

E2 | THE RIGHT TO HEALTH: FROM CONCEPT TO ACTION

The People's Health Movement initiated a global Right to Health campaign in 2007. In this chapter we discuss how health activists can engage with this framework. Examples are presented from some regions, illustrating how this approach has been used (in some cases by social movements outside the PHM). Finally the emerging PHM global Right to Health and Health Care campaign has been briefly described as an attempt to promote this approach in a coordinated manner and on a global scale.

Using the right to health approach while developing it¹

The Right to Health (RTH) approach is a critical conceptual perspective, as well as a practical framework which can help to develop health movement actions. Combined with complementary approaches, it offers us concrete direction and strategies to wage struggles and campaigns (from local to global levels); it provides a framework to critique existing health-related policies; and it offers a vision to help shape alternative, people-centred health systems and social services. This approach needs to be wielded as part of a broader socio-political perspective for transformation, rather than being constrained by 'apolitical', consumer-oriented versions of human rights.² Here we will focus on the functional aspects of this framework, not dealing with valuable theoretical debates on critical use of the rights framework, which have been dealt with in detail by others.³

Why use a rights-based approach to health?

- The rights language has a *strong universal appeal*, and can enable large masses of people, beyond health professionals and activists, to relate to key health issues and to get involved.
- The approach helps to directly *empower individuals, communities and organisations*, enabling them to demand specific outcomes.
- The health rights approach *focuses on functional outcomes*, and measures all general policy declarations or system commitments in terms of *what people actually receive in terms of real entitlements*.
- When the idiom of health rights pervades the overall discourse, health services become understood as important public goods, which should be universally accessible without conditions.



46 Children demand Right to Health at a demonstration by Peoples Health Movement in South Africa (Louis Reynolds)

- Once certain rights are obtained through struggle by a few groups, it can become a precedent for other groups to demand similar rights.
- The approach *strengthens the claims of the most disadvantaged and vulnerable* sections of society, and helps to challenge discrimination while demanding certain entitlements.
- *Rights once granted cannot be easily reversed.*
- *The rights approach talks in terms of obligations and violations*, thus squarely placing the responsibility to deliver on the system.

Contextualising the right to health approach

The rights approach is not understood as a static framework – rather, with evolution of the movement and changes in context, the way it is used may also be reshaped. Today, in many situations the fight for health rights (in the domain of health care) is primarily a form of *resistance and accountability* in a context of stagnation, weakening or privatisation of public health services. Moving forward from resistance, the rights framework could also form the basis for *policy critique*, exposing specific health policies and programmes designed within the neoliberal framework. Further, we may want to use the rights approach as the basis for *counter-hegemony*,⁴ challenging the entire dominant conception of the ‘market-oriented approach’ to health and its determinants. Finally, the rights approach gives us a *vision* of a society that promotes health in the broadest sense.



47 Public hearing on right to health in Maharashtra, India (Abhay Shukla)

There are different interpretations and versions of human rights, ranging from liberal and essentially status-quo-oriented approaches to more radical perspectives which definitely locate the establishment of rights in the context of social movements.⁵ It is necessary for health activists to think in terms of the need to socially and politically contextualise the rights approach while engaging in health movement work.⁶ The rights approach, while useful in its own sphere, must be complemented and supported by analysis of the wide range of conditions and structures which shape the fulfilment or denial of rights. Such a contextualised approach to health rights may have some of the following features:

- It would be based on a vision of collective (along with individual) health rights, emphasising the rights of communities (such as people living in a village or an urban settlement) and hence *should strongly promote community mobilisation*.
- It would be informed by a critical understanding of the health sector crisis, including the underlying political economy of the impact of neoliberal policies, weakening of public health systems, privatisation and their impact on health services.
- It would not hesitate to *identify and challenge the social and political barriers that block the fulfilment of health rights*.

- It would combine demands for the *Right to Health Care* and the *Right to Health determinants* as part of a holistic approach.
- It would *facilitate alliances of the health movement* with other social movements.

