

Mutamad Amin, PhD, is Professor and Director of Research at Ahfad University for Women, Omdurman, Sudan.

Malcolm MacLachlan, PhD, is Professor at the Centre for Global Health & School of Psychology, Trinity College Dublin, Ireland and Extraordinary Professor at the Centre for Rehabilitation Studies, Stellenbosch University, South Africa.

Hasheem Mannan, PhD, is Senior Research Fellow at the Centre for Global Health.

Shahla El Tayeb, PhD, is Assistant Professor at School of Psychology at Ahfad University for Women, Omdurman, Sudan.

Amani El Khatim, MD, is Assistant Professor at School of Physiotherapy at Ahfad University for Women.

Leslie Swartz, PhD, is Professor in the Department of Psychology, University of Stellenbosch, South Africa.

Alister Munthali, PhD, is Associate Professor at the Centre for Social Research, University of Malawi.

Gert Van Rooy, MA, is Research Fellow at the Multidisciplinary Research Centre, University of Namibia.

Joanne McVeigh, HDip Psych, is Research Assistant at the Centre for Global Health & School of Psychology.

Arne H. Eide, PhD, is Chief Scientist at SINTEF Health Research, Norway.

Marguerite Schneider, MA, is Research Officer in the Department of Psychology, University of Stellenbosch, South Africa.

Please address correspondence to Malcolm MacLachlan, Centre for Global Health and School of Psychology, Trinity College Dublin, Ireland, email: malcolm.maclachlan@tcd.ie.

Competing interests: None declared.

Copyright © 2011 Amin, MacLachlan, Mannan, El Tayeb, El Khatim, Swartz, Munthali, Van Rooy, McVeigh, Eide, and Schneider. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

EQUIFRAME: A FRAMEWORK FOR ANALYSIS OF THE INCLUSION OF HUMAN RIGHTS AND VULNERABLE GROUPS IN HEALTH POLICIES

Mutamad Amin, Malcolm MacLachlan, Hasheem Mannan, Shahla El Tayeb, Amani El Khatim, Leslie Swartz, Alister Munthali, Gert Van Rooy, Joanne McVeigh, Arne Eide, and Marguerite Schneider.

ABSTRACT

Ensuring that health policies uphold core concepts of human rights and are inclusive of vulnerable groups are imperative aspects of providing equity in health care, and of realizing the United Nations' call for Health for All. We outline the process of extensive consultation undertaken across countries and stakeholders culminating in the development of EquiFrame, in conjunction with its associated definitions of core concepts of human rights and vulnerability. EquiFrame is a systematic policy analysis framework that assesses the degree to which 21 core concepts of human rights and 12 vulnerable groups are mentioned and endorsed in health policy documents. We illustrate the scope of the framework by reporting the results of its application to two health policy documents from (Northern) Sudan: the rather generalist Health Policy of (Northern) Sudan, and the more specific National Drug Policy of (Northern) Sudan. We outline some limitations of the framework and highlight issues for consideration in its interpretation. EquiFrame offers a systematic approach to analyzing and facilitating the inclusion of core concepts of human rights and vulnerability in existing or developing health policies and ultimately to promoting greater equity in health care.

INTRODUCTION

There has been a significant increase in resources committed to programmatic action in the global health arena, underpinned by deliberation of human rights.¹ Human rights and ethics scholars support public health strategies that aspire to balance individual and community rights, asserting that public health interventions that support human rights can concurrently realize population health.² The proposition that promoting and protecting human rights is inseparably associated with the task of promoting and protecting health emanates, at least to some degree, from the acknowledgment that health and human rights are complementary approaches to the critical problem of defining and progressing human wellbeing.³ Public health and human rights are therefore typically congruous; public health is most effectively protected through the promotion of human rights and the protection of the inherent dignity of the person.⁴

In recent years, international human rights laws have instigated the direction of policy objectives towards prioritizing improving the health of the disadvantaged, so that health systems are effectively reoriented toward equity in health care. One of the parameters used to assess the efficacy of health sector reforms in achieving affirmed objectives therefore has been their effect on equity.⁵ Indeed, 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, “An equitable health system is a core social institution, no less than a fair court system or democratic political system... Reinforced and protected by the right to the highest attainable standard of health and other human rights.”^{6,7}

