The EquiFrame Manual

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and
The EquitAble Consortium

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SEVENTH FRAMEWORK PROGRAMME

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SEVENTH FRAMEWORK PROGRAMME

The EquiFrame Manual: A tool for Evaluating and Promoting the Inclusion of Vulnerable Groups and Core Concepts of Human Rights in Health Policy Documents

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Contents

Overview 4
1. Background 5
1.1 Health for All and Equity 7
1.2. Health for All and Accessibility 8
1.3. "Process of Health Policy Development" Versus "On the Books Policy Content" 9
2. Profile of Equity in Health Policy Analysis 9
3. Development of *EquiFrame* 10
3.1. Synthesis of Core Concepts 13
3.2. Vulnerable Groups 17
3.3. Criteria for rating issues in policies 19
3.4. Scoring 19
3.5. Summary Indices 20
Discussion 24
References 27
Annexes 37
Annex I: Nondiscrimination 39
Annex II: Individualized Services 41
Annex III: Entitlement 42
Annex IV: Capability based Services 43
Annex V: Participation 44
Annex VI: Coordination of Services 48
Annex VII: Protection from Harm 50
Annex VIII: Liberty 51
Annex IV: Autonomy 52
Annex X: Privacy 53
Annex XI: Integration 54
Annex XII: Contribution 55
Annex XIII: Family Resource 56
Annex XIV: Family Support 57
Annex XV: Cultural Responsiveness 58
Annex XVI: Accountability 60

Annex XVII: Prevention 62
Annex XVIII: Capacity Building 63
Annex XIX: Access 65
Annex XX: Quality 68
Annex XXI: Efficiency 70
Annex XXII: Limited Resources 71
Annex XXIII: Increased Risk of Relative Morbidity 73
Annex XXIV: Mother Child Mortality 74
Annex XXV: Women Headed Household 76
Annex XXVI: Children with Special Needs 78
Annex XXVII: Aged 79
Annex XXVIII: Youth 80
Annex XXIX: Ethnic Minorities 81
Annex XXX: Displaced Populations 82
Annex XXXI: Living Away from Services 83
Annex XXXII: Suffering from Chronic Illness 84
Annex XXXIII: Disabled 85

Overview

The purpose of this manual is to outline an analytical framework for assessing the degree to which social inclusion and human rights feature in policy and policy-related documents. The framework was developed with regard to health policy documents with the motivation to contribute to enhancing equity in healthcare. In its current form it is directed towards health policy-oriented researchers and policy-makers. It is hoped that this framework can be used to support the systematic review of the content of health policies, as well as being a means of facilitating greater social inclusion and human rights in the revision of existing policies and the development of new policies.

EquiFrame identifies the degree of commitment of a given policy to specified *Vulnerable Groups* and to *Core Concepts of Human Rights*. We see social inclusion and human rights as key components of equity in the context of service provision. We hope that health policies, that inculcate the values and importance of equity, are more likely to result in health services that are more justly distributed across the population. This means, in accordance with the World Health Organization (2008), that priority is given to vulnerable groups as healthcare founded on equity contributes to the empowerment and social inclusion of such groups.

While we do not claim that this manual sets out a definitive approach to the complex concepts and issues it addresses, it is hoped that it does provide a useful step towards health policies more effectively addressing equity, social inclusion and human rights. We also recognise that policy development and policy implementation are critical determinants of the effectiveness of policy content: *EquiFrame* has been developed very deliberately to focus on the assessment of "policy on the books". It is not an alternative but, hopefully, it is complementary to, the related and complex processes involved in assessing the development, implementation and evaluation of policy.

We would welcome, very much, ideas for the improvement and the development of *EquiFrame*, and offer this tool, free-to-download, without copyright restriction. We will also provide annual revisions and updates, available on the same bases, which may be downloaded from EquitAble partner websites (including http://global-health.tcd.ie)

1. Background

The Power of ideas can transform the ideas of Power

Frenk, 1995

It is, often, supposed that we have good policies, if only we could implement them. It is the implementation, rather than the content, that much contemporary policy analysis addresses. Yet, if the policies are not so good – if they are better for some than for others – their implementation may, unwittingly, exacerbate inequity and stimulate social exclusion. Polices should be written for all, but they should also be sensitive to different types and different contexts of need: as Thomas Jefferson suggested: "There is nothing more unequal, than the equal treatment of unequal people". To promote Health for All, we need to focus on *equitable healthcare* – that is, healthcare appropriate to peoples' health needs, their personal situation and their broader socioeconomic context – rather than *equal healthcare* – where everybody gets the same (MacLachlan et al., 2011). This assumption is resonant with the principle of vertical equity, which upholds unequal treatment for unequal need, that is, the allocation of more healthcare resources to those who have the greatest needs (Block, 2006).

Discrimination is linked to the marginalization of specific population groups and, traditionally, discriminated groups bear a disproportionate share of health problems. Non-discrimination implies that States must recognize and provide for the specific needs of groups that confront particular challenges; through *disaggregation* of their health policies (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). Thus, to ensure equal opportunities for accessing health, health policies need to make special efforts to address those who are less well positioned - physically, socially, culturally or economically - in and by society. In the context of low income countries, where resources are scarce, marginalised or vulnerable people may experience greater social exclusion, with the result that their right to health is undermined to an even greater extent than in wealthier countries. London (2007, p.1) argues that "developing countries are faced with declining expenditures on health and social services, increasing burdens posed by both communicable and non-communicable diseases, and economic systems that are *not* orientated to fostering sustainable development for the poorest and most marginalized". If this is the case, then,

it undermines the United Nations' call for *Health for All,* with its implicit assumption of universal and equitable access to healthcare.

Progress towards the health-related Millennium Development Goals (MDGs) has, arguably, been achieved through being able to help those with easier access to healthcare. Subsequent gains will be dependent on addressing the challenges faced by a range of vulnerable groups, who have less access to healthcare. Vulnerable groups are "social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality" (Flaskerud & Winslow, 1998, p.69), and this may include children, the aged, ethnic minorities, displaced people, people suffering from some illnesses, persons with disabilities and others. Importantly, Eichler and Burke (2006) have recognized that the social discrimination and bias that arises, based on such categories, is the result of social hierarchies: similar exclusionary practices disadvantage and disempower different groups, undermining their human rights and their rights to health, other social services and to social inclusion – to being full participants in society. Burke and Pupulin (2009, p.7) argue that there is an urgent need for "building equitable, more inclusive societies based on respect, equality, human rights and the full participation and benefit of all people". While the number of persons with disabilities is increasing globally, adequate disability policies, in conjunction with their implementation and enforcement, remain globally largely undefined (Wiman, Helander, & Westland, 2002).

It is, therefore, important to establish whether health policies include, not only commitments to core concepts of human rights 'for all', but, also, whether these are promoted for vulnerable groups in a way which takes account of their 'vulnerabilities'. In other words, it is important to know if human rights are promoted in health policies and, if so, whether they are promoted in a socially inclusive way. This manual, therefore, seeks to accommodate the need for social inclusion in healthcare through the promotion of greater equity in health policies. Before describing the development and application of a framework for doing this – *EquiFrame* – we briefly contextualize the framework within the context of recent developments within health policy analysis, with a particular emphasis on low-income countries. We, then, set out our justification for the core concepts of human rights and the vulnerable groups adopted in *EquiFrame,* as well as the process of their derivation. We give examples of the application of *EquiFrame* to existing policies. We conclude

with recommendations and limitations for use of the *EquiFrame* methodology, while emphasizing its flexible and adaptive nature to a broad range of policy and policy-related questions.

1.1 Health for All and Equity

The Alma-Ata Declaration declares that attaining health for all, as part of overall development, begins with primary health care founded on "acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford" (Alma-Ata, 1978, p. 1). That Declaration, of three decades ago, aspired for all countries to use the 'Health for All' concept when formulating policies and action plans, for the purpose of achieving the global aim of 'health for all by the year 2000'.

A core value of Health for All is equity and a concern for equity has direct implications for how decision-makers choose their priorities in health policy, in particular how decision-makers select which public health issues and population groups merit the most attention. Braveman and Gruskin (2003a, p. 254) define equity in health as "the absence of systematic disparities in health (or in the major social determinants of health) between groups with difference levels of underlying social advantage/disadvantage". According to Whitehead (1992, p. 433), equity in health "implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided". As affirmed by EQUINET (2009), equity is a propitious political message, indicating social solidarity, and fortifying a pro-poor political agenda.

Braveman and Gruskin (2003a, p.254) state that equity "is an ethical principle; it also is consonant with and closely related to human rights principles". Both human rights principles and equity impose striving for equal opportunities in health for population groups who have historically suffered discrimination or social marginalization (Backman et al., 2008; Braveman & Gruskin, 2003b). Realization of equity through advancing the condition of the poor and underprivileged in all aspects of life including health is one of the central objectives of the contemporary development paradigm (Bhuiya, Hanifi, Urni, & Mahmood, 2009). Consequently, one of the parameters used to

assess the efficacy of health sector reforms in achieving affirmed objectives has been their effect on equity (Zere et al., 2007). As contended by Tamburlini (2004), current trends in the global economy, in the environment and in the scientific and technological development, may all contribute to increasing disparities in vulnerability to risk factors for ill health and access to health services, so that equity in health may be realised only through an explicit commitment, with specific objectives, as well as a clear consciousness of the influential driving forces that are presently operating in the opposite direction. As asserted by Bloom (2001), the challenge for governments is to focus on *policy-relevant inequalities* and to certify that their own actions are *pro-equity*.

1.2. Health for All and Accessibility

We propose that accessibility to health services can be understood in terms of the General Comment of the United Nations Committee on Economic, Social and Cultural Rights (United Nations Economic and Social Council, 2000); and that this Comment should become a central tool to better understand the facilitators and barriers to health care. The General Comment calls for the core concept of *Accessibility,* which refers to the need for health facilities, goods and services to be accessible to everyone without discrimination, and within the jurisdiction of the State. This first element of accessibility has been further broken down into the related dimensions of Non-discrimination; Physical Accessibility; Economic Accessibility (affordability) and Information Accessibility. As emphasized by Whitehead (2000), inequities in access may transpire when resources and facilities are unevenly distributed around a country, generating resource insufficiency in deprived and rural regions. As deprived communities are liable to suffer the worst health, such unequal distribution means that health services are least available where they are most needed – the purported *Inverse Care Law*, signifying that the availability of efficient health care tends to inversely vary according to the need of the population served (Tudor Hart, 1971). This perverse contradiction should be addressed at the level of health policies by ensuring that they stipulate some commitment, and measure of the extent, to which those with least accessibility are provided with appropriate health services.

1.3. "Process of Health Policy Development" Versus "On the Books Policy Content"

Many health policy practices have been developed and researched in higher income countries (HIC) and, subsequently, transferred to low and middle income countries (LMIC). However, the variability of context makes generalisation problematic (Exworthy, 2008; Walt et al., 2008). In HICs, this process is well received and recognised within academic circles, but in LMICs, it remains under-utilised (Buse, Dickinson, Gilson, & Murray, 2007; Gilson & Raphaely, 2008; Gilson, Buse, Murray & Dickinson, 2008). Gilson and Raphaely (2008) note that less attention has been afforded to how to perform a policy analysis and little guidance exists with regard to research designs and theories. In their review of published literature from 1994 to 2007, they indicate that many of the studies reviewed offered either little detail, or covered too many issues, without reference to empirical or theoretical context, making little effort to reflect on interpretations made and consider the relevance of their findings. They recommend a transparent focus on methodology by increasing the diversity of methods used, tapping into experience of other fields while, also, paying more attention to possible limitations and benefits of different approaches. Furthermore, they make recommendations for enhancing both the relationship between researchers and policy makers, as well as the manner in which the findings are presented and used to engage with policy makers.

2. Profile of Equity in Health Policy Analysis

Braveman and Gruskin (2003a, p. 254) indicate that "assessing health equity requires *comparing* health and its social determinants between more and less advantaged social groups" (emphasis added) and such *comparisons* are essential to assess whether national and international policies are leading toward, or away from, greater equity in health. Braveman and Gruskin (2003b, p. 539) assert that concepts of poverty, equity, human rights and health have sometimes been viewed "as abstract concepts with little practical application" and links between them "have not been examined systematically". They advocate "institutionalizing the systematic and routine application of equity and human rights perspectives to all health sector actions" (p. 539). There are two elements here, first, that the content of the health policies include concepts related to equity and human rights. No such review of health policies was founded in the extensive review of the published literature carried out by Gilson and Raphaely (2008). Second, the disparities should be

ascertained through some form of measurement. This, too, is problematic. For example, there is no international or national comparative data available on persons with disabilities and health, due to measurement challenges, while this group is acknowledged to be socially disadvantaged. This is in part due to measurement challenges as well as difficulties in operationalising definitions of equity and identifying core concepts of human rights linked to equity in health care. Without the possibility of effectively measuring inequity and social exclusion in health policies, it becomes extremely difficult to undertake meaningful comparisons between policies, or to know how much a policy may have been improved by attempts to revise it.