To conclude, health activists might fruitfully utilise the Right to Health approach as an important strategy of the health movement, provided that this approach is appropriately contextualised, is clearly linked to social mobilisation, and is complemented by deeper analysis of national and global structures and policies. We must begin the struggle for rights here and now, in the deeply iniquitous and unjust world of today; but we should wield rights in a manner that will move us towards a different world, a much more just and equitable world of tomorrow.

Wielding the ‘right to health’ approach: some experiences of PHM-India

The Indian Right to Health Care (RTHC) campaign was initiated in 2003/04 (we discussed the campaign in *Global Health Watch 2*). The RTHC campaign was an important initial phase of mobilisation, when stagnation and decline in the public health system in India had reached a crisis point, and it was necessary to highlight large-scale denial of services. This campaign included documentation of large number of cases of denial of health care, organisation of a national public consultation with presentation of testimonies of denial of health care to the chairperson of the National Human Rights Commission, participatory surveys of rural public health facilities, local ‘*Jan Sunwais*’ (public hearings) in some states, regional public hearings in all regions of the country followed by a national public hearing on health rights, the last two organised in collaboration with the National Human Rights Commission. While this campaign was focused on demanding provision of quality public health services as a right, the PHM-India network has simultaneously been actively involved in the nationwide ‘Right to food campaign’ since its inception in 2002, considering food security and nutrition to be key determinants of health.

Community-based monitoring of health services in Maharashtra

Prior to the national elections in 2004, PHM-India organised a national dialogue with various political parties, and published a policy brief, ‘Make health care a fundamental right!’ Subsequently, a ‘National Rural Health Mission’ (NRHM) was launched by the new government in 2005, which has proposed increased public health financing as well as strengthening of rural public health facilities. In this situation, PHM-India’s health rights activities entered a new phase, attempting to shape NRHM in a pro-people manner while trying to assess to what extent the proposed improvements were actually being implemented, by way of conducting a ‘People’s Rural Health Watch’ in seven northern states during 2006–08.

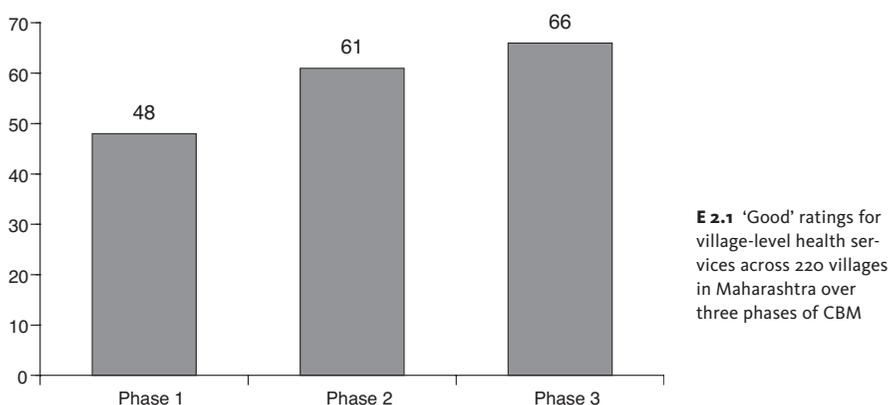


48 Community based monitoring of health services, India (Abhay Shukla)

In parallel with this, advocacy was carried out by certain PHM-India-associated activists to provide an institutional form for the health rights campaign. Carrying this forward, and based on coordination by the NRHM Advisory Group for Community Action, from 2007 onwards an innovative process of ‘community-based monitoring of health services’ (CBM) was developed; in the pilot phase during mid 2007 to early 2009 this was implemented in 35 districts of nine states. PHM-India member organisations have anchored this activity in certain states. Although this is a broad, publicly organised and funded activity, groups and individuals associated with PHM-India continue to play a key facilitating role in this process in certain states.

It is led by networked civil society organisations from block to state levels, with the following key features:

- *Community awareness and activation around health entitlements* have been generated by village meetings, display of health rights posters, expansion and strengthening of village health committees (VHCs), and training of VHC members.
- *Multi-stakeholder community monitoring committees* have been formed at primary health centre, block and district levels, including community members, NGO/CBO representatives, elected political representatives and public health staff.

