authorities. This ambiguity was compounded by entrenched patterns of blame avoidance and defensiveness, which not only limited follow-up but could actively block further discussion.

Across contexts, respondents agreed that without clearly defined roles, structured follow-up processes, and robust trust-building, the checklist risked becoming a reflective exercise rather than a driver of sustainable change. Embedding accountability in a way that protects staff from punitive consequences was viewed as essential.

5.4.2 Knowledge, Motivation, and Buy-In

The perceived relevance of the checklist, and the willingness of staff to engage with it, depended on both individual motivation and baseline knowledge of rights-based approaches. While most found the checklist reasonable in length, often taking 10–20 minutes to complete, engagement was shaped by how meaningful it felt in practice.

In the Netherlands, respondents warned about “checklist fatigue” in an environment already saturated with forms and administrative tools. While they recognised the clarity of the tool, some questioned whether it offered new value without being linked to visible outcomes. Staff unfamiliar with rights-based principles might not immediately see its purpose, and without that understanding, engagement could wane quickly.

In Tanzania, respondents generally found the tool manageable and even engaging. However, they stressed that its relevance could be undermined by heavy workloads, staff shortages, and the perception that some questions addressed issues beyond the control of frontline staff. This risked alienating users if they felt the tool was asking them to account for structural problems they could not influence.

In South Africa, the checklist’s perceived value was seen as the decisive factor for uptake. Highly motivated staff were likely to engage fully, but disengaged or change-resistant colleagues might not participate meaningfully without a clear link between the checklist and tangible service improvements.

Across settings, respondents emphasised that without a clear purpose, visible follow-up, and a baseline understanding of rights-based frameworks, the checklist could be dismissed as another bureaucratic task.

5.4.3 Comprehensibility and Language Accessibility

While the overall structure and intent of the checklist were generally understood, its accessibility was shaped by professional background, familiarity with rights-based concepts, and language use.

In the Netherlands, non-clinical staff sometimes struggled with specialised terminology and lengthy, complex sentences. Respondents worried that this could lead to inconsistent interpretation between users, reducing data reliability.

In Tanzania, the use of English and technical phrasing posed a much greater barrier. Even trained clinicians found some questions overly complex or abstract. Many called for Swahili translations, simpler language, and the use of examples relevant to everyday practice. The reliance on binary “yes/no/maybe” responses was also criticised for failing to capture partial implementation or context-specific realities. Respondents recommended Likert scales, elaboration boxes, and concrete prompts such as service accessibility for people with disabilities.

In South Africa, comprehension issues were less commonly reported but were still relevant, especially for non-clinical roles. Respondents highlighted the importance of ensuring that terminology was locally relevant and accessible to all levels of staff.

Improving accessibility will require targeted adaptations: translation into local languages, simpler and more consistent phrasing, flexible response formats, and the integration of tangible, context-specific examples.

5.4.4 Cultural and Contextual Sensitivity

Respondents stressed that the checklist's universal rights-based framing must be adapted to local realities to ensure relevance and honest engagement.

In the Netherlands, the concepts of equity, non-discrimination, and marginalised group inclusion were seen as broadly important but not always applied consistently across diverse settings. Cultural sensitivity was viewed as a dynamic process requiring regular reassessment of service design, language, and assumptions to ensure continued relevance.

In Tanzania, sociopolitical constraints limited open discussion of certain topics, notably LGBTQ+ rights. Respondents cautioned that unadapted checklist language could generate false negatives or reinforce silence on sensitive issues, even when they were recognised as relevant in private.

> *Quote #9*
>
> *"LGBTQ is a very sensitive topic here. People won't even talk about it; it's like a subconscious taboo."*
>
> Tanzania, respondent 8 – MD specialized in Emergency Medicine at Zonal Hospital

Across both contexts, cultural sensitivity was understood as more than translation. It required political awareness, respectful framing of sensitive topics, and proactive engagement with local stakeholders to encourage truthful responses.

5.4.5 Resource Constraints

While less prominent in the Netherlands, resource limitations were a defining challenge in Tanzania and South Africa.

In Tanzania, overwhelming caseloads, staffing shortages, and limited infrastructure left little room for reflective exercises or systematic improvement work. Even when gaps were identified, chronic underfunding often made it impossible to implement changes, leading some to see the checklist as highlighting problems without providing solutions.

> *Quote #10*
>
> *"Sometimes it's frustrating that you don't have enough doctors. So you only do the basic stuff, you only do the emergencies, you don't have time to do any healthcare improvement."*
>
> Tanzania, respondent 11 – MD Global Health at District hospital

In South Africa, similar pressures on time and staffing meant that even brief reflective activities could conflict with patient care priorities. Without dedicated time or personnel for follow-up, the likelihood of sustained implementation was seen as low.

Quote #11

"A woman with a femur fracture waited three months in a local hospital that could not perform surgery… Her family eventually drove her hundreds of kilometres to another facility, at huge financial and physical cost… This case shows the urgent need to decentralise care and avoid preventable harm."

South Africa, respondent 20 – Global Health specialist and general physician in anesthesia

In the Netherlands, respondents focused less on material resources and more on integration into existing systems, trust, and relevance.

These differences point to a structural equity gap: the contexts in which the checklist could have the greatest impact are often those least equipped to act on its findings.

5.5 Recommendations for Implementation of the Checklist

5.5.1 Ensuring Anonymity and Safe Reporting Structures

Across all three countries, respondents emphasised that anonymity and robust reporting protections are fundamental to the effective implementation of the Right to Health Monitoring and Implementation Checklist. Without these safeguards, respondents feared that honest and critical feedback would be suppressed, particularly when identifying institutional shortcomings, discriminatory practices, or leadership failures.

In the Netherlands, anonymity was seen as essential for fostering candid participation, especially in politically or professionally sensitive environments. While some acknowledged that identifiable responses could be useful for internal problem-solving, most agreed that the risk of professional judgment or reputational harm outweighed the benefits.

In Tanzania, the emphasis on anonymity was even stronger. Respondents linked the absence of confidentiality to potential retaliation, ostracism, or even job loss, particularly in hierarchical health systems. Proposed solutions included digital versions with minimal identifiers and restricted access to safeguard privacy.

South African respondents similarly recommended confidential, individual completion to avoid managerial or peer influence, especially in hierarchical institutions where dissent can be silenced. A prevailing concern was that management defensiveness could undermine openness, making visible commitments to confidentiality a precondition for trust.

Across contexts, anonymity was framed not as a technical convenience but as an ethical necessity. Without clear privacy protocols and a visible commitment to non-punitive use, the checklist risks becoming a symbolic exercise rather than a transformative tool.

5.5.2 Constructive Follow-Up and Accountability

Respondents agreed that the checklist must be accompanied by clear follow-up processes and constructive accountability mechanisms. The tool's credibility depends on ensuring that findings trigger action without fostering fear, blame, or punitive responses.

In the Netherlands, respondents recommended that results serve as a foundation for collaborative reflection and co-created action plans, avoiding rigid ranking or inspection-based approaches. Low scores should be interpreted in light of systemic constraints rather than as evidence of organisational failure.

Tanzanian respondents similarly emphasised the diagnostic value of the checklist, urging that identified gaps be addressed through dialogue and capacity-building. They proposed a staged accountability model, escalating only when issues remain unresolved or require urgent intervention.

In South Africa, respondents underscored the need for accountability that drives improvement rather than punishment. While some saw value in external oversight, they stressed that internal leadership engagement is critical for sustainable change.

Across settings, respondents viewed constructive follow-up as inseparable from implementation. Without leadership commitment, the checklist risks highlighting systemic gaps without delivering the institutional change needed to close them.

5.5.3 Practical Implementation Modalities

Digital implementation was the preferred format in all three countries, valued for efficiency, secure data handling, and ease of integration into existing workflows. In the Netherlands and South Africa, where digital infrastructure is well established, respondents saw no need for paper formats. In Tanzania, digital use was also preferred but required complementary paper-based or in-person formats to ensure participation in rural or lower-resourced settings.

Regarding frequency, Dutch respondents generally recommended annual implementation, aligning with existing review cycles. Tanzanians suggested a flexible model, annual by default but more frequent during early adoption or in low-performing facilities. South Africans leaned towards quarterly use, linking it to existing review and reporting systems.