3. Development of *EquiFrame*

Health policy analysis is a critical process used to explain why certain health issues receive more political attention than others, as well as identifying the frequently unintentional consequences of policy decisions, and the obstacles that are encountered during policy implementation (Gilson et al., 2008). 'In an environment fraught with risks and opportunities, comprehensive policy analysis will increasingly be called upon to illuminate the path of progress' (Frenk, 1995, p. 275). Policy analysis can contribute to realizing health objectives, and to unravelling the complex mechanisms of power and process that underpin change (Buse et al., 2007). Further, it has been asserted that human rights analysis frameworks provide a methodology for assessing health policy from an array of diverse perspectives, providing a broader analysis that utilizes an assortment of disciplines, and can ultimately contribute to more measured consideration concerning how to progress, from which concrete policy can materialize (Ford, Calmy, & Hurst, 2010). While health policy analysis is widely recognized as a critical process, a number of challenges are inherent in this process, and a variety of issues require deliberation in the foremost stages, including such factors as research design and the infiltration of power in the policy process.

There is paucity of literature that outlines and utilizes an analytical framework to analyse the content of policies "on the books" (Stowe & Turnbull, 2001). There is also a limited body of research on the process of health policy development (Gilson et al., 2008), although a limited number of frameworks have been devised that address this process, including the *'Stages' Models* (Exworthy 2008); *Policy Triangle Framework* by Walt and Gilson (cited in Walt et al., 2008); Network

Frameworks (Tantivess & Walt, 2008); and *Policy Space Analysis* (Crichton 2008). Also available are theories to explain and understand the policy process including *Multiple Stream's Theory* (Kingdon, 1984); *Punctuated Equilibrium Theory* (Exworthy, 2008); *Implementation Theory* (Walt et al., 2008); and *Critical Theory Approach* (Duncan & Reutter, 2006). Despite these frameworks, there remains a limited body of research in its application on the process of health policy development (Gilson et al., 2008).

With the intension of developing a health policy analysis framework that would be of particular relevance in low-income countries in general, and in Africa in particular, teams members across the Sudan, Malawi, Namibia, South Africa, Norway and Ireland, incorporating universities, research organisations and non-governmental organisations, undertook literature searchers and discussions with relevant colleagues. These searches and discussions helped to identify key themes around human rights, the right to health and vulnerability, which were of relevance across a variety of health, delivery contexts and particular health equity challenges. In relation to our own research group: Sudan has a high number of internally displaced persons (IDPs); Namibia has a highly dispersed population; Malawi has a very high and chronic level of disease burden; South Africa has significant discrepancies in accessing healthcare, in part as a legacy of apartheid. Initial ideas for the framework were shared at a project meeting in Khartoum, and developed into a draft framework.

The Draft Framework was presented at consultation workshops conducted in Sudan, Malawi, Namibia and South Africa and attended by over a hundred participants drawn from relevant clinicians and practitioners, civil servants, elected government representatives, non-governmental organisations (NGOs), independent consultants, researchers and academics, including members of different vulnerable groups. Feedback was incorporated into a revised Framework, following further discussion and removal of some overlapping terms and categories. The Framework was then used to assess over 70 health policies drawn from the four African country partners, as well as African regional and international documents. The results from this analysis were then presented at Feedback Workshops in Sudan, Malawi, Namibia and South Africa, and the information gained from these workshops was incorporated into the Framework outlined below and into this manual more generally.

The Framework presented here also benefited, significantly, from a workshop conducted for the Ministry of Health in Malawi, for the purpose of revising the Malawian National Health Policy (Munthali et al. 2010), where novice users of the Framework gave feedback suggesting, for instance, simpler labels for Core Concepts and simpler definitions of those concepts, to enhance user-friendliness. Finally, feedback from conference presentations and high level meetings have helped in shaping *EquiFrame* (for example, MacLachlan et al., 2008, at the Global Ministerial Forum on Research for Health, Bamako, Mali; Dube et al., 2010, at the African Union Social Welfare Ministers Annual Meeting, Khartoum, Sudan; Mannan et al., 2010, at the Health System Strengthening Conference, Montreax, Switzerland). Feedback and expert advice, beyond our own project team (see www.equitableproject.org), from a variety of sources has, therefore, helped to shape and add authority and representativeness, to the version of *EquiFrame* presented below. We are very grateful to the large number of people who gave so freely of their time and we hope that the resultant version of *EquiFrame* does justice, both to the variety of views expressed and the depth of expertise offered.

The manual - developed as part of a Work Package led by Ahfad University for Women, within a larger EU FP7 funded project and led by the Centre for Global Health at Trinity College Dublin, with a consortium of international partners (see www.equitableproject.org) – sought to fill a gap in the literature and to look for available research tools to address this gap. However, although we are not able to identify an ideal existing instrument, we drew on several existing approaches in the area. These included the core concepts of disability policy as developed by Turnbull and colleagues (Reichard, Sacco, & Turnbull, 2004; and Stowe & Turnbull 2001); the right to the highest attainable standard of health - and in particular the need to address health inequalities (Braveman, 2006; Oliver, Healey, & Le Grand, 2002) - and current thinking in health policy analysis more broadly (Gilson, Buse, Murray, & Dickinson, 2008; Russell & Gilson, 2006). The Stowe and Turnbull approach, while specific to persons with disability and developed for use in North America, had many features relevant to our own interests. We, therefore, used some of the concepts they had identified, revised others and developed more from elsewhere.

Thus, we set out to develop a framework that enables one to describe a policy in terms of "core concepts (that) informs the analyst concerning what the policy is, what it is intended to accomplish, and perhaps even what it does accomplish" (Stowe & Turnbull, 2001, p. 206), and to ascertain the vulnerable groups included in health policies. The resultant, *EquiFrame*, is a framework for analysing the inclusion of core concepts of human rights and vulnerable groups in health policy. *EquiFrame* allows the analyst to identify the strengths and weaknesses in current policy according to how stongly, or weakly, the policy advances the core concepts of human rights in healthcare among vulnerable groups.

3.1. Synthesis of Core Concepts

Core concepts (CCs) that related individually, or collectively, to principles of universal, equitable and accessible health services were identified and available definitions were extracted from the above and related literature, resulting in the identification of 37 CCs. Through group discussion and e-mail consultation with the Project Team and stakeholders meetings[1], these concepts were refined and integrated, resulting in the 21 CCs utilized in the current framework. The reduction in the number of CCs was necessary to make subsequent policy analysis manageable and to have categories that were sufficiently discrete. The definitions of the resulting 21 CCs cover a broad range of human rights issues in the context of equity in health as well as healthcare more generally (Braveman & Gruskin, 2003b; Oliver, Healey, & Le Grand, 2002) and enable delivery of health services as a basic human right (Gilson, Buse, Murray, & Dickinson, 2008; Russell & Gilson, 2006). The CCs outlined below, alongside key questions and key language on which the concepts are based, were not positioned in terms of equivalent importance within the framework, but rather were included with a view to representing a broad range of salient concerns in striving for equitable, accessible and universal healthcare (See Table 1).

[1] These stakeholder meetings, held between April and July of 2009, were conducted in Sudan, Namibia, Malawi, and South Africa, and were established to deliberate the process and rationale for the inclusion of each concept in *EquiFrame*. They comprised of policy analysts and researchers from relevant ministries, including health and social affairs, and civil society organizations, including organizations of persons with disabilities.

Table 1. *EquiFrame:* Key Questions and Key Language of Core Concepts

No	Core Concept	Key Question	Key Language	Supporting Literature
1.	**Non-discrimination**	Does the policy support the rights of vulnerable groups with equal opportunity in receiving health care?	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (i.e. Living away from services; Persons with disabilities; Ethnic minority or Aged).	See Annex I
2.	**Individualized Services**	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective, and understandable services.	See Annex II
3.	**Entitlement**	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grant	See Annex III
4.	**Capability based Services**	Does the policy recognize the capabilities existing within vulnerable groups?	For instance, peer to peer support among women headed households or shared cultural values among ethnic minorities.	See Annex IV
5.	**Participation**	Does the policy support the right of vulnerable groups to participate in the decisions that affect their lives and enhance their empowerment?	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.	See Annex V
6.	**Coordination of Services**	Does the policy support assistance of vulnerable groups in accessing services from within a single provider system (interagency) or more than one provider system (intra-agency) or more than one sector (inter-sectoral)?	Vulnerable groups know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required.	See Annex VI
7.	**Protection from Harm**	Vulnerable groups are protected from harm during their interaction with health and related systems	Vulnerable group are protected from harm during their interaction with health and related systems	See Annex VII

8.	**Liberty**	Does the policy support the right of vulnerable groups to be free from unwarranted physical or other confinement?	Vulnerable groups are protected from unwarranted physical or other confinement while in the custody of the service system/provider.	See Annex VIII
9.	**Autonomy**	Does the policy support the right of vulnerable groups to consent, refuse to consent, withdraw consent, or otherwise control or exercise choice or control over what happens to him or her?	Vulnerable groups can express "independence" or "self-determination". For instance, person with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice.	See Annex IX
10.	**Privacy**	Does the policy address the need for information regarding vulnerable groups to be kept private and confidential?	Information regarding vulnerable groups need not be shared among others.	See Annex X
11.	**Integration**	Does the policy promote the use of mainstream services by vulnerable groups?	Vulnerable group are not barred from participation in services that are provided for general population.	See Annex XI
12.	**Contribution**	Does the policy recognize that vulnerable groups can be productive contributors to society?	Vulnerable groups make a meaningful contribution to society.	See Annex XII
13.	**Family Resource**	Does the policy recognize the value of the family members of vulnerable groups in addressing health needs?	The policy recognizes the value of family members of vulnerable groups as a resource for addressing health needs.	See Annex XIII
14.	**Family Support**	Does the policy recognize individual members of vulnerable groups may have an impact on the family members requiring additional support from health services?	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support.	See Annex XIV
15.	**Cultural Responsiveness**	Does the policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic, aspects of the person?	i) Vulnerable groups are consulted on the acceptability of the service provided ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, i.e. respectful of the culture of vulnerable groups	See Annex XV

16.	**Accountability**	Does the policy specify to whom, and for what, services providers are accountable?	Vulnerable groups have access to internal and independent professional evaluation or procedural safe guard	See Annex XVI
17.	**Prevention**	Does the policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?		See Annex XVII
18.	**Capacity Building**	Does the policy support the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?		See Annex XVIII
19.	**Access**	Does the policy support vulnerable groups –physical, economic, and information access to health services?	Vulnerable groups have accessible health facilities (i.e., transportation; physical structure of the facilities; affordability and understandable information in appropriate format).	See Annex XIX
20.	**Quality**	Does the policy support quality services to vulnerable groups through highlighting the need for evidence-based and professionally skilled practice?	Vulnerable groups are assured of the quality of the clinically appropriate services.	See Annex XX
21.	**Efficiency**	Does the policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups?		See Annex XXI

3.2. Vulnerable Groups

Equity analysis and monitoring necessitates segregating a population into groups according to social advantage (EQUINET, 2009; Braveman, 2003). Vulnerable groups, as described above, are "social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality" (Flaskerud & Winslow, 1998, p. 69) and this may include children, the aged, ethnic minorities, displaced people, people suffering from some illnesses and persons with disabilities. As emphasized by Braveman (2003), selected factors to categorize groups should reflect specific subgroups of the population, such as poor rural women, or members of an ethnic minority, that require particular awareness due to their underlying social characteristics, which afford them less opportunity to be healthy than their more privileged counterparts.

The failure of a State to recognize health problems, that preferentially affect a marginalized group, may violate the right to non-discrimination by resulting in neglect of essential services (Mann et al., 1994). While the importance of addressing the health needs of vulnerable groups in low-income countries is increasingly being recognised, there are many challenges as to how this should be realised for different categories of vulnerable people. While certain categories of vulnerable populations may present similar challenges, for their equitable access to healthcare, other categories may present distinctive challenges. As emphasized by the ILO (2002), while persons with disabilities are undoubtedly intended to be included in categories used in Poverty Reduction Strategy Papers, such as "vulnerable groups", "marginalised groups of society", or "disadvantaged groups", if precise mechanisms of exclusion and detailed needs of persons with disabilities are not explicitly established, then the associated strategies fall short of their specific target. A grouping such as "vulnerable groups", therefore, while pragmatic at certain levels of analysis, becomes an obstacle when it conceals crucial *diversity* in poverty determinants of an assortment of vulnerable sub-groups as well as strategies for implementation (ILO, 2002). Thus, health policies also need to address the particular circumstances of specific vulnerable groups.

Further, while the term 'vulnerable groups' is one of the most frequently used terms in social science research, difficulties arise when it comes to applying this concept as a measure in policy analysis. Quantifying vulnerability is challenging, just as is identifying who is to be considered 'vulnerable'. This concept needed to be clarified in order to reinforce its heuristic capacity, and

political and practical relevance. Literature, identifying vulnerable groups (VGs) from international and national perspectives, was consulted to draw up a comprehensive list of groups, and this list was refined and integrated to produce relevant groups across the four project countries, as well as regional and international health policies. Hence, *EquiFrame* developed operational definitions of 12 vulnerable groups, through literature review and stakeholders consultation (see Table 2).