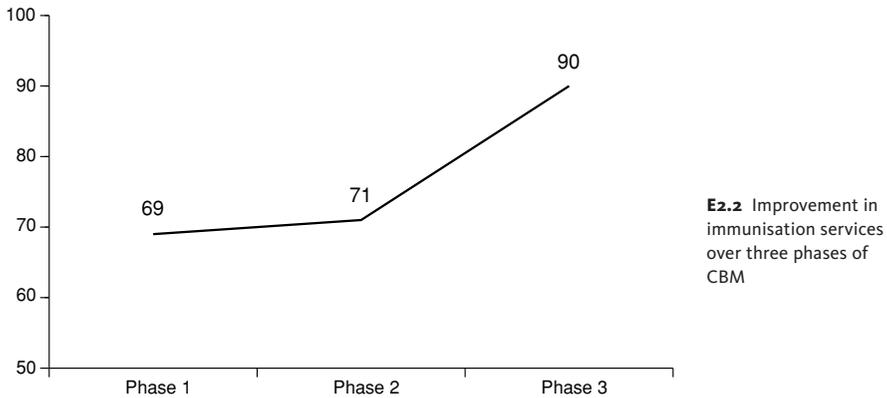


- *VHC and other committee members periodically collect information about health service delivery* using objective semi-quantitative tools, and rate these through publicly displayed *report cards*, each service being rated as 'good', 'partly satisfactory' or 'bad'. This data is collected at both village level (concerning outreach services) and health facility level.
- *Public hearings with mass participation are organised* at primary health centre, block and district levels, where report cards and cases of denial of health care are presented, and public health officials need to respond regarding remedial actions.
- *Periodic state-level events* enable dialogue between civil society monitoring committee members and the state health department, seeking resolution of critical, unresolved and systemic issues, and help reinforce government support for the CBM process.

As an example of this process, one may consider the western state of Maharashtra, where CBM is being implemented in over 500 villages spread over 23 blocks in five districts of the state.⁷ A network of 15 civil society groups including mass organisations, mostly associated with PHM-Maharashtra, have developed this activity to enable people to claim their rights related to rural public health services.

Three rounds of community-based collection of information were organised between mid 2008 and end 2009. Over these one and half years, the *overall proportion of village level health services rated 'good' by communities increased from 48 to 66 per cent while the number of services rated as 'bad' has declined from 25 to 14 per cent*. Community-based data showed that overall PHC services rated as 'good' improved from 42 per cent in the first round to 74 per cent in the third round.

This has been accompanied by significant increase in utilisation of PHC services, as people have started shifting from dominant private providers to improved public facilities. In Thane district of Maharashtra, during the period 2007/08–2009/10, outpatient, inpatient and delivery-related utilisation



of primary health centres in CBM areas increased by 34, 73 and 101 per cent respectively; this was *one and half times to twice as high* as average utilisation increases for PHCs in the district as a whole. Corresponding to this, a wide range of qualitative improvements have also been documented: in most CBM areas, attendance by field staff and doctors has increased, illegal charging by providers has been checked, functionality of PHCs and sub-centres has gone up, and provider behaviour has improved.

Initiatives in Other States in India

Similar processes of community-based accountability have been developed in other states where CBM has been implemented with a strong rights-based perspective. In Tamil Nadu, CBM processes have been facilitated in 446 panchayats (village councils) in six districts.

In Rajasthan, CBM was implemented during 2007–10 in 445 villages in five districts of the state, where major improvements in rating of village-level services were documented during the period of community-based monitoring.

In the southern state of Karnataka, the PHM has intensified its earlier work, which focused on denial of health rights. In 2009, after two years of continuous work at the district level, bringing to light the denial of health care, PHM members organised a public hearing at the state level, to bring to the notice of the state health officials the large-scale denial of health services (attended by over 1,500 participants from 17 districts). This was followed by public hearings in eight districts during 2009/10, where studies and recordings of testimonies were discussed at public forums, involving health authorities and civil society representatives. In May 2010, during the panchayat elections, a health manifesto was presented to over 50,000 households in 12 districts, urging people to take up issues of primary health care and health rights with the local candidates. In parallel, sets of questions on health rights were given to 6,000 panchayat candidates, asking for their commitment to act on these if they were elected.