On the grounds that human rights principles will define the objectives of national strategies and the formulation of policies, the United Nations Economic and Social Council imposes a duty on each state to take the required steps to certify that each person has access to health facilities, goods, and services through the adoption of a national strategy to ensure to all the enjoyment of the right to health.⁸ To promote the United Nations’ call for Health for All, we therefore need to focus on equitable health care—that is, health care responsive to peoples’ health needs, personal situations, and broader socio-economic contexts—rather than equal health care, where everybody gets the same.⁹ Policies should be written for all, but they should also be sensitive to different types and contexts of need. This assumption is in keeping with the principle of vertical equity, which upholds the allocation of more health care resources to those that present the greatest need in terms of greatest vulnerability to and experience with health problems.¹⁰

The extensive gap in access to health care between disparate groups in low- and high-income countries is well established.¹¹ In the context of low-income countries, however, where resources are scarce, marginalized 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 declares 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.”¹² If this is the case, then it undermines the United Nations’ directive of Health for All, with its implicit assumption of universal and equitable access to health care.

Progress towards the health-related Millennium Development Goals (MDGs) has, arguably, been achieved through being able to help vulnerable people improve their access to health care. Subsequent

gains will be dependent on addressing the challenges that a range of vulnerable groups face. “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.¹³ Thus, to ensure equal opportunities for accessing health, health policies need to specifically address those who are less well positioned—physically, socially, culturally, or economically—in and by society. Therefore, it is 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 that takes their “vulnerabilities” into account. In other words, it is important to know if human rights are promoted in health policies, and if so, if they are promoted in a socially inclusive way. While we acknowledge that human rights are indivisible and interrelated, we also recognize that they are multi-faceted, and that it is of value to assess the extent to which different health policies address the presence and range of such rights. It is also important to emphasize that health policies cannot be expected to cover the full range of factors relevant to health. For instance, the Bamako Call for Action on Research for Health (2008) stresses that health is multisectoral, reaching beyond the health sector to include social welfare, education, employment and many other areas.¹⁴

The purpose of this paper is to outline an analytical framework for determining the degree to which social inclusion and human rights feature in policy and policy-related documents. EquiFrame identifies the degree of commitment of a defined policy to specified vulnerable groups and to core concepts of human rights, underpinned by the principles of universal, equitable, and accessible services. The framework was developed with regard to health policy documents with the motivation to contribute to enhancing equity in health care. It is hoped that health policies instituted on the values and importance of equity are more likely to result in health services that are more justly distributed within the population. This means, in accordance with the World Health Organization, that priority is given to vulnerable groups, as health care founded on equity contributes to the empowerment and social inclusion of such groups.¹⁵ While EquiFrame does not prescribe how to do policy analysis per se, it does offer one approach to assessing the extent to which a given policy is consistent with promoting social

inclusion and human rights. 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 systematically review health policies in terms of their technical content and design, and can be useful in promoting social inclusion and human rights in the development of new policies. It has been asserted that while the number of persons with disabilities is increasing globally, this is not reflected by the coverage of this group in relevant policies.^{16,17,18} Accordingly, the research team took particular interest in assessing the degree to which persons with disabilities (identified by EquiFrame as a vulnerable group) were incorporated in policy documents for the purpose of promoting more accessible health care.

Before describing the development and application of EquiFrame, this paper briefly contextualizes the framework within the setting of recent perspectives on equity in health care, alongside recent developments within health policy analysis, with a particular emphasis on low-income countries. It then outlines 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 two existing (Northern) Sudanese health policies: the Health Policy of (Northern) Sudan and the National Drug Policy of (Northern) Sudan. We conclude with recommendations and limitations for the use of the EquiFrame methodology, while emphasizing its flexible and adaptive nature to a broad range of policy and policy-related questions.