Table 2. *EquiFrame* Vulnerable Groups Definitions

No.	Vulnerable Group	Attributes or Definitions	Supporting Literature
1.	**Limited Resources**	Referring to poor people or people living in poverty	See Annex XXII
2.	**Increased Relative Risk For Morbidity**	Referring to people with one of the top 10 illnesses, identified by WHO, as occurring within the relevant country.	See Annex XXIII
3.	**Mother Child Mortality**	Referring to factors affecting maternal and child health (0-5 years)	See Annex XXIV
4.	**Women Headed Household**	Referring to households headed by a woman	See Annex XXV
5.	**Children (with special needs)**	Referring to children marginalized by special contexts, such as orphans or street children	See Annex XXVI
6.	**Aged**	Referring to older age	See Annex XXVII
7.	**Youth**	Referring to younger age without identifying gender	See Annex XXVIII
8.	**Ethnic Minorities**	Referring to non-majority groups in terms of culture, race or ethnic identity	See Annex XXIX
9.	**Displaced Populations**	Referring to people who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence	See Annex XXX
10.	**Living Away from Services**	Referring to people living far from health services, either in time or distance	See Annex XXXI
11.	**Suffering from Chronic Illness**	Referring to people who have an illness which requires continuing need for care	See Annex XXXII
12.	**Disabled**	Referring to persons with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability	See Annex XXXIII

3.3. Criteria for rating issues in policies

Accordingly, the framework (a) defines Core Concepts, (b) identifies the key questions and key language on which the concept is based, (c) identifies Vulnerable Groups, and (d) provides a data extraction matrix to chart the analyzed documents. The *EquiFrame* Matrix lists the 21 Core Concepts along the vertical axis, and 12 Vulnerable Groups along the horizontal axis (see Annex XXXIV).

3.4. Scoring

A data extraction matrix (checklist) was developed to measure the quality of the analyzed policy documents. The *EquiFrame* Matrix was constructed with the vertical axis listing the 21 Core Concepts and the horizontal axis listing the 12 or more Vulnerable Groups.

Each Core Concept received a score on a continuum from 1 to 4. This was a rating of the quality of commitment to the Core Concept within the policy document:

1 = Concept only mentioned.

2 = Concept mentioned and explained.

3 = Specific policy actions identified to address the concept.

4 = Intention to monitor concept was expressed.

If a Core Concept was not relevant to the document context, it was stated as not applicable.

In each document the presence of Core Concepts was assessed for each Vulnerable Group that was identified in the policy. If no Vulnerable Group was mentioned, but a Core Concept addressed the total population (e.g. “all people”), the Core Concept was scored as *Universal*. The total number and scores for mentioned Core Concepts and Vulnerable Groups was calculated for each document, across the four countries. A consensus was reached, through discussion with other team members, in instances where the two researchers formulated incongruent appraisals regarding reference to Core Concepts.

3.5. Summary Indices

The 4 summary indices of *EquiFrame* are outlined below:

(1) **Core Concept Coverage**: A policy was examined with respect to the number of Core Concepts mentioned out of the 21 Core Concepts identified; and this ratio was expressed as a rounded-up percentage. In addition, the actual terminologies used to explain the Core Concepts, within each document, were extracted to allow for future qualitative analysis and cross-checking between raters.

(2) **Vulnerable Group Coverage**: A policy was examined with respect to the number of Vulnerable Groups mentioned out of the 12 Vulnerable Groups identified: and this ratio was expressed as a rounded-up percentage. In addition, the actual terminologies used to describe the Vulnerable Groups were extracted to allow for qualitative analysis and cross-checking between raters.

(3) **Core Concept Quality**: A policy was examined with respect to the number of Core Concepts within it that were rated as 3 or 4; that is, as either stating a specific policy action or intention to monitor that action. When several references to a Core Concept were found to be present, the top quality score received was recorded as the final quality scoring for the respective Core Concept.

(4) Each document was given an **Overall Summary Ranking** in terms of it being of Low, Moderate or High standing according to the following criteria:

(i) High = if the policy achieved ≥50% on all of the three scores above.

(ii) Moderate = if the policy achieved ≥50% on two of the three scores above.

(iii) Low = if the policy achieved <50% on two or three of the three scores above.

Based on these indices, more than 70 health policies from the four African country partners were assessed with regard to Core Concept coverage, Vulnerable Group coverage, and Core Concept quality and were given an Overall Summary Ranking in relation to Core Concepts and Vulnerable Groups. Three policies were common across the four countries, namely HIV/AIDS policy, Disability

policy and Tuberculosis policy (see also Amin et al., 2011). In the Malawian context, HIV/AIDS policy was assessed to be of overall *High* quality (Overall Summary Ranking); Namibian HIV/AIDS policy was assessed to be of overall *Moderate* quality; South African HIV/AIDS policy was given an overall *High* quality assessment; while HIV/AIDS policy in the Sudanese context received an overall *Low* quality assessment. Further overall quality assessments of health policies per country are illustrated in Table 3.

Table 3: Overall Quality Assessments of Health Policies per Country

Policy		Malawi	Namibia	South Africa	Sudan
1	HIV AIDS Policy	High	Moderate	High	Low
2	Disability Policy	Moderate	High	Low	Low
4	Tuberculosis Policy	Moderate	Moderate	Moderate	Low
3	Mental Health	Moderate	High		Moderate
5	Malaria	Low	Low		Low
6	National Health policy	Low		Low	High
7	Reproductive Health Policy	Low	Moderate		Moderate
8	Drug/medication Policy	Moderate			Low
9	Gender Policy		High		Low

This overall summary of a large number of health policies is, therefore, one function that can be provided by *EquiFrame*. Table 4 illustrates how the range of *EquiFrame* indices can be compared across countries with similar policies, in this case related to persons with disabilities.

Table 4: Overall assessment of disability policy quality among Namibia, South Africa, Malawi, and Sudan

Policies	% Vulnerable Groups mentioned	% Core Concepts mentioned	% Core Concepts rated 3 or 4	Composite Quality
Namibia National Policy on Disability	58%	95%	57%	High
South Africa the National Rehabilitation Policy	41%	47%	19%	Low
Malawi National Policy On Equalisation Of Opportunities For Persons With Disabilities	16%	57%	66%	Moderate
Sudan National Disability policy	42%	62%	24%	Low

EquiFrame can also provide a fine grain analysis, at the level of an individual policy. For example, consider the Federal Ministry of Health's Sudanese National Health Policy, 2007. The Vulnerable Group pertaining to *Limited Resources,* is cited in this document on five occasions. For example, the policy states that a guiding principle of the framework of the policy comprises "*an equitable and sustainable health system, especially for the poor, disadvantaged and vulnerable*". *Youth* as a Vulnerable Group was addressed in the policy in terms of the "*development of laws and/or legislation that protect and promote the rights of the child and their welfare*". The policy makes explicit reference to *Mother Child Mortality* as a Vulnerable Group: "*Evidence-based interventions integrated with maternal and child health programmes are an important step towards improving neonatal survival and health*".

With respect to Core Concepts, the Core Concept of *Contribution* was addressed in the policy at a level 1 quality of commitment. That is, this Core Concept was only mentioned in the health policy: "*The mission of the National Health Policy is to ensure the provision of health care to all citizens of Sudan, with emphasis on the health needs of the poor and the underserved, disadvantaged and vulnerable, in order that they are able to lead socially and economically productive lives*". The Core Concept of *Participation* was addressed in the policy at a level 3 quality of commitment. While intention to monitor the Concept was not expressed, specific policy actions were identified to address this Concept: "*National health policies should, therefore, create appropriate conditions and institutions for people irrespective of gender or their regional, religious, racial, cultural or ethnic affiliation in order that they are provided with the opportunity and ability to make decisions about their health and lives. This could be achieved through the creation of mechanisms whereby these groups become involved in the institutions assigned to undertake policy analysis at various levels and due consideration is given to their input*." The Core Concept of *Quality* was addressed in this policy at a level 4 degree of commitment. An intention to monitor the Core Concept was expressed: "*Good quality health care is a prerequisite for the utilization of health care services by consumers… The FMoH, in collaboration with the SMOH [State Ministry of Health], will develop mechanisms to measure performance against pre-established standards*."

EquiFrame can, therefore, provide an indication of the relative prominence of Core Concepts or the inclusion of Vulnerable Groups in a policy, or policies. Again, for illustrative purposes, *Figure 1* and

Figure 2 summarise the extent to which Vulnerable Groups are mentioned, across all policies and all four countries. It can be seen that the relative prominence given to Vulnerable Groups varies considerably. While the rationales for some variations are clear (for instance, displaced people in Sudan) for others the variation may reflect factors relevant to marginalisation within the countries.

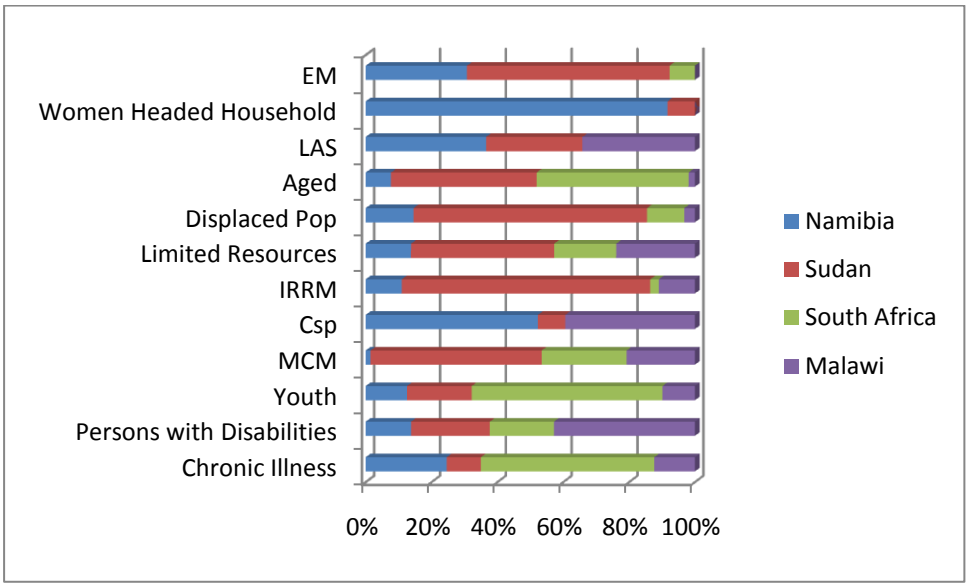

Figure 1. The relative frequency of mention of different vulnerable groups in health polices across four countries (expressed as a percentage)

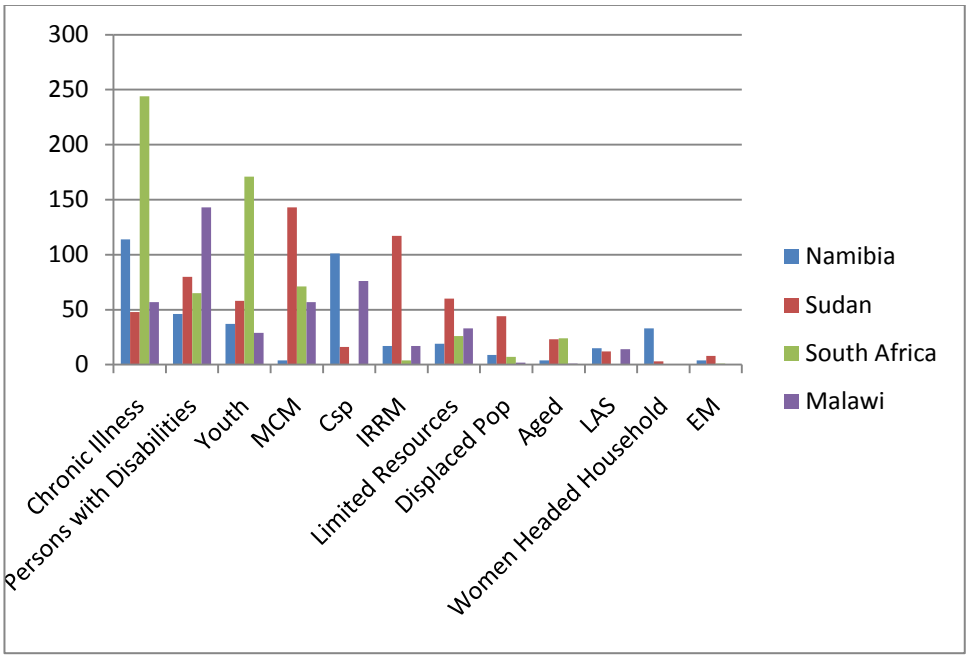

Figure 2. The absolute frequency of mention of different vulnerable groups in health polices across four countries [2]

[2] Vulnerable Groups are presented in the order from highest to lowest total coverage

Discussion

The above results are simply meant to illustrate the variety of ways in which *EquiFrame* can be used to illuminate aspects of human rights and social inclusion in policies. Ultimately, *EquiFrame* allows one to evaluate and to measure - the extent of inclusion and prominence of rights, accorded to persons with disabilities. This is important as, according to the old adage, "what gets measured, gets done".

Both through the process of undertaking this research and feeding-back the results to stakeholder workshops in each of the four countries, we have noted several factors that are important to consider when interpreting results, either within or across countries. While the inclusion criteria sought the relevant policy documents in each country, not all of the documents analyzed were official 'policies'; some were described as "guidelines", or "strategic plans", or "programmes". Clearly these instruments may not have been designed with an equivalent purpose and, so, in some cases it may be misleading to deem them as being policy-related or to compare them, even in the absence of a policy document in that area. To the extent that such documents are not policy-related, one could simply highlight the lack of a policy.