Box E2.1 Campaign on patients' rights

The private medical sector is the major provider of inpatient and outpatient care in India; however, this dominating sector is almost totally unregulated and functions in an often irrational and exploitative manner, its services being unaffordable for the majority of people. PHM-Maharashtra has been active in forming patients' rights forums in various cities and towns. These are citizens' bodies with participation of people from broad sections of society. In several cities, 'Patients' Rights Conventions' have been organised, with demands being made for immediate implementation of legally enforceable patients' rights. PHM-Maharashtra conducted a state-level consultation on patients' rights in February 2010, where activists from different parts of Maharashtra presented cases of patients' rights violation before a member of the National Human Rights Commission, and raised the issue of provision of free health care for poor patients in trust hospitals. The event was followed up by a press conference and media coverage.

A related front has been *engaging private doctors in dialogue on patients' rights*. The Patients' Rights Forum-Pune and PHM-Maharashtra have conducted several rounds of discussion with the Indian Medical Association and have drafted a 'Joint Charter of Patients' Rights and Responsibilities', which has been circulated and publicised. This is a strategy to reduce doctors' opposition, increase civil society mobilisation on the issue of patients' rights, while creating awareness among the public regarding the need for regulation of the private medical sector.

Protecting undocumented migrants' right to health in Italy

At the end of 2008, during the discussion of a bill on 'security' among a group of bills called 'Security Package' (Act 733) in the Italian Senate, six senators of the Lega Nord party (a member of the ruling right-wing coalition) presented two amendments that severely threatened the guarantee of access to health services for undocumented migrants. The two amendments proposed to change Article 35 of the law on immigration (n. 286 of 1998). The article established that access to health facilities (both hospital- and territory-based) by foreigners in non-compliance with residence rules does not lead to any kind of alert or registration except in those cases where a report is mandatory by law, putting foreigners on an equal footing with Italian citizens. This regulation had existed since 1995.

Being reported to the police while seeking treatment can create an insurmountable barrier to access, encouraging 'clandestine health behaviour', which



49 Signature campaign on patient's rights in India (Abhay Shukla)

may be extremely dangerous for the individual as well as for the community (diseases do not make any ethnic, legal or racial distinctions). The denial of the right to health and health care to a part of the population opens the doors to further discriminations for other groups. Moreover, it results in the establishment of a parallel, 'illegal' health care system, and deeply undermines the state's capacity to promote individual and community health and security.

Despite fierce opposition led by the Italian Society of Migration Medicine (SIMM), one of the amendments was approved by the Senate in February 2009. Backed by the position of the National Federation of Medical Boards, by several statements from scientific societies and by the legal support of prominent jurists, SIMM mounted a struggle to influence the Italian parliament's decision. In many Italian regions a day of protest was organised, asking for the amendment to be withdrawn. Civil society associations, non-governmental organisations, university scholars, migrants' groups, church groups, activists and citizens joined the actions, often led by young doctors and medical students and with the support of local medical boards.

Soon after, several Local Health Authorities and Regional Health Departments instituted formal moves against the amendment. As the protests grew, 101 members of parliament, belonging to the ruling coalition that had voted for the Act, issued a letter in support of its withdrawal. On 27 April 2009, the amendment was removed from the law.

Ingredients of a success story The struggle has been one of the most successful and effective campaigns on health-related issues in Italy in the past several years. It was poorly funded, organised by non-professionals, yet extremely timely and focused and had a major impact.

The key reasons for success included:

- *The ‘untouchable’ right to health:* In Italy, having a universal health system that guarantees health care and prevention for the whole population is a reality that the majority of people value. It is probably one of the few rights that people still perceive as ‘untouchable’.
- *Doctors in the front line:* In Italy, as in many countries in the world, doctors are a highly powerful and influential group. Their position on the issue, backed by a formal statement by the National Federation of Medical Boards, was crucial in its impact.
- *Cooperation and networking:* Unlike a majority of scientific societies, SIMM is not funded by pharmaceutical companies. Two distinctive features make SIMM different from other scientific societies: willingness to share and cooperate, and proactive networking. Both of these proved to be extremely effective during the campaign against the amendment.