On completion formats, collective discussion was widely valued for fostering shared responsibility and learning. Dutch and Tanzanian respondents favoured combining group dialogue with prior individual completion to protect confidentiality while benefiting from diverse perspectives. South African respondents echoed this hybrid model, noting that individual completion can mitigate hierarchical barriers to open discussion.

Across all three settings, successful implementation was seen to require a balance of efficiency, inclusivity, and contextual flexibility, ensuring that the checklist becomes a routine, participatory practice.

5.5.4 Institutional Integration & Continuous Learning

For long-term sustainability, respondents stressed that the checklist must be embedded within existing governance, quality assurance, and operational processes rather than treated as a stand-alone exercise. In the Netherlands, respondents recommended integration into established review structures, such as quality improvement systems and patient-centred care teams.

In Tanzania, embedding was linked to formal endorsement by hospital leadership and inclusion in national policy frameworks. Respondents proposed designating a focal team to oversee implementation, ensuring continuity and institutional ownership.

South African respondents similarly emphasised alignment with existing workflows to avoid additional administrative burden. Embedding the checklist into routine operations was seen as essential for uptake in already resource-constrained settings.

Continuous learning was identified as central to sustained relevance. Respondents across contexts recommended cyclical use linked to structured follow-up, action planning, and progress monitoring. Without these feedback loops, the checklist risks becoming a symbolic compliance task rather than a driver of change.

5.5.5 Inclusivity and Accessibility

Respondents agreed that the checklist's language and structure must be accessible to all intended users. In the Netherlands, concerns centred on vague or overly complex terminology that risked excluding non-clinical staff. Tanzanian respondents called for translation into Swahili and simplification of technical terms to engage a wider range of healthcare workers. In South Africa, dual-language versions, particularly in Xhosa, were seen as essential for inclusion of community-facing staff.

Inclusivity also applied to the range of respondents. Dutch respondents stressed that non-clinical staff, such as drivers, logistics personnel, and administrators, should be included to capture diverse perspectives on access and service delivery. Tanzanian respondents advocated a multi-level approach involving both leadership and frontline staff. South African respondents highlighted the importance of engaging all hierarchical levels to ensure alignment of priorities and collective ownership of results.

Across all contexts, broad and inclusive participation was seen as critical for generating comprehensive, actionable insights.

5.5.6 Capacity Building and Training

Preceding training was considered essential for effective checklist use. Respondents in all countries stressed that without a shared understanding of the right to health and the checklist's purpose, engagement risks being superficial or inconsistent.

In the Netherlands, training was seen as necessary to bridge gaps in rights-based knowledge and to motivate participation. Interactive formats, such as workshops, were preferred over passive e-learning. Tanzanian respondents proposed stepwise, team-based learning to build understanding and encourage active engagement. In South Africa, preparatory training was also framed as vital for ensuring consistent interpretation and embedding the checklist into institutional culture.

Across settings, training was viewed not only as a technical necessity but as a means to secure buy-in, foster ownership, and strengthen the link between checklist use and meaningful institutional reflection.

Quote #12

"A short educational talk or presentation before going through this checklist would make all the difference."

The Netherlands, respondent 15 – MD Global Health, PhD candidate

5.5.7 Design Refinements

Respondents offered concrete suggestions for improving the checklist's design. The purpose should be clearly communicated to avoid confusion about whether it is an evaluative, developmental, or compliance tool. The binary "yes/no/don't know" format was seen as too limiting; respondents recommended adding Likert scales and open-text fields to capture nuance.

Thematic gaps were identified, including patient consent, patient awareness of their rights, and experiential measures. Simplifying language, adding examples, and presenting marginalised groups with greater contextual sensitivity were also recommended. These refinements were intended to improve clarity, relevance, and cultural applicability, ensuring that the tool resonates across diverse settings.

5.5.8 Strengthening Stakeholder Collaboration

Respondents agreed that successful implementation depends on collaboration between multiple stakeholder groups. In the Netherlands, national professional bodies were seen as potential drivers for formalising the checklist within accreditation systems, while grassroots advocacy was considered key to sustaining change.

In Tanzania, a cascade model of implementation was proposed, starting with government-level endorsement and extending to community outreach. Facility-level peer learning was encouraged to promote horizontal exchange and shared problem-solving.

South African respondents stressed the importance of vertical coordination between healthcare facilities and government structures, alongside active involvement of community health workers.

In all contexts, broad stakeholder engagement was viewed as critical for building legitimacy, fostering mutual learning, and ensuring that the checklist becomes a meaningful, integrated component of health system practice.

6. Discussion

6.1 Introduction and Integration of Key Findings

This study assessed the applicability, challenges, and potential of the Right to Health Monitoring and Implementation Checklist (RHMIC) across three distinct healthcare contexts: the Netherlands, Tanzania, and South Africa. Guided by the Health Equity Framework (HEF), the findings highlight how healthcare professionals engage with rights-based tools and how structural, relational, individual, and emotional factors shape this engagement. Across all contexts, respondents expressed a conceptual awareness of the right to health but described an absence of concrete mechanisms to operationalize it. The RHMIC was widely viewed as a promising tool to bridge this gap, supporting reflection, identifying rights violations, and fostering institutional learning. However, its successful implementation depends on context-sensitive adaptation, ethical framing, and sustained follow-up.

The study revealed considerable variation in how the right to health is interpreted and acted upon. In the Netherlands, respondents often encountered the concept through academic or advocacy roles, whereas in Tanzania and South Africa, it was tied to community health, public sector reform, or historical legacies. Despite this variation, a shared pattern emerged: health professionals across countries relied heavily on ethical instincts and informal advocacy rather than structured, system-wide rights-based frameworks. The RHMIC was seen as a way to formalize this commitment and promote institutional accountability.

However, significant challenges emerged, including lack of training, institutional resistance, ambiguous accountability structures, and emotional fatigue. These barriers demonstrate that empowering healthcare workers to advocate for the right to health cannot rely on tools alone; implementation must be supported by training, trust-building, and system-level reforms. The HEF helped illuminate these dynamics, emphasizing the interdependence of structural, relational, personal, and emotional domains. The following sections discuss each of these thematic areas in greater depth.

6.2 Knowledge, Potential, and Challenges Through the HEF

6.2.1 Knowledge of the Right to Health

While respondents across all countries were familiar with the idea of the right to health, few had received formal training on how to apply it in practice. This was particularly pronounced in clinical education. In the Netherlands, respondents encountered rights frameworks primarily through postgraduate study or NGO work, while Tanzanian and South African respondents reported some exposure through community health or constitutional mandates. Yet most saw the right to health as an aspirational rather than actionable concept, echoing Hunt's(22) observation that even health professionals who know of the right often do not know how to operationalize it.

From a systems of power perspective, this reveals significant structural gaps.

Quote #13

"Here in Maasai culture, the man is the boss of the family, so they decide. We had a woman who needed an emergency cesarean because of fetal distress. The husband was drunk and refused. The mother had already approved, but because the husband refused, she could not approve for surgery. We called the village leader, and only after he approved could we save the mother and the child."

Tanzania, respondent 11 – MD Global Health at District hospital

This vivid example shows how entrenched gender norms and decision-making hierarchies directly obstruct women's access to life-saving care. Health institutions and training programs rarely provide professionals with the legal or procedural knowledge to recognize and report rights violations. In such contexts, relationships and networks often fill the void: professionals rely on personal judgment and informal advocacy. While this form of engagement reflects ethical commitment, it also renders rights-based practice inconsistent and vulnerable to institutional pressures.(39)

At the individual level, awareness varied widely. Some respondents displayed strong rights-based reasoning, while others expressed discomfort or skepticism. This variation is concerning: without a clear institutional mandate, personal attitudes and confidence become the primary drivers of rights-based care.(40) These knowledge gaps also affected physiological pathways. Respondents described stress, frustration, or helplessness when they were unable to respond to violations, highlighting the emotional toll of inadequate training and support.(21)

6.2.2 Potential of the Checklist

Despite the knowledge gaps, the RHMIC was seen as a valuable tool to translate abstract principles into practice. Its perceived potential spanned all four HEF domains. Within systems of power, respondents viewed the checklist as a mechanism to inform quality improvement, influence policy, and create institutional memory of rights violations. In Tanzania and South Africa, it was seen as especially useful for linking local issues to broader accountability systems.