The indices we have used – scores of over 50% for each of our ratings – are essentially arbitrary but, at least intuitively appealing, as we are determining if half, or more, of a particular attribute is present in a document. However, such indices could be changed to reflect different weighting or sensitivity with regard to human rights, vulnerability or specific actions to address a concept or intention to monitor a concept being expressed. Indeed, these latter two categories could be treated separately, rather than combined, as we did here. Ultimately, *EquiFrame* is a methodology for descriptive analysis that can provide quantitative indices that can be fine-tuned for the required purpose.

Even when there may be strong comparability between the structure and function of policy instruments, it may be that it is less reasonable to expect some documents to address human rights and vulnerable groups, than others. For instance, is it reasonable for the Sudanese Voluntary Sector Policy (0%) and the Mental Health Policy (92%) to each mention vulnerable groups? It could be argued that one is about how a sector operates, while the other is about provision of specific

services. Even if one accepts this argument we feel that it can still be illuminating to know the extent to which they focus on social inclusion. In the case of Sudan, more comparable sector policies (National Health Policy, 83%) and service provision policies (Malaria Policy, 58%) also different, considerably, with regard to social inclusion.

In our country feedback workshops some stakeholders argued that some documents us the term "All", as in "all people" to be fully inclusive and, therefore, reference to specific Vulnerable Groups is not necessary. Indeed, subsidiary analysis of the use of "All", or its synonyms, indicates that documents using such 'catch-all' terms, also specify certain Vulnerable Groups, but not others. Accordingly, we feel it is important to establish which vulnerable groups are included, and which are not, as the use of inclusive terminology does not, necessarily, address the concerns of specific Vulnerable Groups.

EquiFrame essentially provides an approach to analysis – a framework- that can be customised to the requirements of the purpose of the analysis. For instance, Vulnerable Groups and Core Concepts may be added or removed to suit specific requirements, political, cultural or other contextual interests or constraints. Some recognised groups (such as gay people) may be marginalised to such an extent that in some countries their inclusion as a vulnerable group may be difficult to achieve with government cooperation. Furthermore, if oppressive laws ban homosexuality then the rights and potential vulnerabilities of gays is hardly likely to feature in the nation's policies. Whilst very regrettable, this should not prohibit the examination of how other marginalised groups are treated in such countries. Thus, the application of *EquiFrame* does not side-step difficult moral and pragmatic issues about whom to include in the term 'vulnerability', or whom to recognise as a vulnerable group. The terms included in the version of *EquiFrame* presented in this manual are simply those that the *EquitAble* consortium reached consensus on.

While *EquiFrame* has been developed for the purposes of policy analysis, we believe that its form of analysis can, also, be applied usefully to other types of planning and guiding documents, and that the coverage of Core Concepts of human rights and the inclusion of Vulnerable Groups is pertinent to these documents too. Fuller understanding of the content of any such documents can, and should always, be strengthened by an understanding of the context in which the document was developed, as well as the process of its development. However, describing 'policy on the books' is

not only a legitimate practice, but a vital one, if we are to recognize and develop documents that are most likely to support human rights and promote greater inclusion in health service provision. As emphasized by Walt et al. (2008), health policy analysis may be beneficial, both retrospectively and prospectively, in the understanding of past policy failures and successes and the development of future policy implementation. Accordingly, it is hoped that the utility of *EquiFrame*, as a policy analysis tool will extend, beyond its application as a framework for evaluation, to the development of new policy documents and to the revision of existing documents. By highlighting some high quality documents, *EquiFrame* can point those developing countries towards some supreme examples of human rights coverage and vulnerable group inclusion. It can also provide a check-list of factors for consideration, as well as indicating specific terms and phrasing for use in a policy.

The extensive gap in access to healthcare between disparate groups in developing as well as developed countries is well established (Ensor & Cooper, 2004). While the number of persons with disabilities is increasing globally, adequate disability policies, in conjunction with their implementation and enforcement, remain globally largely undefined (Wiman, Helander, & Westland, 2002). In the context of low income countries, where resources are scarce, marginalised or vulnerable people may experience greater social exclusion with the result that their right to health is undermined, to an even greater extent than in wealthier countries. As declared by Marmot (2007), the health achievements that have been realized in Europe have, by now, been initiated in south Asia and other regions however, and could ensue in sub-Saharan Africa, so that no country is forced to withstand levels of ill-health that are preventable. Equity in healthcare is an astute and feasible political aspiration. If human rights and social inclusion do not underpin policy formation, it is unlikely equity will be inculcated in service delivery however. Through its discernment of policy commitment to core concepts of human rights and vulnerable groups, underpinned by the principle of universal and equitable access to healthcare, *EquiFrame* stands to promote the United Nations' call for *Health for All,* with its implicit assumption of universal and equitable access to healthcare.

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Annexes

Annex I: **Nondiscrimination**

Annex II: **Individualized Services**

Annex III: **Entitlement**

Annex IV: **Capability based Services**

Annex V: **Participation**

Annex VI: **Coordination of Services**

Annex VII: **Protection from Harm**

Annex VIII**: Liberty**

Annex IV: **Autonomy**

Annex X: **Privacy**

Annex XI: **Integration**

Annex XII: **Contribution**

Annex XIII: **Family Resource**

Annex XIV: **Family Support**

Annex XV: **Cultural Responsiveness**

Annex XVI: **Accountability**

Annex XVII: **Prevention**

Annex XVIII: **Capacity Building**

Annex XIX: **Access**

Annex XX: **Quality**

Annex XXI: **Efficiency**

Annex XXII: **Limited Resources**

Annex XXIII: **Increased Risk of Relative Morbidity**

Annex XXIV: **Mother Child Mortality**

Annex XXV: **Women Headed Household**

Annex XXVI: **Children with Special Needs**

Annex XXVII: **Aged**

Annex XXVIII: **Youth**

Annex XXIX: **Ethnic Minorities**

Annex XXX: **Displaced Populations**

Annex XXXI: **Living Away from Services**

Annex XXXII: **Suffering from Chronic Illness**

Annex XXXIII: **Disabled**

Annex XXXIV. ***EquiFrame* Matrix**

Annex I: Nondiscrimination

According to Braveman (2006), an imperative human rights principle, with particular application to health equity, is the concept of non-discrimination, alluding to the right not to experience discriminatory conduct as a consequence of affiliation with one's social group. Equity, according to La Rosa-Salas and Tricas-Sauras (2008), denotes recognition of diversity, without this affording a motive for discrimination. Correspondingly, Mugisha (2004) declares that equity symbolizes the provision of support for those groups that have extensively, and historically, suffered discrimination. As outlined by the UN Economic and Social Council (2000), by virtue of article 2.2 and article 3, the Covenant forbids any discrimination in access to healthcare and underlying determinants of health, as well as to means and entitlements to their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status, which has the effect of nullifying the equal enjoyment of the right to health. Further, health facilities, goods and services must be accessible to all, but particularly to the most vulnerable segments of the population, in law and in fact, without discrimination on any of the prohibited grounds (UN Economic and Social Council, 2000).

Antidiscrimination policy guarantees equal access and opportunity, declaring that everyone has value; further, equal justice under the law is a slogan that establishes individual dignity, and by verifying individual dignity, policy that requires equal treatment advances the national value of a pluralistic society (Turnbull & Stowe, 2001). According to the Center for Universal Design at North Carolina State University *(Center for Universal Design, 1997),* universal access is realized through the principle of *Equitable Use*, that is, the design does not stigmatize or disadvantage users. According to the Office of the United Nations High Commissioner for Human Rights and World Health Organization (2008), health services, goods and facilities must be provided to all without discrimination; non-discrimination is a fundamental human rights principle and is critical to the enjoyment of the right to the highest standard of health. States have a legal and a moral obligation to ensure that a health system is accessible to all, without discrimination, including those living in poverty, indigenous peoples, and other disadvantaged individuals and communities (MacLachlan, 2006; Hunt & Backman, 2008). Discrimination, a violation of a primary human rights principle and

implicated at the heart of poor health status, can manifest itself in inefficiently targeted health programmes and limited access to health services (WHO, 2002b).

Annex II: Individualized Services

For maximum efficacy, policy must modify service delivery to the specific circumstances of each qualified individual and family beneficiary; individualization recognizes and responds to the strengths, needs and cultures of individuals and families (Turnbull & Stowe, 2001). According to the Center for Universal Design at North Carolina State University (Center for Universal Design, 1997), universal access is realized through the principle of *Flexibility in Use*, specifically, that a wide range of individual preferences and abilities can be accommodated by the design. The provision of individualized services does not, however, negate the greater needs of the community and it may be that evaluating services for a particularly disadvantaged group (for instance, persons with disabilities) can probe the accessibility of services for a much broader range of needs (MacLachlan, Mannan & McAuliffe, 2011).

Annex III: Entitlement

As outlined by Turnbull and Stowe (2001), classification requires that decisions about the distribution of resources take into consideration the strengths and resources of each individual recipient, so that services will be provided in a way that benefits the individual to the utmost extent possible, given all the resources accessible to all other comparably situated recipients. The obligation of promoting the right to health requires States to engage in actions that generate, preserve and re-establish the health of the population, including dissemination of pertinent information concerning the availability of services (UN Economic and Social Council, 2000). As declared by Ensor and Cooper (2004a), reliable information on service providers, including what providers offer and the best places to seek care, conventionally viewed as the duty of the health sector, is critical if the consumer is to make an informed decision with respect to whether, when and where, to present for treatment. Further, information and education are associated with failures in the form of knowledge of healthcare choices but also in the capacity to utilize this information in an effectual mode (Ensor & Cooper, 2004b). As emphasized by Goddard and Smith (2001), variations in access presented by the supply side may transpire as a result of information, *id est*, healthcare services may fail to make certain that the availability of specific services is recognized with equal clarity by all population groups (for example, relating to persons with disabilities see MacLachlan & Swartz, 2009).

Annex IV: Capability based Services

Services should be focused, not exclusively on the individual's needs but, also, on their capacities or capabilities. Capacity-based services recognize that if improvement of the individuals' or family's quality of life is the objective, in place of solely the amelioration of disability, for instance, then services must be person-centered and cultivate from the strengths of the individual, not just their disability (Turnbull, Beegle, & Stowe, 2001). As emphasized by Rifkin (2003), capacity-building is a requirement for empowerment for both individual improvement and for ensuring that health equity issues are identified and confronted. Sen's 'capability approach' suggests that health services must provide people with "practical opportunities" that are relevant to their situation whether this be one of poverty, or disability or any other marginalizing situation or attribute (Sen, 2009).

Annex V: Participation

Individuals with disability have the right to have their voices heard, pertaining to matters affecting them, and to have their opinions and choices recognized in the community (Turnbull & Stowe, 2001). Rifkin (2003) affirms that in the field of healthcare, throughout the past five decades, the principle of participation has increasingly been acknowledged as a critical constituent of improvements in health. Meaningful participation of those who represent the poor or disadvantaged is indispensable (Braveman & Gruskin, 2003b). As emphasized by Thiede and McIntyre (2008), information is a critical constituent of access to healthcare, underpinned by empowerment as a fundamental objective in a democratic society. Ultimately, the vision for improved access to healthcare services in democratic societies is reliant on public dialogue, in which pervasive perceptions are challenged by objective information (Savedoff, 2009).

According to the Center for Universal Design at North Carolina State University (Center for Universal Design, 1997), universal access is realized in part through the principle of *Perceptible Information*: Information is effectively communicated to the user, regardless of the user's sensory abilities, or surrounding conditions. Moreover, it is contended that a central task of health policy is to instigate and assist communicative processes that involve the health system in conjunction with communities, integrating the outlook of the community in the evaluation of corresponding information (Thiede & McIntyre, 2008). From an equity and human rights perspective, targeted short-term campaigns that fail to regard broader concerns fundamentally associated with poverty and ill-health, such as disempowerment, may be politically practical but unlikely to realize sustained health progress for the disadvantaged (Braveman & Gruskin, 2003b) and may alienate the very groups they are intended to assist (MacLachlan, Carr & McAuliffe, 2010).

Walt et al. (2008) assert that policy analysis needs to become more *deliberative*, that is to say less top-down, incorporating into decision-making people's stories, understandings, and values. As such, policy documents are consensus documents (Iannantuono & Eyles, 1997). As alluded to by Whitehead (2000), therefore, equity policies require a genuine commitment to decentralizing power and decision-making, encouraging people to participate, through articulation of their own needs, in every stage of the policy-making process. Correspondingly, Friel (2009) contends that the conception of a socio-environmental and socio-economic environment, that enables all social

groups to participate in health behavioural choices, depends critically on the empowerment of individuals and groups to successfully represent their needs and interests and, as such, challenge and modify the conditions that influence health. As declared by Rifkin (2003), recognition of the relation between empowerment, equity and improved health outcomes is intensifying, with appreciation of the need to use and support indigenous knowledge as an example. Marmot (2007) declares that fundamental progress in health equity necessitates empowerment of individuals, communities, and entire countries. As emphasized by Tamburlini (2004), voice and power*, id est* democracy, are crucial instruments in the realization of a more equitable allocation of services at community level. McIntrye and Gilson (2002) affirm that health equity goals are significantly dependent on the central participation of the disadvantaged in decision-making, in relation to who should receive priority, what services need to be delivered and how equity-promoting programmes should be employed.