BACKGROUND

Equity in health care

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.”¹⁹ That declaration, written more than three decades ago, aspired for all countries to employ the Health for All concept when formulating policies and action plans, for the purposes 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. Equity in health may be defined as “the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage.”²⁰ 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.”²¹

Equity “is an ethical principle; it also is consonant with and closely related to human rights principles.”²⁰ Both human rights principles and equity impose striving for equal opportunities in health for population groups that have historically suffered discrimination or social marginalization.^{7, 22} Braveman and Gruskin state 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.”²² They stipulate “institutionalizing the systematic and routine application of equity and human rights perspectives to all health sector actions.” Correspondingly, Tamburlini contends that current trends in the global economy, in the environment, and in 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 realized 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.²³ Bloom emphasizes that the challenge for governments is to focus on policy-relevant inequalities and to certify that their own actions are pro-equity.²⁴ Equity is a propitious political message indicating social solidarity and fortifying a pro-poor political agenda.²⁵

Health policy analysis

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 unintended consequences of policy decisions and the obstacles that are encountered during policy implementation.²⁶ “In an environment fraught with risks and opportunities, comprehensive policy analysis will increasingly be called upon to illuminate the path of progress.”²⁷

Policy analysis can contribute to realizing health

Table 1: EquiFrame key questions and key language of core concepts

Number	Key Language	Key Question	Core Concept	Supporting Literature
1	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (for example, disability, age, ethnicity, proximity to services).	Does the policy support the rights of vulnerable groups with equal opportunity in receiving health care?	Non-Discrimination	8 13 39 49 51 52
2	Vulnerable groups receive appropriate, effective, and understandable services.	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Individualized Services	9 46 49
3	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grant.	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	Entitlement	8 11 49 53 54
4	For instance, peer-to-peer support among female-headed households or shared cultural values among ethnic minorities.	Does the policy recognize the capabilities existing within vulnerable groups?	Capability-Based Services	48 55 56
5	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.	Does the policy support the right of vulnerable groups to participate in the decisions that affect their lives and enhance their empowerment?	Participation	8 23 49 57 58 59

Table 1: EquiFrame key questions and key language of core concepts

Number	Key Language	Key Question	Core Concept	Supporting Literature
6	Vulnerable groups know how services should interact where inter-agency, intra-agency, and intersectoral collaboration is required.	Does the policy support assistance of vulnerable groups in accessing services from within a single provider system (intra-agency) or more than one provider system (inter-agency) or more than one sector (intersectoral)?	Coordination of Services	7 11 49 57 60 61
7	Vulnerable groups are protected from harm during their interaction with health and related systems.	Are vulnerable groups protected from harm during their interaction with health and related systems?	Protection from Harm	8
8	Vulnerable groups are protected from unwarranted physical or other confinement while in the custody of the service system/provider	Does the policy support the right of vulnerable groups to be free from unwarranted physical or other confinement?	Liberty	48 49 62
9	Vulnerable groups can express “independence” or “self-determination.” For instance, a person with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice.	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?	Autonomy	4 8 49 59
10	Information regarding vulnerable groups need not be shared among others.	Does the policy address the need for information regarding vulnerable groups to be kept private and confidential?	Privacy	8 13 52

Table 1: EquiFrame key questions and key language of core concepts

Number	Key Language	Key Question	Core Concept	Supporting Literature
11	Vulnerable groups are not barred from participation in services that are provided for general population.	Does the policy promote the use of mainstream services by vulnerable groups?	Integration	49 57
12	Vulnerable groups make a meaningful contribution to society.	Does the policy recognize that vulnerable groups can be productive contributors to society?	Contribution	12
13	The policy recognizes the value of family members of vulnerable groups as a resource for addressing health needs.	Does the policy recognize the value of the family members of vulnerable groups in addressing health needs?	Family Resource	13
14	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support.	Does the policy recognize that individual members of vulnerable groups may have an impact on the family members, requiring additional support from health services?	Family Support	49 57 62
15	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, that is, respectful of the culture of vulnerable groups.	Does the policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic aspects of the person?	Cultural Responsiveness	11 13 54 57