The RHMIC also played a relational role. Many respondents appreciated how the checklist facilitated team-based reflection, encouraging professionals to speak about equity in structured, constructive ways. This aligns with Daniels'(41) concept of "accountability for reasonableness," in which fair and transparent deliberation is essential for ethical decision-making.

At the individual level, respondents found the checklist empowering. It provided language and structure for naming issues they had previously only sensed or informally addressed. For professionals in under-resourced settings, the tool was a source of validation, an external structure that legitimized their concerns and actions. Additionally, some respondents reported that using the RHMIC helped reduce emotional strain, contributing positively to the physiological domain. This supports literature on moral resilience, which links clarity, support, and collective action to emotional wellbeing.(42, 43)

6.2.3 Challenges to Implementation

Despite this potential, the RHMIC faces considerable implementation barriers. Within systems of power, the most common concern was the lack of follow-up and unclear accountability. Respondents feared the checklist would become symbolic or punitive, an administrative burden rather than a mechanism for change. This echoes long-standing critiques of rights-based frameworks that emphasize documentation without enforcement.(44)

Relational dynamics also posed challenges. While some respondents described rich team discussions, others, especially in hierarchical or politically sensitive environments, feared retaliation. In Tanzania and South Africa, discussing discrimination or marginalization risked professional backlash. In the Netherlands, professionals working with undocumented migrants raised similar concerns, though within different institutional logics. These findings highlight how weak relationships and networks undermine trust and candor, limiting the RHMIC's utility.

At the individual level, barriers included checklist fatigue, unclear language, and limited training. Several respondents felt the tool placed unfair responsibility on individuals who lacked time or influence to act on identified issues. This tension, between empowerment and overburden, mirrors critiques of neoliberal health governance, where structural responsibility is offloaded onto individuals.(45) The emotional consequences were evident in the physiological domain. In already strained environments, the checklist risked becoming another stressor rather than a support mechanism.

6.3 Recommendations and Interlinkages Across HEF Domains

Respondents offered detailed, context-specific recommendations. These addressed not only the checklist's design, but also its ethical framing, implementation strategy, and institutional embedding.

In terms of systems of power, respondents called for integration of the RHMIC into quality assurance processes and policy guidelines. They emphasized the need for clear, non-punitive follow-up structures, preferably involving staff from different professional cadres. Institutionalizing the tool in this way would reduce the risk of symbolic or tokenistic use and increase accountability.

Quote #14

"The Batho Pele principles we work with in South Africa serve a similar purpose to the checklist. If they were merged or used hand in hand, they could achieve more. They sort of need each other for it to be effective."

South Africa, respondent 16 – Clinical dietician at District hospital

Relationships and networks were seen as both a target and a mechanism of implementation. Respondents recommended group-based reflection sessions facilitated by trained moderators to reduce power imbalances. In all countries, hybrid models were proposed: combining anonymous input with collective analysis to balance psychological safety with team learning.

At the individual level, respondents stressed the importance of training, simplification of language, and alignment of expectations. A lack of clarity could lead to mistrust or disengagement. The checklist must be introduced as a developmental tool, not a diagnostic one.

The physiological dimension emphasized emotional safety and reflection. When well-framed, the RHMIC helped surface unspoken tensions, supported resilience, and created moral alignment within teams. However, if introduced insensitively, it risked deepening emotional exhaustion.

Importantly, these domains are not discrete. Weaknesses in one area, such as lack of follow-up, can undermine relational trust and individual motivation. Conversely, success in one domain, such as effective team facilitation, can reinforce others. The findings support an implementation model that is bottom-up, participatory, and attentive to context, aligning with global health scholarship on equity-based intervention design.(46)

6.4 Reflection on the Analytical Framework

The HEF proved highly effective in guiding the analysis. Its structure made visible the multiple, interdependent layers that shape the implementation of tools like the RHMIC. Unlike traditional frameworks that focus solely on system-level reform or individual behavior, the HEF allowed for an integrated examination of policy, practice, and lived experience.

However, some limitations were evident. First, the HEF does not sufficiently distinguish between external systems of power (e.g., national policy) and internal hierarchies (e.g., hospital leadership). This distinction was critical in understanding fears of retaliation and staff silencing, particularly in South Africa and Tanzania. Incorporating complementary frameworks such as intersectionality(47) or critical health systems analysis could enrich future studies.

Second, the physiological pathways domain, while conceptually useful, remained underdeveloped. Respondents offered rich descriptions of burnout, emotional conflict, and moral injury, but the HEF provided limited vocabulary for analyzing these experiences in depth. Literature on moral distress and resilience(42, 43) may help refine this domain in future adaptations.

Third, the HEF’s general references to “life course” and “history” were insufficient to capture the influence of colonial legacies, legal reforms, and past health system transformations on contemporary rights discourses. In contexts like South Africa, post-apartheid equity agendas shaped institutional memory and professional expectations; in Tanzania, donor-driven reforms influenced local interpretations of voice and responsibility. Future use of the HEF in cross-national research would benefit from stronger tools for political and historical contextualization.

Nonetheless, the HEF offered a clear and practical structure for organizing findings. It supported an analysis that was sensitive to equity, intersectionality, and implementation dynamics, while remaining grounded in respondents' lived experiences.

6.5 Additional Considerations: Discrimination as a Social Determinant of Health

Although discrimination was not an explicit category within the Health Equity Framework applied in this study, it emerged consistently across all interview contexts. Respondents described how marginalised groups, including racial or ethnic minorities, migrants and other socially excluded populations, frequently experience discriminatory treatment in healthcare and its broader systems.

> *Quote #15*
>
> *"Sex workers in Myanmar are very discriminated and excluded within MOH facilities. They avoid going because they are shouted at, treated differently, or police get involved. We set up mobile clinics inside brothels and nearby in vans because mixed waiting rooms, daytime opening hours, and lack of confidentiality meant they simply wouldn't come."*
>
> The Netherlands, respondent 13 – MD Global Health and Sexual, Reproductive Health & Rights specialist at NGO

These findings align with empirical research positioning racism and discrimination themselves as direct determinants of health.(48, 49) Thorpe and colleagues(50) further advance this evidence with a theoretical model that conceptualises how race-based discriminatory laws, policies, and practices cascade through structural and social determinants, culminating in adverse health outcomes. Such a model complements the HEF by illustrating the interconnected nature of structural discrimination, relational dynamics, individual experiences, and physiological stress in warping equitable health. Although this framework was not used during analysis and thus cannot be presented as a finding, it offers a vital lens for future iterations of tools like the RHMIC, especially when designing interventions that aim to target root inequities to accelerate improved outcomes for minoritised groups.

6.6 Methodological and Ethical Considerations

As a qualitative study conducted within a twelve-month master's timeline, this research faced practical and ethical constraints. Sample diversity was limited by time, access, and geography. Despite proactive outreach, representation from rural areas, community health workers, and lower-cadre professionals may have been limited. Given the emphasis on rights and power, these missing voices could have significantly enriched the analysis.

Logistical challenges included time zone coordination, digital access issues (especially in Tanzania), and language barriers. Some interviews were impacted by technical limitations, which may have constrained respondent depth or disclosure.

Ethical concerns also shaped both research and findings. Social desirability bias and fear of institutional retaliation may have influenced responses, particularly in relation to sensitive populations such as undocumented migrants or LGBTQ+ groups. These risks mirror the implementation challenges identified by respondents and underscore the importance of building institutional cultures of trust and safety.

Resource limitations were also a factor. The study was self-funded and conducted without formal institutional backing—mirroring the very inequities it set out to examine. Yet despite these limitations, the findings offer rich, cross-contextual insight into how the right to health is understood and enacted—and how tools like the RHMIC might contribute to its realization when introduced with care, collaboration, and critical awareness.

This discussion has shown that while healthcare professionals across diverse settings share a strong ethical commitment to equity and human rights, the operationalization of the right to health remains inconsistent and deeply shaped by structural, relational, and individual-level factors. The Right to Health Monitoring and Implementation Checklist emerged as a promising tool — not only for fostering awareness but also for guiding institutional learning and advocacy. However, its potential is contingent upon careful and context-sensitive implementation that addresses challenges such as unclear accountability, institutional mistrust, knowledge gaps, and emotional strain.