According to the UN Economic and Social Council (2000), the implementation of national health strategies should respect the principles of people's participation; in particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an essential component of any policy or programme developed to discharge governmental obligations under article 12; promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. As outlined by the WHO (2010a), work should be performed concomitantly from the bottom and the top through social participation and vertical integration, involving national, in addition to local, government, and high level civil servants as well as grass-roots associations. Specifically, the WHO (2010a) makes recommendations for the implementation of local logs as a mode of improving health at a local level, testing different forms of interventions, empowering communities, and putting them in control of information, including data on lack of access, improper activities of providers or inequitable results of treatment, that information systems may be incapable of providing. As affirmed by Braveman (2003), participatory research techniques may be invaluable, not only by producing otherwise unattainable information, such as data concerning perceptions of unmet healthcare needs, but also by ensuring that grassroots organizations experience integration in action to address problems.

Smaller scale, local initiatives that frequently assists active participation in community planning and programme development, is seemingly imperative in addressing health inequities (WHO & Public Health Agency of Canada, 2008). Recurrently in healthcare markets, absence of healthcare information or inability to assimilate and employ information means that consumers are incapable of making well-informed decisions, and such information gaps may be mitigated by way of information and education (Ensor & Cooper, 2004b). As emphasized by Ensor and Cooper (2004a), intervention designs must comprise broader, extensive consultation with household members and community, both on service barriers and acceptable interventions, so that communities are empowered and the disadvantaged and other sub-communities are afforded a voice in service delivery. Shaw and Kalo (2002) affirm that a fundamental right of patients is to have access to sufficient information, to be educated and empowered in self-management of their health and diseases. As emphasized by Gostin, Mann, and Gostin (1994), discussions with individuals affected by the policy, and their advocates, are of particular significance. The right to the highest attainable standard of health generates legally binding obligations concerning the health system, including arrangements to guarantee the participation of those affected by decision making in health (Backman et al., 2008). According to the WHO (2010b), treatment, education and activity planning in institutions for children with disabilities should be organized, appropriate to best-practice processes and techniques, including the provision of opportunities for children to make choices in everyday issues.

According to the Pan American Health Organization (2008), persons with disabilities should have an awareness of their human rights, as they are protected under national and international law, as well as how the domestic, regional, and international mechanisms, available to promote and protect these fundamental rights, operate. Further, they should unite to actively participate in the development or review of disability policies, plans, programs and laws, and in the evaluation of rehabilitation services that aim to protect their human rights (Pan American Health Organization, 2008). The right to health contains entitlements comprising participation of the population in health-related decision-making at the national and community levels (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). All individuals and communities are entitled to active and informed participation on issues associated with their health; in the context of the health system, this includes participation in identifying overall strategy, policy-making, implementation, and accountability (Hunt & Backman, 2008). A substantive element of a human

rights approach to health comprises ensuring free, meaningful, and effective participation of those affected by health development policies or programmes in decision-making processes (WHO, 2002b). The State, when shaping pro-equity policies, should facilitate participation of civil society and affected communities, in particular groups and communities that have tended to suffer acute forms of disempowerment and marginalization (WHO, 2010c). From a right-to-health perspective, health systems must include arrangements for ensuring, to the greatest extent possible, “bottom-up” participation in the formulation of health policies (Hunt, 2007).

Annex VI: Coordination of Services

Each professional in the system requires the ability to work cooperatively with others, an ability derived from the interpersonal relationships that are established, as well as the structural mechanisms operating within and across service-delivery agencies, levels of government (local, state, and federal), and healthcare service systems (Turnbull & Stowe, 2001). Persons with disabilities have requirements that frequently cut across a variety of domains of life, while services are habitually organized and delivered without recognition to those transecting need, establishing the need for services that are coordinated, professionals that collaborate, and funding streams that are "braided" with one another (Turnbull, Beegle, & Stowe, 2001). As affirmed by the WHO (2010a), abating inequities necessitates the involvement of an assortment of programmes and stakeholders, both within and outside of the health sector, which can collectively address social determinants. Further, it is contended that collective, rather than individual action, has a superior probability of determining how healthcare services are provided and how health systems are designed and function (WHO, 2010a).

Makwiza et al. (2009) contend that service integration implies that services are more likely to be available to persons in need. As declared by Bloom (2001), governments devoted to equity-elevating health development require enhanced capacity to facilitate coalition building and manage change. According to the WHO and Public Health Agency of Canada (2008), local government frequently provides the initial invitation to initiate an intersectoral approach, by taking the primary steps in bringing people to the table, and they provide a framework and other support for intersectoral action to proceed at the local level. As emphasized by Ensor and Cooper (2004a), many of the interventions on the demand side may only be accomplished through ministries other than health, with cross-government collaboration as a requirement. As contended by Ensor and Cooper (2004b), cross-sector initiatives may be critical in contending with some of the barriers to access, such as cultural barriers, that cannot be addressed by the public health sector in isolation. Effective coordination is required between disparate health services (Backman et al., 2008). Developing managerial skills to efficiently coordinate is a significant element of any intersectoral activity and is required in services connected with disability (Maulik & Darmstadt, 2007). A health system, as well as the right to the highest attainable standard of health, is critically dependent upon effective

coordination across a range of public and private actors at the national and international levels, (Hunt & Backman, 2008).

Annex VII: Protection from Harm

According to the UN Economic and Social Council (2000), violations of the responsibility to protect, proceed from the deficiency of a State to enforce all required procedures to shelter persons within their jurisdiction from infringements of the right to health by third parties, including the failure to regulate the actions of individuals, groups or corporations so as to prevent them from infringing on the right to health of others, as well as the failure to impede the sustained execution of harmful traditional medical practices.

Annex VIII: Liberty

According to Turnbull and Stowe (2001), the constitutional principle of liberty declares that every person has entitlements to certain freedoms, including physical freedom and the general freedom to carry on the pursuits of life without undue interference from others. In accordance with Turnbull, Beegle, and Stowe (2001), persons with disabilities have the right to obtain services that are offered in a manner that is least restrictive of their liberty, with a preference toward generic and community-orientated services over specialized and institutional-based services. Deprivation of liberty constitutes a grave infringement on fundamental rights and freedoms; A policy decision to imprison, isolate, or otherwise restrict a person's liberty has a considerable impact on the person's life (Gostin, Mann, & Gostin, 1994). According to the WHO (2010b), approaches toward disability are globally in transition, embracing a shift from models founded on segregation in institutions to those that prioritize community-based living and social inclusion. This transition is arising in response to research into the process of deinstitutionalization that has clearly illustrated that outcomes are, in general, superior in the community than in institutional care (WHO, 2010b).

Annex IV: Autonomy

The UN Economic and Social Council (2000) affirm that the right to health comprises freedoms, including the right of an individual to control their health and body, including sexual and reproductive freedom, and the right to be free from intrusion, including the right to be free from non-consensual medical treatment and experimentation. The concept of informed consent is imperative for ensuring robust public health practice, affording the opportunity to counsel and educate, while protecting the integrity of health professionals and the dignity of the patient (Gostin, Mann, & Gostin, 1994). Admissions personnel and other staff dealing with rehabilitation procedures and care should make certain that they have the informed consent of persons with disabilities being admitted to the facility, or subject to any medical experimentation, consonant with international human rights standards (Pan American Health Organization, 2008). According to Turnbull and Stowe (2001), as a legal principle in healthcare, consent requires that a person be competent to act and to act voluntarily, and be afforded a sufficient amount of information to make a knowledgeable decision concerning whether to accept treatment or not. The right to health requires that all health facilities, goods and services must be respectful of medical ethics, including the requirements of informed consent (Hunt, 2007).

Annex X: Privacy

The UN Economic and Social Council (2000) uphold that the right to health is closely associated with, and dependent upon, the realization of other rights, as promoted in the International Bill of Rights, including the rights to privacy, so too that all health facilities, good and services must be devised to respect confidentiality. The obligation to respect requires States to refrain from interfering directly or indirectly with the right to health, including infringing on the right to privacy (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). According to the World Health Organization (2002b), the right to seek, receive, and impart information should not impair the right to privacy, denoting that personal data should be treated with confidentiality.

Annex XI: Integration

According to the WHO (2010a), dedicated services for persons who are less able to use standard services may have inadvertent repercussions, such as stigmatization or further barriers to use, if costs of extra time and exemptions are endured by the provider. Furthermore, dedicated services may easily become underfunded and less desirable to professionals, resulting in diminished service quality (WHO, 2010a). Through integration, persons with disabilities are afforded the opportunity to be productive and contributory, and to have an enhanced quality of life; further, greater assurances for sanctity of life are generated as the community comes to recognize and value the person (Turnbull & Stowe, 2001).

Annex XII: Contribution

As recommended by the WHO (2010a), interventions associated with empowerment may include advancing ability to participate in income-generating activities. More generally, however, many health policies assume a charity model towards vulnerable groups, rather than one which seeks to enhance their individual's positive identity, self-growth and empowerment, by promoting opportunities for contributing to their own health and welfare or the health and welfare of the community more broadly (MacLachlan, 2011).

Annex XIII: Family Resource

As affirmed by Turnbull and Stowe (2001), the principle of family as foundation recognizes that the strengths, needs and decisions related to children with and without disabilities are typically managed within the context of the family, so that issues involving children are, therefore, appropriately regarded as family concerns; by addressing the strengths, needs, and autonomy of families, we more effectively support their members. Further, according to Turnbull and Stowe (2001), the principle of family as foundation reflects extensively held societal ethics, values, beliefs and ideals, while it is recognized that for a policy to demonstrate efficacy as well as permanence, it must be conventional with the values of the society in which it is administered. As asserted by Shaw and Kalo (2002), a particular issue that is central to the objectives of health and social reform is the rights of individual patients and their families. It has been asserted in the literature that policy that affects a person with a disability concurrently affects family of that individual, providing the person and family are involved with each other with respect to performing family functions collectively (see Turnbull, Beegle, & Stowe, 2001). As affirmed by the UN Economic and Social Council (2000), while States only are parties to the Covenant and, therefore, ultimately liable for observance of it, all members of society, including families, have responsibilities concerning the realization of the right to health, and that State parties should afford an environment that supports the discharge of these responsibilities. Further, as upheld by the WHO (2010a), when taking into consideration the pattern of inequity, it is evident that for a “bottom inequity” or “marginal exclusion” pattern, programmes that are targeted at the family level are appropriate as the poorest children fall behind all others. Researchers recognize the value of community-based interventions and services that involve the family as the most sustainable of activities (Maulik & Darmstadt, 2007). According to the WHO (2010b), families are a critical source of information regarding children with intellectual disabilities and the fulfillment of their needs, as they are in a unique position to observe changes in the behavior of the child and how they may be connected with environmental influences.

Annex XIV: Family Support

As outlined by the WHO (2010a), the effect on the individual, but also on their immediate dependents, should be emphasized when determining the consequences of healthcare outcomes. Services should be family centered, directed by as well as to the family as well as to the child or adult with disabilities to the highest extent appropriate, that is, to the degree that the individual derives a benefit from family unity, integrity, capacity, and quality of life (Turnbull & Stowe, 2001). According to the WHO (2010b), family members of children with intellectual disabilities are a high-risk group with a considerable need for support, which is frequently unfulfilled. A continuum of family support services in the community, therefore, including day care and home-based care (family outreach services), psychosocial support for children and/or parents, legal aid, and respite care, should be in operation to circumvent the institutional placement of children and facilitate their integration (WHO, 2010b).

Annex XV: Cultural Responsiveness

Consistent with the WHO (2010a), for the purposes of ensuring optimal provider compliance and recipient adherence throughout delivery channels, understanding socio-cultural norms and practices, both of providers and users is critical. According to the UN Economic and Social Council (2000), the right to health comprises the element of *acceptability,* signifying that all health facilities, goods and services must be culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples, and communities, and sensitive to gender and life-cycle requirements. As emphasized by Goudge et al. (2009), constraining factors include the gap between indigenous and allopathic explanations of ill health, alongside perceived effectiveness and the possibility of cure. The absence of cultural responsiveness in the delivery of services may exacerbate the impact of existing disability discrimination or even cultivate the growth of socially created disability, which accompanies stigma and diminishes the dignity and value of the individual (Turnbull & Stowe, 2001).

In the context of the requirements of the right-to-health, health-related services should be cultural acceptable (Backman et al., 2008). Ensor and Cooper (2004a) contend that cultural concerns regarding the appropriateness of services may be mitigated to a certain extent by information (demand-side), but also by ensuring that services themselves are appropriate to the community (supplyside). As outlined by Ensor and Cooper (2004a), interventions must be culturally sensitive, realized by way of extensive consultation with communities, both on the barriers that inhibit use of services as well as the forms of interventions that may be acceptable.

As outlined by Goddard and Smith (2001), while a service may be, in principle, available to all, there may be considerable disparities in awareness concerning its availability and effectiveness due to language or cultural differences. According to Braveman and Gruskin (2003b), equity and human rights principles require the identification and overcoming of obstacles, such as language and cultural beliefs, which preserve the exclusion of disadvantaged groups from the full benefits of health initiatives. Providers of healthcare who speak local languages and who demonstrate an awareness of the culture and customs of minority groups may be more responsive to their needs, thereby increasing demand for healthcare services within those communities (World Health Organization, Regional Office for the Western Pacific, 2007). All services, goods and facilities must

be culturally appropriate, i.e. culturally acceptable (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). A health system must be respectful of cultural difference, in part requiring consideration of traditional preventive care, healing practices, and medicines (Hunt & Backman, 2008). The right to health requires that all health facilities, goods and services must be culturally appropriate (Hunt, 2007; MacLachlan, 2010).