Table 1: EquiFrame key questions and key language of core concepts

Number	Key Language	Key Question	Core Concept	Supporting Literature
16	Vulnerable groups have access to internal and independent professional evaluation or procedural safeguard.	Does the policy specify to whom, and for what, services providers are accountable?	Accountability	8 24 49 52 61
17		Does the policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?	Prevention	8 11 13 57 64
18		Does the policy support the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?	Capacity Building	7 8 49 57 59
19	Vulnerable groups have accessible health facilities (that is, transportation; physical structure of the facilities; affordability and understandable information in appropriate format).	Does the policy support vulnerable groups –physical, economic, and information access to health services?	Access	8 13 58 60 65
20	Vulnerable groups are assured of the quality of the clinically appropriate services.		Quality	8 11 13 54 57
21		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?	Efficiency	60 66 67

objectives and to unravelling the complex mechanisms of power and process that underpin change.²⁸ Importantly, 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. This methodology can ultimately contribute to more measured consideration concerning how to progress, and from there, concrete policy can materialize.²⁹ While health policy analysis is widely recognized as a critical process, a number of challenges are inherent to this process. 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 a paucity of literature that outlines and uses an analytical framework to analyze the content of policies “on the books.”³⁰ There is also a modest body of research on the process of health policy development, with a limited number of frameworks that have been devised to address process issues, including the “stages” models; policy triangle framework; network frameworks; and policy space analysis.^{26, 31, 32, 33, 34} There are also theories that attempt to explain and understand the policy process. These include multiple streams theory; punctuated equilibrium theory; implementation theory; and critical theory approach.^{35, 32, 31, 36} Despite these frameworks and theories, there is a limited body of research on their application in the process of health policy development.²⁶

Profile of equity in health policy analysis

Braveman and Gruskin indicate that “assessing health equity requires comparing health and its social determinants between more and less advantaged social groups,” and such comparisons are essential to assess whether national and international policies are leading toward or away from greater equity in health.²⁰ There are two assertions made here. First, that the content of the health policies actually include core concepts related to equity and human rights; and second, that measurement is available to ascertain the disparities. Neither assertion is evident in Gilson and Raphaely’s extensive review of the published literature.³⁷ For example, while persons with disabilities are acknowledged as being significantly socially disadvantaged, there are no international or national comparative data available on disability and health. This is due in part to measurement challenges as well as difficulties in operationalizing definitions of equity and identify-

ing core concepts of human rights linked to equity in health care. Another potentially influential factor is the prevailing focus on the process of the development of health policies, with less attention being given to the development of analytical frameworks for establishing existing policies’ commitments.

“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 generalization problematic.^{31, 32} In HICs, this process is well received and recognized within academic circles, but in LMICs, it remains underused.^{26, 28, 37} Gilson and Raphaely note that less attention has been given to how to perform a policy analysis and little guidance exists with regards to research designs and theories.³⁷ In their review of published literature from 1994 to 2007, they indicate that many of the reviewed studies either offered little detail or covered too many issues, without reference to empirical or theoretical context, making little effort to reflect on interpretations and consider the relevance of their findings. They recommend increasing the diversity of methods used and 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 policymakers. Our focus has thus been on developing a framework to guide policy analysis in terms of what actually exists “on the books,” and doing so from a LMIC perspective.

THE PROCESS OF EQUIFRAME DEVELOPMENT

With the intention of developing a health policy analysis framework that would be of particular relevance in low-income countries in general, and in Africa in particular, team members across Sudan, Malawi, Namibia, South Africa, Norway, and Ireland undertook literature searches and discussions with colleagues to identify potential frameworks that could address the principles of universal, equitable and accessible health services. The team members incorporated universities, research organizations, and non-governmental organizations. Although we were unable 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; the right to the highest attainable standard of health—and in particular the need to address health inequalities—and current thinking in health policy analysis more broadly.^{30, 38, 39, 40, 26, 41} The Stowe and Turnbull approach, while specific to persons with disabilities and developed for use in North America, had many features relevant to our own interests. Therefore, we used some of the concepts they had identified, revised others, and developed more from elsewhere. As indicated in the following section, the literature from which all of our core concepts of human rights were derived is identified in Table 1, and the basis for concept amalgamation is outlined.

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 more than 100 participants drawn from relevant clinicians and practitioners, civil servants, elected government representatives, non-governmental organizations (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. The information gained from these workshops was incorporated into the framework outlined below and into the manual. 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. On that occasion, novice users of the framework gave feedback on how to make the framework more user friendly, suggesting, for instance, simpler labels for core concepts and simpler definitions of those concepts.⁴² Finally, feedback from conference presentations and high-level meetings have helped shape EquiFrame (for example, MacLachlan et al; Dube et al; Mannan et al).^{43, 44, 45} Feedback and expert advice from a variety of sources beyond our own project team (see www.equitableproject.org) has, therefore, helped to shape and add authority and representativeness to the version of EquiFrame presented below.