The migrants’ right to health in Italy: to be continued ... We cannot, however, forget the broader context in which the struggle took place. The ‘Security Package’ became law in July 2009. Among many discriminatory rules against migrants, one provision stated that entering or staying in Italy without a legal permit is a criminal act, punishable with detention (earlier, it was an administrative offence). It obliges any functionary (including doctors) to report violations to the police. Therefore, even if the amendment (which forced health personnel to report undocumented migrants who sought medical attention) had been withdrawn, this provision still threatened the right to health of undocumented migrants. Fortunately, the enthusiasm and support for the campaign did not fade and a clarifying note from the Home Office, in December 2009, stated that the obligation to report did not apply to personnel working in health facilities.

The war against discrimination, however, has not been won. Undocumented migrants are one of the most disadvantaged social groups in Italy. They are prey to different inequalities affecting the social determinants of health: employment, work, housing, education, social networks, welfare, etc. This is why doctors and health professionals in Italy need to build on the example of SIMM, advocating for all human rights – social, economic and cultural ones. If this is not taken forward – hiding behind the assumed neutrality of science – the battle for the right to access to health care for undocumented migrants will not have helped much.⁸

The global right to health and health care campaign

The People's Health Movement states in its founding document, the People's Charter for Health, that 'Health is a social, economic and political issue and above all a fundamental human right'. This understanding of the Right to Health includes rights to the full range of the social determinants of health (clean water, food security and nutrition, education, housing, a clean and safe environment, among others), as well as more specifically the Right to Health Care.

While few would disagree that the Right to Health is a justifiable goal, the actual attainment of the entire spectrum of health rights in today's world would obviously require a large-scale, sustained struggle and social mobilisation. Keeping this context in mind, over the past five years PHM has been carrying out a global Right to Health and Health Care campaign, supporting a number of coordinated activities directed at strengthening these rights; in this PHM tries to collaborate with the existing human rights campaigns of various partner coalitions.

PHM's global Right to Health and Health Care campaign is a step in the direction of proposing remedial actions to the health system crisis. The campaign seeks transformations in a large number of countries, adding an element of global solidarity, indispensable to resolving the whole range of inequities found in health systems the world over. The campaign has a focus on strengthening the Right to Health Care; it further documents violations of the right to the underlying determinants of health (for example, showing how denial of food security leads to worsening malnutrition, increased morbidity and mortality) and seeks to strengthen efforts and campaigns that enable people to attain these important health-related rights. Furthermore, PHM pursues reversing the tide promoting 'health care as a commodity'. Through the campaign, PHM addresses the absolute need to establish a global consensus on 'health as a right' and 'health care as a right'. PHM's understanding of human rights violations is thus based on the broader analyses of power and social inequalities and their social, economic and political determinants.

The campaign has been carrying out diagnostic assessments reporting on actual RTH violations. For this, many PHM country circles have been using the PHM RTHC Assessment Guide⁹ to produce reports with some consistency and comparability. The country reports produced so far address health care systems and also look at other health determinants of concern. Going through the assessment process has led PHM national circles to better understand the human-rights-based framework – which will now be applied to demand concrete changes. The process has included the participation of several grassroots organisations in the respective countries and has aimed at PHM movement-building, providing an opportunity for in-country coalition-building and, to the greatest extent possible, fostering rights holders' ownership of the campaign process.



50 Right to Health campaign in South Africa (Louis Reynold)

In the last four years, the campaign has advanced significantly with RTH activities under way in the Democratic Republic of Congo, Congo, Benin, Burkina Faso, Mali, Togo, Gabon, Cameroon, Senegal, South Africa, Zimbabwe, Kenya, Morocco, Uruguay, Guatemala, Bolivia, the UK and India. Eleven of these countries have already finalised assessments reports on the Right to Health. New PHM circles have been formed in several countries that have joined the campaign. A case study of the campaign in Guatemala is briefly mentioned as an example.