By applying the Health Equity Framework, the study illuminated how the four spheres of influence, systems of power, relationships and networks, individual factors, and physiological pathways, interact to either support or constrain the RHMIC’s use. These findings point to the need for implementation strategies that go beyond checklist distribution, focusing instead on trust-building, co-creation, and structural reform. The following chapter synthesizes these insights into concrete conclusions and recommendations, offering a roadmap for refining and scaling the RHMIC in ways that are equitable, inclusive, and effective.

7. Conclusions and Recommendations

This study set out to explore the applicability, challenges, and potential of the Right to Health Monitoring and Implementation Checklist (RHMIC), developed by IFHHRO, as a tool to strengthen rights-based healthcare delivery. Drawing on qualitative interviews with 20 health professionals across the Netherlands, Tanzania, and South Africa, and analyzed through the Health Equity Framework (HEF), the findings reveal both strong support for the checklist's purpose and critical insights into the conditions required for its effective implementation. This chapter summarizes the conclusions in relation to each research objective, offers a response to the overarching research question, and presents recommendations aimed at IFHHRO, healthcare institutions, and broader health policy actors.

7.1 Answer to the Main Research Question

This study sought to answer: *To what extent is the Right to Health Monitoring and Implementation Checklist applicable in healthcare institutions in different settings, and how might its implementation empower healthcare professionals to more effectively identify and address right to health violations, thereby contributing to improved patient care and reduced health disparities?*

The evidence suggests that the checklist is broadly applicable across settings and holds significant potential to empower healthcare professionals. However, this potential is conditional. The checklist is not a standalone solution but a facilitator of reflective practice, institutional accountability, and systems change. Its success depends on thoughtful implementation that addresses local power dynamics, fosters professional trust, and includes structural follow-up. In this sense, the checklist is best understood not as an evaluative tool, but as an enabling mechanism, one that can transform latent professional values into collective action when supported by systems that value equity, safety, and collaboration.

7.2 Conclusions per Objective

Objective 1: To explore the potential of the RHMIC

The checklist is widely perceived by respondents across all three countries as a valuable tool for raising awareness, fostering reflection, and initiating rights-based conversations in healthcare settings. Its flexibility and broad scope enable adaptation across different professional roles and institutional contexts. The RHMIC was credited with supporting individual empowerment, strengthening team-based dialogue, and fostering a culture of accountability. Framed through the HEF, the checklist operates across all four spheres of influence: it enhances individual knowledge and motivation, strengthens professional networks through team reflection, informs systems of power by generating actionable insights, and contributes to emotional resilience and moral alignment among healthcare providers. The RHMIC's strongest potential lies in its ability to bridge the gap between abstract human rights norms and daily clinical realities, particularly when introduced as a participatory, non-punitive instrument.

Objective 2: To explore the challenges that may be encountered in implementation

Despite broad endorsement of the RHMIC's purpose, respondents identified a range of structural, relational, and contextual barriers to its implementation. These include lack of accountability mechanisms, fear of professional repercussions, limited familiarity with human rights concepts, vague or overly formal language, and contextual misalignment. Resource constraints, such as time, staff shortages, and limited infrastructure, were particularly acute in Tanzania and South Africa. In all countries, respondents expressed concern that the checklist could be misunderstood as an evaluative or punitive tool, rather than a mechanism for learning and improvement. These challenges underscore the need for strong institutional support, culturally sensitive design, and clarity of purpose. The findings affirm that without adequate investment in trust, training, and feedback structures, the checklist risks becoming tokenistic, or worse, counterproductive.

Objective 3: To provide recommendations for improvement of the RHMIC, including safety, confidentiality, and professional protection

Respondents provided a wealth of practical, context-sensitive recommendations to enhance the checklist's usability and ethical foundation. Across all settings, there was a strong call for anonymity, safe reporting structures, and a clear shift away from punitive interpretations. Collective, team-based formats were preferred for fostering dialogue, but respondents also advocated for hybrid models that allowed for anonymous input where appropriate. Pre-implementation training was universally emphasized as essential to build knowledge, clarify purpose, and establish trust. Respondents also suggested design modifications, including clearer language, inclusion of Likert scales, digital versions with offline options, and cadre-specific adaptations. Finally, institutional embedding, through integration into quality assurance systems, national guidelines, and regular monitoring cycles, was seen as key to long-term sustainability and impact.

7.3 Recommendations

- For IFHHRO (Checklist Developers):
    - Clarify the purpose of the RHMIC: Explicitly position the checklist as a learning and awareness-raising tool rather than an audit or performance evaluation.
    - Improve accessibility and inclusivity: Simplify language, avoid legalistic jargon, and provide translations in key languages.
    - Revise format and structure: Incorporate Likert scales (e.g., 0–5), allow space for elaboration where relevant, and offer both digital and paper-based formats.
    - Develop training materials: Create instructional videos, e-learning modules, and facilitation guides to support pre-implementation training across contexts.
    - Create context-sensitive versions: Tailor checklist formats for different healthcare cadres and settings, including non-clinical staff and rural environments.

- For Healthcare Institutions and Facilities:
    - Embed the checklist in institutional routines: Integrate it into quality improvement cycles, staff onboarding, and team reflection sessions.

  - Ensure psychological safety: Introduce anonymous completion options and foster a non-punitive culture that encourages honest dialogue.
  - Promote collective learning: Use the checklist in group settings to generate shared insights, build trust, and reduce blind spots.
  - Assign dedicated focal points: Designate responsible staff or committees to collect, interpret, and act on checklist findings.
  - Use results for internal reform, not external punishment: Leverage insights to drive equitable change, not to discipline or blame staff.

- For Policymakers and National Stakeholders:
  - Integrate the RHMIC into national guidelines: Recognize the tool as a formal mechanism for advancing equity in healthcare service delivery.
  - Support scale-up with funding and training: Ensure facilities have the resources and capacities needed to implement the checklist meaningfully.
  - Foster horizontal learning: Encourage sharing of best practices across institutions and regions through workshops, case studies, and communities of practice.
  - Promote bottom-up implementation: Avoid top-down mandates. Empower frontline professionals to lead adaptation and uptake, increasing legitimacy and buy-in.

7.4 Suggestions for Future Research

While this study offers valuable insights, several questions remain open:

- How does the checklist function when used longitudinally, over time, in the same facility?
- What is the impact of pre-training on staff engagement with the checklist?
- How do patients and communities perceive the impact of checklist-informed changes?
- Can the RHMIC be adapted to monitor other rights (e.g., reproductive rights, mental health rights) in specific contexts?

Future research should include participatory action studies, implementation pilots with built-in feedback loops, and mixed-methods evaluations to measure outcomes over time. Investigating these areas will help refine the checklist and ensure it remains responsive, effective, and grounded in real-world practice.

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Annexes

Annex 1: The Right to Health Monitoring and Implementation Checklist
Annex 2a: Informed Consent live respondents
Annex 2b: Informed Consent digital respondents
Annex 3: Interview guide
Annex 4: Ethical Waiver Application
Annex 5: Codebook

IFHHRO
medical
human
rights
network

Right to Health Monitoring & Implementation Checklist for Health Professionals

Enter your score with a checkmark : YES (Y) / NO (NO) / DON'T KNOW (DK)				
I	**Availability**: *Sufficient quantity of functioning health care facilities, goods and services, as well as programs for all.*			
		YES	**NO**	**DK**
1.1.	Is sufficient well-trained staff available at your health facility?			
1.2	Is a multicultural interpreter available at your health facility?			
1.3	Are there multilingual information brochures and low-literacy brochures available at your facility?			
1.4	Are services available to address unmet needs for marginalized groups at your health facility? (women, ethnic minorities, LGBTQI+, low-literacy, low health literacy, disability, lower socio-economic status)			
1.4	Are essential medicines (on basis of the WHO essential medicines program) available and affordable at your health facility?			
1.6	Is medical equipment (e.g. supplies and devices) available and affordable at your health facility?			
II	**Accessibility:** Physical, financial & monitoring systems of health-related information and whether this information is reaching all populations.			
		YES	**NO**	**DK**
2.1	Do all people in need of special health services receive the needed essential health services at your health facility?			
2.2	Is the service capacity delivered sufficient at your health facility? (number of people in need of services and the number of people who receive the services)			
2.3	Do all patients have adequate access to appropriate health(care) at your health facility?			
2.4.	Are all services offered at your health facility affordable to all patients? (e.g. nobody is excluded for financial reasons, insurance coverage is adequate)			
2.5	Are there non-discrimination policies in place at your health facility?			