Annex XVI: Accountability

According to the UN Economic and Social Council (2000), the national health strategy should be founded on the principle of accountability, such that any person or group that is victim of an infringement of the right to health should have access to effective judicial or other suitable remedies, at both national and international levels. Further, all victims should be entitled to sufficient reparation, in the variety of restitution, compensation, satisfaction, or certification of non-repetition (UN Economic and Social Council, 2000). The WHO and Public Health Agency of Canada (2008) in their examination of bottom-up approaches in healthcare, certify that such initiatives require the support of an accountability structure that allows the initiative to transform as necessary, based on the shifting needs of the community. According to Turnbull and Stowe (2001), accountability for outcomes and efficiency is obligatory for all policy decisions and all provider systems, whether generic or specified to disability; measures of costs, activities, and outcomes are required in order to know whether a policy is effective in achieving its goals (outcome-accountability) and efficient in its administrative (efficiency-accountability), as well as remedy and correction for those administrative and service-delivery strategies that are unsuccessful.

As accentuated by Perry, King-Schultz, Aftab, and Bryant (2007), equity must take precedence in the design of health delivery strategies, and mechanisms must be present to ensure accountability at the local, national, as well as international level for the purpose of addressing and reducing inequities. Correspondingly, Bloom (2001) states that while there is significant interest in broadening the concept of rights to healthcare, the establishment of such rights will be undoubtedly ineffectual unless the loci of responsibility for delivering on them are explicitly articulated. As emphasized by Rifkin (2003), without accountability, policies that allege to address equity and empowerment engender minimal confidence and credibility. Shaw and Kalo (2002) affirm that public and political discontent concerning health services demonstrates a global consensus, with concerns associated predominantly with, *inter alia*, public accountability.

Accountability strengthens health systems; the complexity and importance of health systems necessitates effectual, transparent, accessible, and independent accountability mechanisms, including health commissioners, national human rights institutions, democratically elected local health councils, public hearings, patients' committees, impact assessments and judicial proceedings

(Backman et al., 2008). Further, it is maintained that human-rights accountability is concerned with making certain that health systems are progressing, and that the right to the highest attainable standard of health for all is being increasingly realized, including those persons that experience disadvantage (Backman et al., 2008). According to the WHO (2010b), stringent professional ethic codes should be outlined for all staff of institutions caring for children with intellectual disabilities, as well as complaint filing procedures and consequences for failure to abide by codes of professional standards. Mechanisms of accountability are critical for making certain that States' obligations arising from the right to health are respected (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008).

Accountability with respect to health systems is frequently extremely weak, such that accountability mechanisms are urgently required for all those (public, private, national and international) working on health-related issues (Hunt & Backman, 2008). A State has a core obligation to establish effective, transparent, accessible, and independent mechanisms of accountability in relation to duties arising from the right to the highest attainable standard of health (Hunt & Backman, 2008). Gruskin and Tarantola (2008), in their overview of health and human rights, outline *accountability* as an example of how connections between sound public health and human rights standards can be explicitly established and fortified, encompassing questions in the policy and legal context such as 'Is a reporting mechanism in place to address claims of violations of policies and laws?' and 'Is a functioning judicial process in place to handle these claims?' As outlined by the World Health Organization (2002b), a substantive element of a rights based approach to health comprises increasing accountability for, and transparency in, health as a central consideration at all stages of programme development. There must be accessible, transparent and effective mechanisms of accountability with respect to health and human rights (Hunt, 2007).

Annex XVII: Prevention

In accordance with the UN Economic and Social Council (2000), the right to prevention, treatment and control of diseases requires the formation of prevention and education programmes for behavior-related health concerns, such as HIV/AIDS, and those negatively affecting sexual and reproductive health, such as education and gender equity. The right to treatment includes the development of a system of urgent medical care in cases of accidents, epidemics, and similar health hazards and the provision of humanitarian assistance in emergency situations. The control of diseases refers to State's efforts to, *inter alia*, provide relevant technologies, using epidemiological surveillance and data collection on a disaggregated basis, the implementation of immunization programmes and other approaches of infectious disease control (UN Economic and Social Council, 2000).

As affirmed by the WHO (2010a), the debate surrounding most advantageous methods of realizing long-term impact targets for TB control should be guided by one fundamental principle: that effective TB control can only be accomplished through *both* outstanding diagnostic and curative interventions, as well as primary preventive interventions that contend with risk factors and social determinants. Ensor and Cooper (2004a) exhort, however, that while some treatment, particularly preventive care, may be programmed on a regular basis, much curative care is uncertain, so that individuals and households frequently confront extensive bills for treatment just at the time when their income is lowest, conceivably furthering poverty. In summary, the principle issue in low- and middle-income countries is that insurance, loan, or prepayment systems to extend the cost of care across individuals and across time, frequently are not present and so signify market failure (Ensor & Cooper, 2004a). According to Article 26 of the Convention on the Rights of Persons with Disabilities (World Health Organization, Regional Office for South-East Asia, 2010), State Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes for, *inter alia*: prevention of secondary disabilities; early identification and intervention as appropriate; and provision of appropriate, affordable and accessible assistive devices. The right to health contains entitlements, including the right to prevention, treatment and control of diseases (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008).

Annex XVIII: Capacity Building

For a policy to achieve its preferred outcomes, the service –delivery must have the capacity to implement the policy, requiring sufficient resources (sufficient funding), a sufficient number of qualified individuals with sufficient pre-service or in-service education and sufficient experience to comprehend the policy goals and to apply state-of-the-art practices to secure those goals, an effective organization and infrastructure, the ability to integrate services on an intra- and interagency/sector level, and the ability to establish partnerships among its professionals and administrators and partnerships between them and the individuals and families they serve (Turnbull & Stowe, 2001).

The UN Economic and Social Council (2000) declare that States must guarantee the suitable training of doctors and other medical personnel, the provision of an adequate number of hospitals, clinics and other health-related facilities, and the promotion of the establishment of institutions providing counseling and other mental health services, with due consideration of equitable distribution throughout the country. Further, the Council recommends education for health personnel on human rights, as well as training to recognize and respond to the particular needs of vulnerable groups (UN Economic and Social Council, 2000). According to the Pan American Health Organization (2008), administrators of primary health care centers, general hospitals, and community based rehabilitation services should ensure that regulations governing the admission, treatment, holding, rehabilitation procedures of persons with disabilities conform to human rights protection standards (MacLachlan, Mji, McLaren, & Gcaza, 2009), and that all staff in their facilities are conscious of, and clearly comprehend, these norms.

As affirmed by the WHO (2010a), at a minimum, health systems need to ensure that providers have the essential knowledge, skills, equipment and infrastructure to perform their duties. As outlined by Bloom (2001), as low- and middle-income countries are unable to obtain benefits from existing healthcare technologies, by simply importing health-related commodities, these countries need to establish a capacity to generate health benefits. This requires training and regulating of an assortment of personnel, establishing and managing clinics and hospitals, organizing national programmes, and constructing systems that allow individuals to contend with unpredictable

expenditure on medical care (Bloom, 2001). It is contended by Backman et al. (2008) that health-related facilities and services must comprise suitably trained personnel and be available in sufficient quantity throughout a region. According to the WHO (2010b), staff of long-term care institutions for children with disabilities should receive rigorous instruction in implementing best practices in working with individuals with disabilities, including a series of workshops focusing on the development of understanding of the social model of disability, the internalizing of the code of ethics, and the provision of guidance on child-centred approaches to care as obligatory.

Annex XIX: Access

According to the WHO (2010a), a variety of population groups experience difficulty in accessing services due to the combined effect of several determinants, while the global financial crisis that developed during 2008, has meant that those who are most vulnerable are becoming even more vulnerable, in terms of access to healthcare services. As stated by La Rosa-Salas and Tricas-Sauras (2008), equity in healthcare in essence signifies equality in access to services and treatments. Zere et al. (2007) define equity in healthcare as equal access to a basic package of services for equal need, where access indicates the primarily financial and geographical barriers confronted by prospective users. As emphasized by Stewart Williams, Byles and Inder (2010), barriers to access may be present in many varieties and may become embedded within a healthcare system. As contended by Ong, Kelaher, Anderson, and Carter (2009), the *opportunity* to attain full health potential, through, *inter alia,* equality of access, is essential to realize health equity. According to Penchansky and Thomas (1981), problems with access are alleged to influence clients and the system in three measurable ways: (1) utilization of services; (2) client satisfaction with the system and services they receive; and (3) provider practice patterns. As contended by Ensor and Cooper (2004a), diminished access is an issue of equity, such that those with impaired access to community or household resources necessitate support to access services, through targeted subsidies as well as culturally sensitive health services delivery. When health services fail to take logistic, financial, and socio-cultural barriers to their access into consideration, intentional or unintentional discrimination may transpire (Mann et al., 1994). Access to health services is a fundamental human right (Turmen, Troedsson, & Stahlhofer, 2001).

In accordance with the UN Economic and Social Council (2000), health facilities, goods and services must be accessible to all without discrimination, within the jurisdiction of the State party, with four overlapping dimensions: (1) *Non-discrimination*: health facilities, goods and services must be accessible to all, in particular the most vulnerable, in law and in fact, without discrimination on any of the prohibited grounds; (2) *Physical Accessibility*: health facilities, goods and services must be within safe physical reach for all sections of the population, in particular vulnerable or marginalized groups, such as adolescents and children. Accessibility, also, signifies that medical services and underlying determinants of health, such as safe and potable water, are within safe physical reach, including in rural areas. Further, accessibility denotes sufficient access to buildings for persons with

disabilities; (3) *Economic Accessibility* (affordability): health facilities, goods and services must be affordable for all. Payment for healthcare services must be founded on the principle of equity, ensuring that these services, whether privately of publicly provided, are affordable for all, including socially disadvantaged groups. Further, equity demands that poorer households should not be disproportionately burdened by health expenses when compared to richer households; (4) *Information Accessibility*: accessibility comprises the right to seek, receive and impart information and ideas concerning health issues. Bloom (2001) cautions, however, that a government commitment to a unified health service may obscure significant structural inequalities in the health sector, concealing government failure to provide a number of social groups with access to the most basic services. According to Backman et al. (2008), from a right-to-health perspective, access is critical, due to its association with non-discrimination, equality and equity.

As part of the 7 principles of universal design outlined by the Center for Universal Design at North Carolina State University (Center for Universal Design, 1997), universal access is realized through the principles of: *Low Physical Effort*: The design is used efficiently and comfortably with a minimum amount of fatigue; *Size and Space for Approach and Use*: Regardless of the user's body size, posture, or mobility, appropriate size and space is provided for approach and reach; *Simple, Intuitive Use*: How to use the design is easy to understand regardless of the experience, knowledge, language skills, or current concentration level of the user: *Equitable Use*: The design is useful and marketable to people with diverse abilities; *Flexibility in Use*: The design accommodates a wide range of individual preferences and abilities; *Perceptible Information*: The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities; *Tolerance for Error*: The design minimizes hazards and the adverse consequences of accidental or unintended actions.

All services, goods and facilities must be accessible physically, financially, and on the basis of non-discrimination, where accessibility also implies the right to seek, receive and impart health-related information in an accessible format for all, including persons with disabilities (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). States have a core obligation to ensure access to health-related services and facilities as well as health information on a non-discriminatory basis, particularly for disadvantage individuals, communities, and populations (Hunt & Backman, 2008). A substantive element of a human rights based approach to health entails

ensuring that health systems are made accessible to all (MacLachlan & Mannan, 2011), particularly the most vulnerable or marginalized segments of the population, in law and in fact, without discrimination on any of the prohibited grounds (WHO, 2002b). The State should take responsibility for developing flexible systems that facilitate access on the part of its citizens (WHO, 2010c). The right to health imposes an obligation on a State to ensure that health facilities, goods and services are accessible to all within its jurisdiction (Hunt, 2007).

Annex XX: Quality

The UN Economic and Social Council (2000) affirm that health facilities, goods and services must be scientifically and medically appropriate and of good quality, necessitating, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment. Tamburlini (2004) asserts that quality of care, realized through delivery of effective interventions, competent staff, and appropriate supplies of equipment, represents a critical constituent underpinning inequalities between the rich and poor, ratifying the importance of quality indicators to assess the extent to which a health system is promoting health equity. McIntyre and Gilson (2002) propose that delivering quality outputs may be at least, if not more, significant than fulfilling quantitative targets in reaching the poorest, as perceived quality of services is frequently a considerable deterrent to service utilization.

According to the WHO (2010a), entry points for preventive interventions as well as interventions to improve disease management include enhanced quality of services. Ong et al. (2009) propose that it is the *opportunity* to achieve full health potential, through quality, as well as equality of access and utilization, that is necessitated to achieve equity on health. As emphasized by Ensor and Cooper (2004a), evidence on relative use of public and private facilities connotes that even poor people will travel long distances to attain good quality services and will circumvent local, poor quality facilities, indicative of the futility of demand stimulation, if health services are not of sufficient quality. As maintained by Odaga (2004), however, there has been weak linkage between equity objectives and incentive mechanisms for health personnel to provide quality services to target groups.