Various Right to Health assessment reports¹⁰ are now being used by PHM country circles to design and carry out action plans to address the major violations that have been documented. This has been done in a participatory manner with input from grassroots organisations. The rationale behind this mobilisation of rights holders is that when the state does not respect human rights, these groups have to demand their rights from the duty bearers in government, particularly by interacting with all potential agents of accountability (e.g. human rights commissions, ombudspersons, etc.) who oversee the procedures put in place by government to make duty bearers fulfil their obligations (including remedies and restitutions). Through such activities, PHM groups seek to overcome the culture of silence and apathy surrounding human rights violations in health.

At the end of 2009, PHM set up a commission to assess the progress of the campaign and to help plan the campaign in its next phase. This commission has conducted an internal evaluation and has identified key health sector issues that are campaign priorities for various country groups.¹¹ The commission is also recommending that national campaigns link their activities and focus them

Box E2.2 TH campaign in Guatemala

The Movimiento Ciudadano por la Salud (Citizens' movement for health) used the support from PHM to implement the process *Monitoring and evaluating health, equity and human rights: a citizens' perspective*. This used an action-research design in which community-based organizations from 12 rural indigenous municipalities were trained to collect and analyse data on barriers to access to health care and other issues related to social exclusion and discrimination. Concomitantly, data was collected and analysed assessing the performance of the health system, including its financing, equity aspects, health outcomes and policy development and implementation.

The assessment of the Right to Health in rural areas resulted in an action plan for advocacy. The grassroots organisations gave inputs into the design of the assessment tools; they were trained to apply the respective human rights and Right to Health tools and to carry out the analysis of the data, together with the core team of the five organisations of the Movimiento Ciudadano. The assessment of public facilities in rural areas included interviewing health care workers.

The relationship of the Movimiento Ciudadano with the Ministry of Health has had highs and lows. This reflects, in part, the constant changes in public authorities. Some of them respect this work and maintain a good relationship with the Movimiento, whereas other authorities see the work as a problem since it frequently points out the weaknesses of public health policies.

Based on the assessment, a public event was organised, which received wide media coverage. The assessment of the situation used indicators recommended by the UN, but also the perspectives of the population, and this is where the manual adapted from PHM was helpful. At the end of the study, the Movimiento had reliable, proven tools for monitoring the Right to Health, and community groups and civil society became involved in the issues, making a significant political impact.

The RTH assessment is now being replicated in new municipalities.

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primarily on four overarching themes, which could now become a unifying thread for PHM Right to Health activities around the world.

PHM has no illusions that systematically raising the issue of the Right to Health will by itself lead to actual achievement of this right in countries across the globe. However, PHM expects to work on certain achievable objectives that can take us towards the progressive realisation of the Right to Health.

Box E2.3 Fighting for the human right to health care in the United States

A pioneering grassroots campaign for the human Right to Health Care has made Vermont the first US state mandated by law to establish a health care system based on human rights principles. For the past two years the Vermont Workers' Center, a community-based workers' rights organization, has led a statewide campaign for universal and equitable health care. The Healthcare Is a Human Right Campaign was initiated in 2008, and in May 2010 the campaign's signature human rights principles – universality, equity, accountability, transparency, and participation – were enshrined in a new law that commits the state of Vermont to design and implement a health care system based on these norms.

The campaign kicked off with volunteers going into communities and talking with hundreds of Vermonters about health care. People from different regions and diverse backgrounds shared their experiences of suffering from a lack of access to care, often caused by financial barriers. The campaign then held a series of human rights hearings across the state, putting the health care system on trial. Many people came forward to testify how the market-based system had failed to meet their health care needs. By documenting these human rights denials in a video and a report – *Voices of the Vermont Healthcare Crisis* – the Workers' Center was able to reach out to even more people and set up organising committees in all regions.

Grounded in community-based mobilisation, the campaign's mass organising efforts – collecting surveys, postcards and petition signatures, and holding an annual May Day rally – have directly engaged over 7,000 Vermonters (more than 1 per cent of the state's population), and indirectly reached a far wider segment of the population through grassroots-driven, volunteer-led media strategies. The Workers' Center also used the human rights framework to forge solidarity among different groups and struggles, including through collaborations with progressive labour unions (especially nurses' unions), faith community groups, and disability rights organisations.