2.6	At your health facility, are all group interventions accessible for persons with special needs? (low-literacy, migrants etc.)			
2.7	Is your health facility accessible for people with disabilities?			
III	**Acceptability**: Respect for medical ethics, culturally appropriate, sensitivity to gender & lifecycle. Services are people-centered and cater for the specific needs of diverse population groups			
		YES	**NO**	**DK**
3.1	Are services delivered at your health facility people-centered organized, including special groups (e.g. gender, LGBTQI+, religion)?			
3.2	Do the health facility policies include also special minorities (migrants, deaf, blind, low-literacy rate, stigmatized diseases)?			
3.3	Do the services offered by your health facility meet the local needs?			
3.4	Are all services delivered at your health facility in line with medical ethics and gender, cultural and lifecycle sensitive?			
VI	**Quality:** Facilities & services must be scientifically and medically approved.			
		YES	**NO**	**DK**
4.1	**Safety** - Are safety measurements in place at your health facility? (including monitoring accidents and complaints)			
4.2	**Effective** - Are quality monitoring reporting systems in place at your health facility?			
4.3	**People-centered** – Is evaluation of services conducted and are patient satisfaction (and inclusiveness) services in place at your health facility?			
4.4	**Timely** - Are health services waiting times at your health facility in line with the national guidelines?			
4.5	**Equitable** – Are healthcare and rehabilitation care given to all in need at your health facility?			
4.6	**Integrated** – Is healthcare and rehabilitation care given throughout the full life course at your health facility?			
4.7	**Efficient** - At your health facility, are the resources available of sufficient quality? (e.g. staff, equipment)			
4.8	**Quality** of information - At your health facility, are adequate information signs and directions in place, including for persons with special needs?			
4.9	Are appropriate sanitation facilities available for persons with special needs at your health facility?			
V	**Accountability**			
		YES	**NO**	**DK**
5.1	At your health facility, is adequate information available about effective implementation of the right to health and its accountability mechanisms?			

5.2	At your health facility, are safety and reporting procedures in place?			
5.3	At your health facility, is an ombudsperson in place and operational?			
5.4	At your health facility, are whistleblower protection procedures in place?			
VI	**Participation**			
		YES	**NO**	**DK**
6.1	At your health facility, are recipient participation programs in place (local and/ or national)? Including reports of implementation.			
6.2	At your health facility, is a patient satisfaction measuring and reporting mechanism in place?			
VII	**Underlying conditions of health**			
		YES	**NO**	**DK**
7.1	Is food available, affordable and accessible in adequate supply and of good quality at your health facility (i.e. for the people you serve)?			
7.2	Is there housing available and accessible for all at your health facility (i.e. for the people you serve)?			
7.3	Is water and sanitation accessible for all at your health facility (i.e. for the people you serve)?			
7.4	Are healthy occupational and environmental conditions in place at your health facility (i.e. for the people you serve)?			
7.5	Are social services available and accessible at your health facility?			
7.6	Are regular controls of one’s health and body performed at your health facility?			
7.7	Is there adequate education for all (primary – and secondary education) within the area of your health facility (i.e. the people you serve) ?			
VIII	**Contextual checklist – all to be found by Websearch**			
		YES	**NO**	**DK**
8.1	Is there a national health plan in place?			
8.2	Is the Right to Health embedded in the constitution?			
8.3	Are government periodical reports submitted to the Committee of Economic, social and Cultural rights (CESCR) and other UN supervising committees?			
8.4	Are parallel (shadow) reports, submitted to UN supervising committees by NGO’s and/or professional organizations, available?			
8.5	Is the Right to Health included during the universal periodic review (UPR)			
8.6	Are there country reports and recommendations available by the Special Rapporteurs on the right to Health?			

Annex 2 – Informed consent interview respondents

Informed consent form live participant – thesis Charissa Rahmee, MIH student KIT

Dear prospective participant,

Thank you for considering participation in this study. My name is Charissa Rahmee, hereafter named the researcher, and I am a Master student at KIT Royal Tropical Institute.

This study is part of my Master thesis and focuses on the healthcare professionals' perspective on the Right to Health Monitoring and Implementation Checklist (RHMIC), developed by the Medical Human Rights Network (IFHHRO - International Federation of Health & Human Rights Organization). If you agree to participate in this study, the information you provide will not only help my Master thesis but will also help in creating recommendations for further improvement and implementation of the checklist. The study takes place between June and September 2024.

Procedures including confidentiality

Participation in this study will include filling out the RHMIC with the researcher and questions that focus on your perspective of the right to health, the RHMIC, and its potential.

The interview will take place face-to-face, with filling out the RHMIC taking about 20 minutes, and questions about your experience with the RHMIC will take about 40 minutes. Present during the interview will only be you, the participant, and myself, the researcher.

With your consent, the interview will be audio recorded, for data collection and notes will be taken during the interview. If you do not consent to the audio recording, only notes will be taken during the interview. All information gathered will be kept strictly confidential and all data will be anonymized. All recordings will be transcribed and the recordings will subsequently be deleted. No details that can be traced back to you, including your name or other personal identifiable information, will be recorded or written down. In publications, the findings will focus on the perspective of healthcare professionals in general and not on your individual answers, to ensure confidentiality.

All anonymized information will be kept in either a secured filing cabinet or in a secured folder on the laptop of the researcher.

Data analysis will take place in the four months following data collection. All data will be deleted six months following completion of the study.

Risk, discomforts and right to withdraw

Your participation is voluntary. You are free to withdraw from the study at any time and you are free to decline answering any questions that make you uncomfortable or for any other reason without this having any consequences for you or your professional position.

Benefits

The results of this study will help to further improve and implement the RHMIC. In future, the results of this study and the implementation of the RHMIC, might help to improve the access to care, the quality of care, and the compliance to the right to health.

They are no reimbursements or compensations for participating in this study.

Sharing the results

After the study is completed, the researcher will share the results in a Master thesis. Furthermore, the results will be shared with IFHHRO (the medical human rights network) and possibly through publication in a scientific journal. If you would like to receive a copy of the thesis, please contact the researcher.

Consent and contact

If you have any question or comments or if you would like more information or further explanation, please ask the researcher before signing.

If you agree on participation in this study, please sign below.

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)

____

WITNESS SIGNATURE

____

Signed Date

If you have any questions, comments or want to file a complaint about the research you may contact:
Charissa Rahmee
cnsrahmee@gmail.com

Contact information organization Contact for Ethics Committee
Sandra Alba
s.alba@kit.nl

Annex 2 – Informed consent interview respondents

Informed consent form online participant – thesis Charissa Rahmee, MIH student KIT

Dear prospective participant,

Thank you for considering participation in this study. My name is Charissa Rahmee, hereafter named the researcher, and I am a Master student at KIT Royal Tropical Institute.

This study is part of my Master thesis and focuses on the healthcare professionals' perspective on the Right to Health Monitoring and Implementation Checklist (RHMIC), developed by the Medical Human Rights Network (IFHHRO - International Federation of Health & Human Rights Organization). If you agree to participate in this study, the information you provide will not only help my Master thesis but will also help in creating recommendations for further improvement and implementation of the checklist. The study takes place between June and September 2024.

Procedures including confidentiality

Participation in this study will include filling out the RHMIC with the researcher and questions that focus on your perspective of the right to health, the RHMIC, and its potential.

The interview will take via an online video connection (either Zoom or Teams), with filling out the RHMIC taking about 20 minutes, and questions about your experience with the RHMIC will take about 40 minutes. Present during the interview will only be you, the participant, and myself, the researcher.