According to Goddard and Smith (2001), variations in access presented by the supply side may exist as a corollary of the variation of quality of services offered to identical patients between population groups. As outlined by Shaw and Kalo (2002), the general health of a population is critically dependent on the quality of the health system, such that improvement of quality is, for the majority of countries, fundamental to the reform of health systems and service delivery. Activating demand for child-survival interventions may be unsuccessful if the actual or perceived quality of general healthcare services is low (World Health Organization, Regional Office for the Western Pacific, 2007). All services, goods and facilities must be scientifically and medically appropriate and of good quality, necessitating trained health professionals, and scientifically approved and unexpired drugs

and hospital equipment (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). All health services and facilities must be of good quality; for example, ensuring access to good quality medicines, and the treatment by health workers of patients with respect (Hunt & Backman, 2008). According to the World Health Organization (2002b), States are called upon to pursue policies that promote the availability and accessibility for all, without discrimination of scientifically appropriate and good quality pharmaceuticals and medical technologies used to treat pandemics such as HIV/AIDS. Health facilities, goods and services must be scientifically and medically appropriate and of good quality (Hunt, 2007).

Annex XXI: Efficiency

The pursuit of efficiency has become a central objective of policy-makers within most health systems (Jacobs, Smith, & Street, 2006). The idea of efficiency is frequently invoked but seldom analyzed in public health debates. Yet the manner in which this concept is understood and employed can produce quite diverse policies (Roberts & Reich, 2002). A health system should have an appropriate mix of primary (community-based), secondary (district-based), and tertiary (specialized) facilities and services, providing a continuum of prevention and care, alongside an effective referral process whereby a health worker can assess a client's need for additional services and make a referral from one facility to another (Hunt & Backman, 2008) based on the optimal treatment being provided by the most appropriate facility, in the most cost-effective manner.

Annex XXII: Limited Resources

The worst off, as affirmed by Ridde (2008), have been identified as those who are perpetually excluded from healthcare, due to lack of financial resources to pay for it. High levels of poverty restrict access to quality health care and, by extension, human development (Lanre-Abass, 2008). As emphasized by Marmot (2007), the evidence demonstrates that the lower an individual's socioeconomic position the worse their health. Promoting equity in health is a multifaceted aspiration, which requires explicit commitment of the health sector to target diseases most prevalent among the poor (Tamburlini, 2004). Gilson et al. (2001) contend that for pro-poor policies, it is particularly important to monitor the impact of policy on the poorest. As postulated by McIntyre and Gilson (2002), redistribution necessitates effectual strategies to put the needs of the poorest at the heart of policy-making. The incapacity of households to pay for care may engender unconstructive patient-provider interactions, associated with insufficient care (Goudge et al., 2009). As maintained by the UN Economic and Social Council (2000), the full enjoyment of the right to health remains a distant objective, and one that is becoming progressively more remote for those living in poverty. As emphasized by the WHO (2010a), in poorer families, people are frequently incapable of paying for care, particularly for non-communicable diseases and, therefore, fail to seek opportune treatment when it is still effective, thereby risking degeneration of their health condition. It is declared by Zere et al. (2007) that while defining what is contained in the basic package of services may be multifaceted, a package that does not contend with the needs of the poor is divergent to the principle of equitable resource allocation. Roy and Hill Howard (2007) assert that the efficacy of public health subsidies depends chiefly on its capacity to target benefits toward the neediest, necessitating correct identification of indigent patients including administrative capacity for implementation, which is simply absent in most low-income countries.

As contended by Bloom (2001), a government legitimately dedicated to the formation of an equitable health sector needs to reconcile a strategy for health sector development that provides benefits to all social groups, while ensuring that the welfare of the poor is adequately represented in the competition between stakeholders. Ensor and Cooper (2004a) affirm that, in most instances, income has a positive impact on use of services, as financial demand barriers are likely to significantly impact the poor more than the rich. As postulated by Ensor and Cooper (2004b), interventions, habitually, do not differentiate between their impact on poor and non-poor groups,

representing a critical liability, for the reason that several of the interventions are anticipated to reduce financial barriers, which are likely to be higher for the poor.

As affirmed by Braveman (2003), priorities for distribution of public resources must be set in view of extensive evidence that suggests that disadvantaged social groups experience unequal opportunities for health, as a corollary of underlying social disadvantages. When contrasted with the more affluent, the poor are consistently deprived in the availability, accessibility, and quality of health services (World Health Organization, & World Bank Working Group on Child Health and Poverty, 2001). The cost of seeking healthcare services, including direct costs (such as user fees), indirect costs (such as costs for transportation), and opportunity costs (such as lost wages) may delay or prevent poor households from accessing care, as such costs impinge more profoundly on poor households than the non-poor (World Health Organization, Regional Office for the Western Pacific, 2007). The effects of severe poverty on health include the impact of poor nutrition, crowded and unsanitary living conditions, and inadequate medical care (WHO, 2010c). Today, one of the most critical health and human rights challenges is to advance the enjoyment of the right to health for those persons living in poverty (Hunt, 2007).

Annex XXIII: Increased Risk of Relative Morbidity

As emphasized by Mugisha (2004), equity means targeting those groups that have extensively and historically endured discrimination, specifically people with terminal sicknesses such as HIV/AIDS and TB who are unable to engage in employment. Braveman and Gruskin (2003b) affirm that, where resources are greatly restricted, it is most equitable that highest precedence is placed on contending with a limited number of highly preventable but prevalent conditions, such as malaria, HIV/AIDS and tuberculosis, which disproportionately affect the underprivileged and intensify poverty. As emphasized by MacNaughton (2004), all international instruments that enunciate human rights in the context of HIV/AIDS are reliant on States as the primary parties liable for promoting and protecting these rights, and are effectively designed to encourage States to establish national laws and systems for human rights protection. There is no doubt that many countries have failed to meet their commitments to enact the legislation required to address the HIV/AIDS epidemic, however, and research indicates that human rights violations with respect to HIV/AIDS are recurrent in healthcare settings (MacNaughton, 2004). States should prohibit discrimination on the grounds of health status, including actual or presumed HIV/AIDS status, and moreover ensure universal access to care and treatment for persons living with HIV/AIDS to ensure the right to health for such persons is upheld (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). Epidemiological conditions, particularly major epidemics such as HIV/AIDS, are highly influential on social structure and must be factored into global and national policy-setting (WHO, 2010c).

Annex XXIV: Mother Child Mortality

According to the World Health Organization (2005), in the year 2000, 10.6 million children under five years of age died globally, over half of them due to only five preventable communicable diseases compounded by malnutrition. It is contended that failure to adequately address neonatal mortality is one significant reason for these trends, and that reductions in childhood deaths cannot be achieved without making the *health of mothers and newborns* a higher priority (WHO, 2005). It has been asserted that poverty is a significant cause of maternal morbidity, as many women are prevented from receiving adequate medical attention due to an inability to afford sufficient antenatal care (Lanre-Abass, 2008). Further, the eradication of differentials in maternal morbidity and child mortality has been outlined as a critical progress marker in the advancement of equity in health (EQUINET, 2009).

It is, furthermore, declared by the UN Economic and Social Council (2000) that the right to maternal, child and reproductive health, as outlined in article 12.2, comprises "the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child", requiring measures to advance child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources to proceed on that information. Monitoring equity in maternal health services is imperative for the purposes of targeting sparse public resources to those with most need and advancing progress towards realizing global objectives (Zere et al.). As outlined by Perry et al. (2007), children in poorer households are exposed to greater health risks than those with better socio-economic conditions, and these inequities are intensified by restricted access to preventive and curative heath care services. It is recommended by Braveman and Gruskin (2003b) that, when resources are radically restricted, it is most equitable to place maximum priority on managing a limited number of devastating but highly preventable conditions, such as maternal morbidity and mortality.

As emphasized by Marmot (2007), in numerous poor countries, maternal mortality ratios surpass 500 per 100,000 live-births, whereas in Sweden this ration is two per 100,000, while the tragedy of infant and child deaths in poor countries is that the majority are avertable. Tamburlini (2004) asserts that adverse health events transpiring early in the life cycle have higher probability to

generate irreversible and, at times, intergenerational effects, such that interventions intended at improving the health of mothers, babies and young infants should be granted precedence among health programs. As contended by Mugisha (2004), as equity in a sense denotes providing support to those groups that have extensively and historically endured discrimination, targeting pregnant women and children who are socially marginalized and are economically immobilized is, therefore, corresponding to equity obligations. As the majority of neonatal high-risk conditions may be avoided or minimized through the provision of appropriate maternal and child health services, it is highly rational for policy makers to concentrate on strategies required for their countries to diminish neonatal risk factors (Maulik & Darmstadt, 2007).

As outlined by Tugwell et al., 2006, surveys from the World Bank in over 50 countries reveal that coverage of maternal and child-health services is worst in the poorest environments. In accordance with the WHO (2010a), healthy mothers and families should be high priority for every society, as the ability of women to control their fertility and to have access to essential, safe maternity care is a fundamental health and human right. Further, it is contended by the WHO (2010a) that morbidity and mortality related to pregnancy and childbirth is outstanding among health conditions with regard to the degree to which it may be minimized by access to comparatively simple care. While cost-effective technical interventions exist for many of the major causes of childhood morbidity and mortality, what appears to be absent are sufficient resources, political commitment and appropriate health systems to ensure that such interventions reach the poor and achieve adequate coverage levels that can give rise to considerable reductions in child mortality (WHO, Regional Office for the Western Pacific, 2007). The right to health contains entitlements, including maternal, child and reproductive health (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). While maternal mortality has received virtually no attention from the mainstream human rights community, there are 500,000 maternal deaths each year, the burden of which disproportionately falls on developing countries, signifying profound health inequities (Hunt, 2007). Preventable maternal mortality violates women's rights to life, health, equality and non-discrimination (Hunt, 2007).

Annex XXV: Women Headed Household

Women, particularly in low-income countries, have been denied equal access with men to basic resources including healthcare (Rifkin, 2003). As asserted by Whitehead (2000), rehabilitation services frequently focus on returning people to employment and may, therefore, be biased in favour of human capital and against the selection of cohorts such as women headed households. As emphasized by Marmot (2007), the differential position of men and women, in close to every society, is conceivably the most invasive and ingrained inequity, such that the relation between the sexes characterizes as pressing a societal concern for health as the social gradient itself. While the intersection between national health policy and women's health needs is multifaceted in developing countries (Rizvi & Nishtar, 2008), social factors selected to categorize groups should reflect identifiable subgroups of the population, incorporating poor, rural women, whom require particular consideration due to their underlying circumstances (Braveman, 2003).

Recommendations by the UN Economic and Social Council (2000) encompass the development and implementation of a comprehensive national strategy for promoting women's right to health throughout their lifespan. Accordingly, a significant goal should be reducing health risks of women, particularly lowering rates of maternal mortality, realized through, *inter alia,* interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and inexpensive healthcare, including sexual and reproductive services. According to the WHO (2010a), notwithstanding decades of efforts, sustained by powerful technical interventions, the health of women still falls critically short of goals outlined in international commitments.

Ensor and Copper (2004a) declare that schemes to empower women may be supportive in collapsing historical barriers to healthcare demand. Gilson et al. (2001) emphasize that women may be most excluded from decision-making due to entrenched beliefs concerning the traditional roles of men and women. Consequently, as outlined by Ensor and cooper (2004b), that women in some communities have substandard access to resources and may be prohibited from making their own choices has implications for health, and has associations with the universal need to empower weaker segments of society to formulate independent choices. Integrating the sphere of disability

with gender can generate imperative knowledge to be used in advancing women's living conditions and for political action (Loeb & Grut, 2005).

According to the WHO (2002a), disparities are evident in the opportunities and resources available to women and men, and in their ability to make decisions and exercise their human rights, including differential access to, and utilization of, health information, care and services. The prevalence of poverty and economic dependence among women, their experience of gender bias in the health system and society at large, the limited power many women have over their sexual and reproductive lives and their lack of influence in decision-making, mean that women confront particular health issues and particular varieties of discrimination (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). States have a legal obligation to ensure that a health system is accessible to all without discrimination, including women, and other disadvantaged individuals and communities (Hunt & Backman, 2008). In numerous societies, women suffer systematic discrimination regarding access to power, prestige and resources, the health effects of which may be instant and brutal, such as gender-based domestic violence (WHO, 2010c). Further, gender divisions within society shape health through less visible biosocial processes, whereby women's lower social status and lack of control over resources increases their exposure to health risks (WHO, 2010c).

Annex XXVI: Children with Special Needs

According to Maulik and Darmstadt (2007), progress in the sphere of childhood disability has been critically lagging, predominantly in low- and middle-income countries, in which knowledge, recognition of, and activities directed towards childhood disabilities are severely inadequate. Further, it is contended that almost no information is available concerning existing policies and legislation regarding childhood disability in low- and middle-income countries (Maulik & Darmstadt, 2007). The vast majority of children with disabilities have little or no access to the enjoyment of the highest attainable standard of health, including access to medical and rehabilitation services (Pan American Health Organization, 2008). According to the WHO (2010b), children with intellectual disabilities are disadvantaged in three ways with respect to health care: they have greater health needs, are at high risk of receiving poor care when treated, and finally, they experience greater barriers in accessing appropriate healthcare, including poor knowledge of health professionals concerning disability issues, communication difficulties, negative attitudes, poor intersectoral collaboration, and lack of reliable health monitoring data for this population. Street children are socially excluded, an exclusion that comprises lack of access to healthcare; in contemporary welfare literature, street children are a category of “children at risk” (Panter-Brick, 2002).