As the campaign developed the critical mass capable of changing

Some of these 'achievable' to be considered are, among others: (a) the explicit recognition of the Right to Health and Health Care at country level in several countries; (b) the formation, in several countries, of health rights monitoring bodies (accountability agents) with PHM and civil society participation; (c) a clearer delineation of health rights at both global and country levels; and (d)

what was considered ‘politically possible’, it started pushing state legislators to act. Representatives were invited to attend public accountability sessions across the state and asked to use human rights principles as guidance for health care reform in Vermont. During the 2010 legislative session, a People’s Team had a daily lobbying presence on the floor of the Statehouse, blogging about their progress and sending advocacy alerts to activists in legislators’ constituencies.

Throughout its efforts, the campaign kept the focus on a principled approach to reform. This was particularly remarkable when compared to the federal health reform debate taking place at the same time. While the national discussion remained stuck in a market-based approach, the Healthcare is a Human Right Campaign emphasised that health care must be provided as a public good shared by all. Vermont’s new health care law, which was ultimately passed with an overwhelming majority, recognises this.

The process of designing a new system is under way, with a single payer model in the mix. According to the law, implementation should begin no later than July 2012. The Vermont Workers’ Center is keeping up the pressure to ensure that the promise of universal, equitable health care becomes a reality in Vermont. They hope that their model of rights-based grassroots mobilisation offers inspiration for activists elsewhere who seek to turn health care from a market commodity into a public good.

We really need to stop thinking of health care as a for-profit venture and start treating it as a right and a public good. (Peg Franzen, President, Vermont Workers’ Center)

Video: www.workerscenter.org/node/449 A 10-minute video about the campaign, starting with stories from the health care crisis, explaining the campaign principles, and ending with examples of actions.

Report: www.workerscenter.org/healthcare-report *Voices of the Vermont Healthcare Crisis* is the outcome of extensive human rights documentation involving over 1,000 Vermonters.

Photos: www.flickr.com/photos/nesri/sets/72157617738857712/

Campaign website: www.healthcareisahumanright.org

regional and global solidarity on common health rights concerns, manifested in coordinated campaign demands and actions.

The bottom line of the RTH approach is that rights are never given, they have to be fought for! And this is the vision with which PHM’s global RTHC campaign is contributing and moving forward.

Notes

1 Several ideas in this section are adapted from 'The rights approach to health and health care – a compiled review' by Abhay Shukla, published by MASUM for Beyond the Circle, 2008.

2 Bijoy, C. R. (2007) 'Rights panel'. *Seedling*, October 2007.

3 See for example: Campbell, T. (1983). *The Left and Rights*. Routledge & Kegan Paul, 1983; Fields, A. B. and W.-D. Narr (1992). 'Human rights as a holistic concept'. *Human Rights Quarterly*, 14(1); Evans, T. (2009). *The Politics of Human Rights: A Global Perspective*. Pluto Press; Stammers, N. (2009). *Human Rights and Social Movements*, Pluto Press.

4 Hunt, A. (1990). 'Rights and social movements: counter hegemonic strategies'. *Journal of Law and Society*, 17(3), Autumn.

5 Stammers, N. (1999). 'Social movements

and the social construction of human rights'. *Human Rights Quarterly*, 21(4).

6 For a range of articles adopting an analytical approach to the Right to Health, see 'Health and human rights readers' by Claudio Schuftan at www.humaninfo.org/aviva/ch72a.htm#Health_and_Human_Rights_Readers.

7 For further information and a detailed report, see www.sathicehat.org/CurrentProjects/CommunityBasedMonitoringOfHealthServicesUnderNRHM.

8 More information from: Centre for International and Intercultural health – CSI (www.csiunibo.org).

9 www.phmovement.org/en/campaigns/145/page.

10 www.phmovement.org/en/rthhcc/reports.

11 www.phmovement.org/en/node/4126.