With your consent, the interview will be audio recorded, for data collection and notes will be taken during the interview. If you do not consent to the audio recording, only notes will be taken during the interview. All information gathered will be kept strictly confidential and all data will be anonymized. All recordings will be transcribed and the recordings will subsequently be deleted. No details that can be traced back to you, including your name or other personal identifiable information, will be recorded or written down. In publications, the findings will focus on the perspective of healthcare professionals in general and not on your individual answers, to ensure confidentiality.

All anonymized information will be kept in either a secured filing cabinet or in a secured folder on the laptop of the researcher.

Data analysis will take place in the four months following data collection. All data will be deleted six months following completion of the study.

Risk, discomforts and right to withdraw

Your participation is voluntary. You are free to withdraw from the study at any time and you are free to decline answering any questions that make you uncomfortable or for any other reason without this having any consequences for you or your professional position.

Benefits

The results of this study will help to further improve and implement the RHMIC. In future, the results of this study and the implementation of the RHMIC, might help to improve the access to care, the quality of care, and the compliance to the right to health.

They are no reimbursements or compensations for participating in this study.

Sharing the results

After the study is completed, the researcher will share the results in a Master thesis. Furthermore, the results will be shared with IFHHRO (the medical human rights network) and possibly through publication in a scientific journal. If you would like to receive a copy of the thesis, please contact the researcher.

Consent and contact

If you have any question or comments or if you would like more information or further explanation, please ask the researcher before signing.

If you agree on participation in this study, please sign below.

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)

____

WITNESS SIGNATURE

____

Signed Date

If you have any questions, comments or want to file a complaint about the research you may contact:
Charissa Rahmee
cnsrahmee@gmail.com

Contact information organization Contact for Ethics Committee
Sandra Alba
s.alba@kit.nl

Annex 1 Data Collection Tool – Interview Guide

Participant sociodemographic

Opening question: Can you tell me a little bit about yourself?
Crosscheck on paper any relevant information shared spontaneously and probe if data below is missing

Age

Gender

Education

Country of origin

Profession

- Most relevant place of work (for the purpose of this research)
  - What has been your most relevant place of work with regards to working with marginalized populations?
- Main patient group focus in work (which marginalized population)
  - Which marginalized groups have you worked with? Or do you employees/organization work with?
- Country / countries of working experience
  - Which countries have you worked in?
- Clinical or management / non-clinical
  - Is you work mainly clinical or non-clinical? Please specify.

Knowledge of the right to health

Opening question: What are your thoughts on the right to health?
Crosscheck on paper any relevant information shared spontaneously and probe if data below is missing

Familiarity with the concept

- Are you familiar with the concept of the right to health?
  - If yes, what is the most important part of the concept for you, like access to health facilities (non-discriminatory), essential foods, basic shelter and WASH, essential drugs
  - If yes, do you discuss the right to health or issues surrounding it with your colleagues? How do you use the right to health in your daily practice?

Imbedded in formal education

- Was the topic of the right to health embedded in your education?

Use of the right to health in work (previous or current)

Have you ever used to the right to health in your work?

If yes, do you discuss the right to health or issues surrounding it with your colleagues? How do you use the right to health in your daily practice? (if not already covered earlier)

Own role in implementation of the right to health

How do you see your role in the implementation of the right to health (within your organization/work)?

Experience with the checklist

Opening question: What are your thoughts on the checklist?

Crosscheck on paper any relevant information shared spontaneously and probe if data below is missing

Overall understanding of the checklist

What are your thoughts on the checklist?

Time to complete checklist

What are your thoughts on the time it takes to complete the checklist?

User friendly

Paper or digital

Would you prefer a paper or digital version of the checklist?

Use of language

What are your thoughts on the language used in the checklist?

Length of toolkit

What are your thoughts on the length of the checklist i.e. the amount of questions?

Applicability to participant's professional setting

Do you think the checklist is applicable to your place of work? Either direct (clinical) or indirect (non-clinical/management)

What do you think about the applicability of the checklist in different settings, i.e. in a high-resource setting (HRS) and low-resource setting (LRS)?

Comprehensiveness of checklist

Missing topics

Do you feel like there are topics missing in the checklist?

If yes, which?

Would you use this checklist?

- Redundant topics
  - Do you feel certain topics are mentioned too often in the checklist or unnecessary?
    - If yes, which?
  - Would you use this checklist?
    - If yes, why?
    - If no, why?

Implementation of the toolkit

Opening question: What are your thoughts on the implementation of the checklist?
Crosscheck on paper any relevant information shared spontaneously and probe if data below is missing

Target audience

- Who needs to fill out and/or deploy the checklist? (i.e. hospital board, work floor manager, head of department, medical doctors, nursing staff)

Applicability at place of work

- Clinical setting and non-clinical setting
  - Repeat question if not already mentioned under "experience with the checklist"
- Frequency
  - How often does the toolkit need to be deployed?
- Support
  - What are your thought on getting support for implementation "on the ground" from supervisors/facilities/organizations?

Challenges

- Confidentiality
  - What are your thoughts on issues with confidentiality for the patient?
  - What are your thoughts on issues with confidentiality for the health professional?
- Safety and security
  - What are your thoughts on issues with safety and security for the patient?
  - What are your thoughts on issues with safety and security for the health professional?
- Accountability and awareness when violations have been found
  - In case of insufficient adherence to the right to health, what do you think should be the consequence?
  - Where could you report any short fallings?
  - How do you think structural change can be made with regards to awareness about the right to health when short fallings are encountered through the checklist?

Potential

Potential of the toolkit in monitoring right to health

What are your thoughts on the potential of the RHMIC?

Do you see positive potential? How about negative?

Potential of the toolkit in signaling violations in right to health

What are your thoughts on the potential of the RHMIC to signal violations to the right to health?

From: C.N.S. Rahmee Amsterdam, July 11th 2024

To: KIT Research Ethics Committee

Dear Lisanne Gerstel and Fernando Maldonado,

This letter is to request a waiver of ethical clearance for a study on the right to health from the healthcare professionals' perspective.

The study is implemented by Charissa Rahmee for the context of a KIT Master thesis research. The purpose of the study is Piloting the Right to Health Monitoring and Implementation Checklist (RHMIC). The study focuses on health professionals. The results will be used to further assess the applicability of the RHMIC and possibly to publish the results and recommendations resulting from the study.

The Right to Health is a fundamental human right and as such is codified and imbedded in major human rights instruments like Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). The right to health includes, but is not limited to, the assurance of availability, accessibility, affordability, and good quality of care for everyone. Despite the pivotal role of healthcare providers, there exists a significant gap in their understanding and application of the right to health principles in clinical practice. The Medical Human Rights Network (IFHHRO) believes this gap contributes to the lack of access to care for patients worldwide. IFHHRO initiated the 'Dignity at the Bedside' project, which aims to address this gap by equipping healthcare professionals with the necessary tools and knowledge to uphold human rights in healthcare settings. One of the core challenges identified within the 'Dignity at the Bedside' project is the lack of comprehensive training and support regarding the right to health among healthcare professionals. IFHHRO developed the RHMIC to help healthcare providers apply the right to health for their patients by creating awareness on the topic and assess the right to health in their places of work.

The methodology of the study will focus on qualitative research and consists of semi-structured in-depth interviews. The number of respondents is approximately 15. Respondents will come from the Netherlands, Tanzania, and South Africa. Interviews in the Netherlands and Tanzania will be conducted face-to-face and interviews in South Africa will be conducted via an online video connection (Zoom or Teams). Respondents will be selected through non-probability sampling (purposive) through personal and professional connections of the researcher in the capacity of master student. The interview will have two components, at first the researcher will go through the RHMIC with the respondent and secondly, conduct a semi-structured interview about the respondent's experience with the checklist. The aim of the interview is to gain insight into the healthcare providers' experience with the checklist to improve it and assess its applicability. The research team consists of Charissa Rahmee, with Annemarie Middelburg as her external thesis advisor and Fernando Maldonado as her KIT thesis advisor.

We would like to kindly request the Research Ethical Committee for a waiver of ethical clearance for this study for the following reasons:

1. As mentioned above, the questions will solely concern the knowledge, insights and experiences based on the professional roles of the respondents. The data collection tool is

developed for experts in the field of health to share their experience and opinion on the research topic. The data collection tool does not include any personal questions and participants are free to skip questions if they consider them to be irrelevant.