Annex XXVII: Aged

It has been emphasized in the literature that, in a myriad of societies, the elderly may be disadvantaged by policies or customs (see Braveman, 2006). Severe barriers to access arise, therefore, when persons are obstructed from, or are unable to use, health services as *inter alia* a corollary of age (see Whitehead, 2000). It is contended by La Rosa-Salas and Tricas-Sauras (2008) that issues of principle relating to equity and non-discrimination arise in questions such as if a person has been left without a specific treatment on the grounds of age, and restricting someone from access to treatment solely on the basis of age is clearly discriminatory. The UN Economic and Social Council (2000), in recognition of the right of health of older persons, reaffirms the importance of an integrative approach, combing elements of preventive, curative and rehabilitative health treatment aimed at preserving the functionality and sovereignty of older persons. A health system must be responsive to the particular health needs of vulnerable groups including the elderly (Hunt & Backman, 2008).

Annex XXVIII: Youth

In accordance with the UN Economic and Social Council (2000), all policy and programmes intended to guarantee the right to health of children and adolescents shall view their best interests as a principal consideration. Further, it is affirmed that international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness (UN Economic and Social Council, 2000). Improved health in childhood is increasingly acknowledged as a cornerstone of human development and poverty reduction (WHO, Regional Office for the Western Pacific, 2007). Children are frequently the most vulnerable to inadequacies in healthcare (Doebbler, 2001). Children confront particular health challenges associated with the stage of their physical and mental development, which makes them particularly vulnerable to infectious diseases (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). Recognizing the right to health and to high-quality health care is a prerequisite for children's successful enjoyment of their rights, including family life, education, and participation in cultural life, recreation, leisure and sport (WHO, 2010b). States have a legal obligation to ensure that a health system is accessible to all without discrimination, including children (Hunt & Backman, 2008).

Annex XXIX: Ethnic Minorities

The UN Economic and Social Council (2000) proclaim that the right to health is recognized, *inter alia*, in article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965. According to the WHO (2010a), ethnicity is closely allied with disadvantaged position, attributable for instance to low income, poor housing or poor education, and social position exerts a critical influence on the variety, magnitude and circulation of health in societies. Further, Ethnic Minorities has been examined in the literature in terms of potential complications in the alignment of perceptions of health and illness to those of health services (see Dixon Woods et al., 2005; MacLachlan, 2006).

According to Braveman (2003), social factors, selected to categorize groups for monitoring as well as policy-targeting purposes, should reflect identifiable subgroups of the population, such as ethnic minorities, whom require particular attention due to underlying social characteristics that provide them with less opportunity to be healthy, than more advantaged social groups. Low levels of education and linguistic or cultural barriers may make health information inaccessible, particularly for ethnic minorities, who frequently reside in remote areas and who contend with distinctive cultural and linguistic barriers (WHO, Regional Office for the Western Pacific, 2007). A significant element of a human rights based approach to health comprises consideration of the most vulnerable population groups in society, including ethnic minorities (WHO, 2002b).

The UN Economic and Social Council (2000), in view of emerging international law and practice and current procedures enforced by States, affirms that indigenous peoples have the right to explicit measures to advance their access to health services and care, and that these health services should be culturally appropriate, taking into account customary preventive care, healing practices and medicines. As outlined by the Office of the United Nations High Commissioner for Human Rights and World Health Organization (2008), studies have revealed that, in a number of societies, indigenous peoples enjoy fewer health services, receive less health information, and have a higher child mortality rate than the general population. Health status and outcomes among oppressed racial/ethnic groups are frequently significantly worse than those registered in more privileged groups or than population averages (WHO, 2010c).

Annex XXX: Displaced Populations

The enjoyment of the right to health by migrants is frequently limited, simply because they are migrants, alongside other factors such as discrimination, language and cultural barriers, and legal status (Office of the United Nations High Commissioner for Human Rights and WHO, 2008). Specifically, significant difficulties faced by migrants, particularly undocumented migrants, regarding their right to health include: inadequate general coverage by State health systems; the inability to afford health insurance; difficulties accessing information on health matters and available services due to inadequate provision of information by the State; disinclination to access healthcare, for undocumented migrants, due to apprehension that health providers may denounce them to immigration authorities (Office of the United Nations High Commissioner for Human Rights & WHO, 2008). A substantive element of a human rights based approach to health comprises paying attention to the most vulnerable population groups in society, including internally displaced persons, immigrants and migrants, and refugees (WHO, 2002b).

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Annex XXXI: Living Away from Services

As emphasized by La Rosa-Salas and Tricas-Sauras (2008), inevitable inequalities exist when, even if the cost of healthcare at the point of delivery is equal throughout a country, people in rural populations have to travel further to the hospital than those in urban populations, the proportionate burden costs of which may differ depending on economic status. According to the WHO (2010a), equity concerns are critical in selecting the most appropriate delivery channels to reach the poorest families, who frequently live far away from facilities and, therefore, necessitate community or household delivery channels. Ensor and Cooper (2004b) assert that distance, which has a differential impact across income groups, may negatively impact service utilization.

As emphasized by Ensor and Cooper (2004a), a variety of studies reveal that household use of services diminishes with distance, a significant reason why urban residents use services more frequently than those in rural populations, emphasizing the need for well-targeted programs that afford a legitimate redistribution to areas, groups and individuals in need. Odaga (2004) confirms that distance to health facilities is a considerable factor restricting access to care for the largest and poorest segment of the population in poor countries, and proposes reducing distance between health facilities and people as a mode of progressing equity principles. Makwiza et al. (2009) make recommendations for innovative models of decentralization, whilst maintaining quality of services, to advance access of poor rural populations.

Annex XXXII: Suffering from Chronic Illness

According to the WHO (2010a), between 2006 and 2015, non-communicable disease deaths are expected to increase in excess of 20% in low-income countries, with the largest increase in sub-Saharan Africa. As denoted by Goudge et al. (2009), international evidence illustrates high levels of mortality, attributable to uncontrolled chronic disease, such that there is an escalating burden of chronic illness in low and middle income countries impelled by HIV, TB, and non-communicable diseases, a concern that few health systems are designed to adequately address.

Annex XXXIII: Disabled

The UN Economic and Social Council (2000), give prominence to the need to ensure that both the public health sector and private providers of health services and facilities observe the principle of non-discrimination in relation to persons with disabilities. As proposed by Tamburlini (2004), the most vulnerable may be facilitated through the provision of safety nets to those households and individuals who, due to severe disability, may incur calamitous expenditure. Persons with disability tend to be critically disadvantaged by all poverty standards – material deprivation, low human development, lack of voice and influence, and heightened exposure to economic, social, and health risks (Wiman, Helander, & Westland, 2002; MacLachlan & Swartz, 2009; MacLachlan et al., 2009). Disability is recognized as both a cause and a consequence of poverty: disability demonstrates a serial pattern comprising the emergence of a disability to the manifestation of poverty, increasing the risk of disability, thereby sequentially escalating poverty (ILO, 2002).

Persons with disabilities are radically under-supported by all social sector services, including the health care system (Wiman et al., 2002). Debates pertaining to the provision of benefits and services, legislation preventing discrimination and enquiries of how to promote social inclusion define some of the most critical contemporary disability policy topics and concerns (Marks, 2001). For a country to efficiently promote and protect the basic human rights of its citizens with disabilities, it must put into implementation a set of instruments, that is, policies, plans, laws and programs, that explicitly protect the rights of these persons and that adhere to international human rights conventions and standards (Pan American Health Organization, 2008).

According to Article 25 of the Convention on the Rights of Persons with Disabilities (World Health Organization, Regional Office for South-East Asia, 2010), health obligations of State Parties comprise: provision of the highest attainable standards of health for persons with disabilities; assurance of the same range, quality, and standards for free/affordable healthcare and programmes on an equal basis with others; prevention of discrimination on the grounds of disability; assurance of equal access to health services, including in rural areas; provision of care on the basis of free and informed consent of the person with disability; promotion of ethical standards of practice by health workers in the public and private sectors, particularly in dealing with those who need more intensive forms of support, and in dealing with girls and women with disabilities; prevention of

denial of healthcare and services on the basis of disability; prevention of denial of health insurance on the basis of disability; provision of gender-sensitive services, including health-related rehabilitation, and information on reproduction and family planning in accessible formats.

Persons with disabilities contend with a variety of challenges to the enjoyment of their right to health: as examples, persons with disabilities frequently have difficulties in accessing healthcare; persons with psychosocial disabilities may not have access to affordable treatment through the public health system; and medical practitioners may treat persons with disabilities as objects of treatment rather than as rights-holders (Office of the United Nations High Commissioner for Human Rights, & WHO, 2008). States have a legal obligation to ensure that a health system is accessible to all, without discrimination, including persons with disabilities (Hunt & Backman, 2008).

Annex XXXIV. ***EquiFrame*** **Matrix**

No	CONCEPTS	No. of times concept occurs in document	Limited Resources	Increased RR of morbidity	MCM	WHH	Children with special needs	Aged	Youth	Ethnic minorities	Displaced populations	Living away from services	Suffering from chronic illness	Disabled	Universal
1	Protection from Harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	Prevention	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	Autonomy	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Privacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Participation	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	Liberty	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	Non-discrimination	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Cultural Responsiveness	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	Family Resource	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	Family Support	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	Integration	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Contribution	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Coordination of Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	Capacity building	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	Entitlement	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Capability based services	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Individualized Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18	Accountability	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Quality	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Access	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	No. of times vulnerable group is mentioned in document		0	0	0	0	0	0	0	0	0	0	0	0	0

"EquiFrame is a useful tool which can be used in development of policy to include the vulnerable groups on social and human rights issues. You can not miss these issue if its used at the initial development of a policy".

*

"The framework will indeed improve the way policies are formulated. It will definitely not be business as usual".

*

"The Framework is very objective. I will try to review previous policies which have been developed and realign them to the current frame so that they reflect and address human rights concepts especially for vulnerable groups".

*

"The EquiFrame is a useful framework for undertaking a critical analysis of any policy to ensure that social inclusion, ethics, and human rights are taken on board. It is universal but its application may be contextualized. It provides a basis for adaptation".

Comments made during EquiFrame Workshop on Malawi's National Health Policy revision (Lilongwe, Malawi, November 2010)

From the European Commission's brochure on International Cooperation in EU-funded Health Research (2010):

HOW INCLUSIVE IS YOUR SYSTEM?

Does your health system provide the same standard and quality of care for all? Does it strive to be equally accessible to all its users? Is it able to address the specific needs of particularly vulnerable user groups? Answer 'yes' to all three and you may be looking at a system that has truly mastered the principle of equity in healthcare.

But the answers are unlikely to be straightforward. The EquitAble project, a consortium of partners in the EU and Africa, is putting the healthcare systems of Malawi, Namibia, South Africa and Sudan to the test in order to identify the barriers they may need to overcome on the road to genuine equity. The example of these developing systems is yielding valuable insights for emerging and established healthcare systems everywhere.

Cartography of an obstacle course

As Project Coordinator Professor Mac MacLachlan explained, 'There is a lot of rhetoric around the idea that healthcare should be equitable, but that's really not possible unless health services are equally accessible to everyone.' And there are many reasons why that may not be the case. The barriers may be physical, psychological, administrative, financial or cultural, to name but a few. They may be linked to the distance patients must travel to receive treatment, or to the fact that they are displaced, minority or otherwise vulnerable groups that often struggle to obtain the services they need.

These challenges affect different systems to varying degrees, but there is one indicator that can be applied to all: their ability to address the needs of system users with disabilities. All health system users should have equal access to crucial services such as immunisation, dentistry or antenatal care, but only a system specifically *designed for equity* will be able to offer this level of inclusiveness.

Paving the way for equity

A mud road to an immunisation clinic, for instance, can become an insurmountable obstacle to a wheelchair user. 'If you can get the health provision for people with disabilities right and they are able to access services,' said Prof. MacLachlan, 'then you're probably also going to be getting it right for the rest of the population, because you'll be concerned to maximise the intersectoral relationships between education, transport, healthcare and so on, on which peoples' health depends.'

This may be a tall order even in affluent settings, let alone the resource-constrained context of many low-income countries. But as Prof. MacLachlan noted, political determination goes a long way to ensure that available means are deployed equitably. EquitAble is assessing health systems and the policies on which they build. To do so, it has developed its very own methodology: EquiFrame, an analytic tool for evaluating and developing inclusiveness in healthcare policies.

The project is also profiling system users and conducting a survey of 8 000 households to analyse their uptake of healthcare services. One of the aims is to identify people who do not use such services at all, and to establish why. Due to be published by the end of 2012, these case studies will give non-users of the healthcare system a voice, and should give policymakers ample food for thought.

EquitAble

Full name:	Enabling universal and equitable access to healthcare for vulnerable people in poor resource settings
Type:	Collaborative project
Start date:	01/03/2009
Project coordination:	Centre for Global Health & School of Psychology Trinity College Dublin Dublin, Ireland
8 project partners from 6 countries:	Ireland, Malawi, Namibia, Norway, South Africa, Sudan

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