2. The participants will be asked for informed consent before the data collection, to make sure voluntary and informed participation is taking place. The participant is requested to participate and can decide to decline or withdraw participation at any moment during the process without any effect on reputation, or other consequences that could affect their work or their professional status.

3. Participating in this study does not bear any physical, psychological and/or socio-economical risk or discomfort. Data collection will be done by conducting interviews, either face-to-face or by online video call. The researcher will travel to the participant or will make sure data collection from a distance is possible. There will be no need for socio-economical input from participants and the participants will not be put into a situation where they could potentially be at socio-economical risk. During the data collection there will be no inquiries regarding personal details of the participant but it will focus on the professional opinion regarding the right to health.

4. The data collection tool was developed by Charissa Rahmee based on The SAGE Handbook of Interview Research, with further input from Qualitative Methods for Health Research by Green & Thorogood and Qualitative Interview Questions: Guidance for Novice Researchers by Roberts.

5. All information will be derived, processed, stored, and published anonymously. Considering the Right to Health Monitoring and Implementation Checklist, and the possible consequences for the respondents if their input could be traced back to them, the research team will ensure their anonymity. This will be done by removing all personal and retraceable details from the data set, saving all data anonymously by coding them, and deleting all interviews and accompanying data after completion of the thesis.

6. Furthermore, the research is scientifically sound and justified, described in a clearly detailed research proposal, and conducted in accordance with the basic ethical principles of the Declaration of
Helsinki.

The data collection tool (interview guide) can be found in Annex 1 to this letter and the informed consent form can be found in Annex 2. Annex 3 contains the RHMIC developed by IFHHRO.

We hope to have informed you sufficiently on the objective and content of this study to decide on our request.

Yours sincerely,

Charissa Rahmee
MIH student at KIT

Right to Health Monitoring and Implementation Checklist IFHHRO

Codes

Name	Description	Sources	References
01 Respondent sociodemographics		20	371
Age		20	20
30-35		10	10
36-40		3	3
41-45		3	3
46-50		1	1
Above 50		1	1
Under 30		2	2
Countries worked in		20	52
Caraçao		1	1
Ethiopia		3	3
Greece		2	2
India		1	1
Iraq		1	1
Lebanon		1	1
Malawi		2	2

Name	Description	Sources	References
Mali		2	2
Myanmar		1	1
Nigeria		1	1
Sierra Leone		2	2
South Africa		5	5
South Sudan		1	1
Sudan		1	1
Syria		1	1
Tanzania		10	10
Thailand		1	1
The Netherlands		8	8
Aruba		2	2
Uganda		1	1
United Kingdom		1	1
Yemen		1	1
Country of origin		20	25
Germany		1	1
South Africa		4	4
Tanzania		8	8
The Netherlands		7	7
Current country of eployment		20	24
South Africa		4	4
Tanzania		9	9
The Netherlands		7	7

Name	Description	Sources	References
Current role in profession		20	48
Clinical		12	21
Anesthesiologist		1	1
Clinical dietician		1	2
General practitioner		1	2
MD in GHTM		3	5
Physiotherapist		1	1
Resident in emergency medicine		1	2
Resident in orthopedic surgery		1	2
Speech and language therapist		1	1
University lecturer		1	1
Non-clinical		11	27
Clinical manager		1	3
General practitioner		1	2
Global Health specialist		1	3
Head of advocacy at NGO		1	2
Manager		1	2
MD in GHTM		4	8
Regional coordinator (non-medical) at NGO		1	2
Researcher		1	2
Education		20	27
Master degree		17	19
Undergraduate		3	3

Name	Description	Sources	References
Honours degree		1	1
Gender		20	20
Female		9	9
Male		11	11
Main marginalized group	Specific marginalized populations worked with	20	92
Asylum seekers		2	4
Eldery		2	2
Ethnic minorities		4	5
Geographically marginalized people		1	1
Internally Displaced People		1	1
LGBTQIA+		6	6
Minors		2	2
Children with congenital clefts		1	1
Children with Fetal Alcohol Syndrome		1	1
Children with intellectual and developmental disabilities (IDD)		1	4
Palliative care patients		1	1
People experiencing homelessness		3	3
People living with HIV		4	5
People suffering from illiteracy		3	3
People with disabillities		3	4
Cerebral palsy		3	3

Name	Description	Sources	References
People with low socio-economic status		9	17
People with Substance Abuse Disorder		3	3
Recognized refugees		3	6
Religious minorities		1	1
Sex workers		1	1
Undocumented migrants		7	9
Women & survivors of GBV		9	10
Most relevant place of work	Focus on marginalized populations or key healthcare contexts	20	32
Curaçao		1	1
Ethiopia		2	3
Greece		1	1
Lebanon		1	1
Malawi		1	1
Myanmar		1	1
Sierra Leone		1	1
South Africa		4	4
Tanzania		8	9
Thailand		1	1
The Netherlands		3	3
Uganda		1	2
Profession		20	31
Acting director of clinical services		1	1
Clinical dietician		1	1

Name	Description	Sources	References
Head of advocacy at NGO		1	1
Manager	Head of Advocacy Team and part of management team	1	1
Medical doctor		15	17
Anesthesiologist		1	1
Clinical manager		1	1
General practitioner		2	2
General surgeon		1	1
Global Health specialist		1	2
MD in GHTM		6	7
Working as a researcher		1	1
Working at an NGO	Medical Coordinator	1	1
Working at Public Health Services (GGD)		1	1
Working in a hospital in LRS		2	2
Working in conflict settings		1	1
Radiologist		1	1
Resident in emergency medicine		1	1
Resident in orthopedic surgery		1	1
Physiotherapist		1	1
Regional coordinator (non-medical) at NGO		1	1
Researcher		2	2
Speech and language therapist		1	1
University lecturer		1	1

Name	Description	Sources	References
02 Knowledge of the Right to Health		20	297
Applying the right to health in current profession	(HEF: Accountability)	20	56
Yes		20	56
Advocating for patients		13	14
Creating a healthy working environment for staff		1	2
Discussing it at seminars		1	1
Discussing it with colleagues		9	10
Ensuring good quality care		1	1
Increasing access to care		8	8
Influencing policy		2	2
Providing care on a non-discriminatory basis		3	4
Providing clinical care		7	7
Components of the right to health	Respondents' personal affiliation to certain components	16	33
AAAQ	For responses that emphasize the availability of healthcare facilities, the accessibility of services, cultural acceptability, or quality standards.	12	18
Accessibility		7	7
Availability		3	3
Quality		3	3
Non-discrimination	For mentions of equity, fairness, or the importance of ensuring all groups have access to healthcare without bias.	7	8
Underlying determinants of health		4	5
Access to medicines	Availability and affordability of essential medicines, vaccines.	1	1

Name	Description	Sources	References
Food and nutrition	For discussions about the role of adequate food or nutrition in supporting the right to health.	2	2
Healthy occupational and environmental conditions		0	0
Safe water	For specific mentions of clean or potable water being a priority for health.	0	0
Shelter and housing	For statements focusing on the link between proper housing and health outcomes.	2	2
Embedded in formal education	HEF acceptability	20	33
No		4	4
Yes		16	25
Master Emergency Medicine		1	1
Master Global Health		1	1
Master Global Health Policy		1	1
Master International Health		2	2
Master Physiotherapy		1	1
Master Public Health		1	1
Master subject 'Ethics, Human Rights and Health'		1	1
Medical school		7	7
Residency General Practice		1	1
Residency in Global Health		6	7
Varsity Nutrition		1	1
Familiarity with the concept	(HEF - access, equity)	20	26
Familiar		18	20
In-depth knowledge		1	1
No in-depth knowledge		8	8

Name	Description	Sources	References
Not familiar		2	2
Informal knowledge sources	(HEF acceptability)	1	3
Yes		1	3
Discussions		1	1
Mentorship		1	1
Own role within right to health	(HEF accountability)	20	85
Advocating for patients		14	22
Improving access to care		9	9
Improving quality of care		2	2
Influencing policy		5	6
Patient education		7	7
Providing care without discrimination		2	2
Raising awareness		12	15
Regional level		3	3
Researching the underlying determinants of health		2	2
Stakeholder guidance		1	1
Team coordination		2	2
Treating patients		8	8
Reporting mechanism	HEF accountability	20	61
External reporting		10	19
Government		9	15
District level		7	7
Ministry of Health		4	5

Name	Description	Sources	References
Ombudsperson		1	1
Provincial level		1	1
National Professional Association		1	1
Village Executive Officer		1	1
Ward Executive Officer		1	1
Internal reporting		20	42
Director		5	6
Employee concerned		4	4
Head of department		5	6
Hospital board		4	4
Management		11	12
Peers		4	4
Quality assurance department		2	2
Supervisor		1	1
03 Potential of the checklist		20	184
Applicability at current employment	(HEF accessibility, acceptability)	20	67
No		3	5
Not applicable in LRS		2	4
Humanitarian settings		1	3
Non-clinical		1	1
Yes		20	62
Applicable in HRS		10	18
After revision		1	1

Name	Description	Sources	References
Clinical		2	2
Increasing access to care		2	2
Non-clinical		3	3
Raising awareness		2	2
Applicable in LRS		18	36
After revision		2	2
Clinical		7	8
Highlights gaps		2	2
Highlights inclusivity		2	2
Increasing access to care		1	1
Non-clinical		7	7
Promotes accountability		1	1
Raising awareness		3	3
Awareness raising	(HEF equity, quality) Potential to educate healthcare professionals on the right to health.	18	34
Empower professionals	(HEF acceptability, quality) Encourages advocacy and strengthens professional roles.	8	9
Empowers patients		1	1
Encourages policy reform	(HEF quality, affordability) Supports systemic changes in healthcare policies.	8	11
Evaluation tool	(HEF: Quality) Potential to evaluate existing services	7	9
Health systems perspective	(HEF: Accountability, Equity) Captures macro-level systemic barriers, including government accountability, urban-rural disparities, and international influences on healthcare access.	1	2
Improves service delivery	(HEF quality, access) Identifies service gaps and informs interventions.	12	22
Promotes equity and inclusivity	(HEF equity, access) Fosters inclusivity and equal access to healthcare services.	7	7
Signaling room for improvement		11	22

Name	Description	Sources	References
04 Challenges in implementation		20	178
Accountability issues	(HEF: Accountability) Fear of blame or punitive consequences.	18	48
Coordinator		1	1
Director		3	3
Government		8	9
Head of the department		4	4
Hospital board		5	5
Management		9	10
Checklist fatigue	(HEF: Acceptability, Quality) Perception or experience of exhaustion or reluctance by institutions and healthcare providers when faced with another checklist	20	37
Overload of administrative tools		2	2
Questioning relevance or value		7	9
Scarce time and resources		19	25
Adequate time investment		18	21
10 minutes		10	11
15 minutes		3	3
20 minutes		1	1
30 minutes		1	1
Too time consuming		1	1
Comprehensiveness	(HEF: Access, Quality, Acceptability) Respondents’ views on whether the checklist adequately addresses key dimensions of the right to health.	5	8
Overall comprehensiveness	Did the respondent find the checklist difficult, simple or for example non-specific.	5	8
Confidentiality concerns	(HEF: Acceptability) Risk of breaching: - Patient confidentiality. - Professional confidentiality.	7	8
Breach of patient confidentiality		1	1

Name	Description	Sources	References
Breach of professional confidentiality		7	7
Cross-cultural usability	(HEF: Acceptability) Issues in adapting the checklist to diverse healthcare systems or varying levels of resources.	4	6
Lack of knowledge on the subject of the Right to Health	(HEF: accessibility) A lack of prior knowledge on the subject can cause people to not understand the questions	4	5
Language restraints	(HEF: Acceptability, Equity) Need for translation or simplification for diverse user bases.	6	9
Mistrust and fear	(HEF: Acceptability, Accountability) o Lack of trust between healthcare providers and institutions when using the checklist. o Fear of punitive consequences or negative repercussions.	10	17
Fear of financial consequences		3	3
Job security		2	2
Resistance	(HEF: Acceptability) From institutions or individuals	9	13
From leadership		3	4
From staff		4	4
Resource constraints	(HEF: Access, Affordability) Limitations in financial, infrastructural, or staffing resources.	2	6
Safety & security	(HEF: Quality, Accountability)	16	20
Negative consequences	Unintended harm, such as increasing scrutiny or risks to vulnerable groups or professionals.	2	2
Positive consequences	Improving systems, reducing risks, and fostering safer practices for patients and professionals.	15	18
Sustainability	(HEF: Accountability, Quality) Concerns about the long-term implementation and repeated use of the checklist.	1	1
05 Recommendations for implementation		20	482

Name	Description	Sources	References
Anonimity in responses	(HEF: Acceptability) Maintaining confidentiality to ensure honest feedback.	17	40
Anonimity		17	21
Non-anonimity		1	1
Consequences		17	42
External reviewing		8	13
Positive		1	1
Punitive		8	11
Critical report		2	2
Legal action		1	1
Reprimand		3	3
Stopping provision of services		2	2
Internal reviewing		1	1
Positive		3	3
Positive and supportive		15	28
Dissemination form of checklist	(HEF accessibility)	19	26
Digital		18	21
Paper		4	5
Frequency of use	(HEF: Accountability) Recommendations on how often the checklist should be administered, e.g., annually, quarterly, etc.	20	32
After implementing a change		2	2
Annually		12	13
At the start of new employees		1	1
Once every 2-3 years		2	2
Quarterly		6	6

Name	Description	Sources	References
Three times per year		1	1
Twice per year		2	2
Group completion	(HEF: Acceptability, Accountability) Collaborative team sessions for enhanced discussion and understanding.	9	17
Guided completion	(HEF: accountability, accessibility) Fill in the checklist under the guidance of a facilitator / implementer.	2	2
Integration into organizational structures	(HEF: Quality, Accountability) Embedding the checklist in routine workflows or quality improvement programs.	13	32
Implementation team		2	2
National policy		1	1
People-centered care department		1	1
Quality control department		7	9
Social welfare department		1	1
Support from management		8	10
Language accessibility	(HEF: Equity, Acceptability) Translation into local languages to improve usability.	19	56
Too difficult		8	10
Too specific terms		9	11
Too vague		3	8
Translate the checklist to other languages		14	18
Participants		20	75
Interdisciplinary relevance	(HEF: Acceptability) Evaluating how different professional roles perceive the checklist.	14	23
Management		16	19
Medical professionals		16	29
Clinical officers		1	1

Name	Description	Sources	References
Doctors		6	6
Nurses		4	5
Paramedic staff	physio’s, nutritionists etc	4	4
Patients		3	3
Program employees		1	1
Preceding training	(HEF: Quality, Acceptability) Providing education on the right to health before using the checklist.	15	29
Refinement of checklist design	(HEF: Acceptability, Quality) o Clarification of questions and operational definitions. o Addition of missing topics or refinement of existing ones. o Elimination of redundancy. o Inclusion of examples for clarity.	15	77
Adding of missing topics		4	4
Elaborate on people unable to reach the facility		1	1
Patient experience		2	2
Adjust answer model of checklist	Adding a scale or leave room for additional input	14	32
Add a scale		7	11
Include room for elaboration		12	18
Clarification of questions and operational definitions		5	5
Clarification of the aim of the checklist		7	9
Elimination of redundancy		1	1
Inclusion of examples for clarity		1	1
Marginalized groups	Specify the groups better and add groups	6	15
Adjust marginalized groups to setting		4	4

Name	Description	Sources	References
Include more marginalized groups		2	3
Including too many groups into one question		2	3
Introduce background to marginalized groups		1	1
Refining existing topics		3	3
More context specificity		2	2
Rethink the checklist entirely		1	6
Stakeholder collaboration	(HEF: Equity, Accountability) Involving a broader range of stakeholders in the implementation process	9	23
Community healthcare workers		1	2
Community involvement	(HEF: Equity, Accountability) Capturing how patients or marginalized groups themselves might engage with or be impacted by the checklist.	4	5
Medical professionals		2	3
National association for general practitioners		1	1
Patients		4	6
Policymakers		5	5
Unions		1	1
Structured feedback loops	(HEF: Accountability, Acceptability) Processes to ensure findings from the checklist lead to actionable outcomes.	15	31