Our aim was to develop a framework to assess “core concepts (that) inform the analyst concerning what the policy is, what it is intended to accomplish, and perhaps even what it does accomplish,” and to ascertain the vulnerable groups included in health policies.³⁰ The resultant EquiFrame is a framework for analyzing 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 well the policy advances the core concepts of human rights for health among vulnerable groups.

Our aim was to develop a framework to assess “core concepts (that) inform the analyst concerning what the policy is, what it is intended to accomplish, and perhaps even what it does accomplish,” and to ascertain the vulnerable groups included in health policies.³⁰ The resultant EquiFrame is a framework for analyzing 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 well the policy advances the core concepts of human rights for health among vulnerable groups.

THE FRAMEWORK

Our policy analysis framework was developed to ensure that researchers across our four countries explored different health policies from a common starting point, proceeding systematically and using a standard scoring system. The emergent EquiFrame methodology was used to analyze health policy documents in terms of coverage of core concepts and vulnerable groups included in the policy documents. 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 included, and (d) provides a data extraction matrix to chart the analyzed documents.

Core concepts

Core concepts for relevant principles (universal, equitable, and accessible) were identified and the available definitions were extracted from the above and related literature, resulting in 37 core concepts. Through group discussion, email consultation with the project team, and stakeholder meetings, these concepts were refined and, where possible, integrated, resulting in the 21 core concepts illustrated in Figure 1. These stakeholder meetings, held between April and July 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 were attended by policy analysts and researchers from relevant ministries, including health and social affairs and civil society organizations, including organizations of persons with disabilities.

The reduction from 37 to 21 core concepts was necessary to make subsequent policy analysis manageable and to have categories that were sufficiently discrete. Specifically, the core concept of access, used in the current framework, was derived from the consolidation of eight preliminary core concepts corresponding to accessibility derived from the literature.^{8, 46, 47} The core concept of non-discrimination was derived from the synthesis of a further six concepts^{8, 30, 46}; capacity building was derived from the merging of two concepts^{30,47}; cultural responsiveness was derived from the consolidation of two concepts^{8,30}; protection from harm was derived from the synthesis of two concepts^{46, 48}; and individualized services was derived from the amalgamation of a further two concepts.^{46, 49} The resulting 21 core concepts were not established as necessarily being of equal importance but rather as representing a range of salient concerns to be addressed in striving for equitable, accessible, and universal health care.

The core concepts were identified in existing health policies by two researchers who independently analyzed the documents. When a reference to a core concept was identified, the extent to which the concept was addressed was ascertained using a series of key questions and key language (Table 1), each series tailored to elucidate the specified core concept. (See Mannan et al for a fuller discussion of EquiFrame.)⁵⁰

Vulnerable groups

While the term “vulnerability” is one of the most frequently used terms in social science research, difficulties arise when it comes to applying this concept as a tool for measurement and analysis. Vulnerable groups may be defined as social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality.¹²

This definition squares with the idea that vulnerability should be related to claims for special protection (for instance, in health policies), where there is a) a greater likelihood of people experiencing “wrongs,” and b) a duty to avoid identifiable “wrongs.”⁶⁸ The inclusion of vulnerable groups is an ethical imperative for health policy, and requires the development of appropriate indicators.⁶⁹ Furthermore, the social

determinants approach to public health sees the identification of vulnerable population groups and the causes of differential vulnerability as being of critical importance, allowing us to sensitize vulnerable populations to the health benefits of programs, extend service coverage, and reduce barriers to access—all key components of inclusive health.^{70, 71} However, quantifying vulnerability is challenging, as is identifying just who is to be considered “vulnerable.” This concept needed to be clarified in order to reinforce its heuristic capacity and political and practical relevance. To draw up a comprehensive list of appropriate social groups, we conducted a literature review spanning the international and national literatures. The resulting list was then refined and integrated to produce a categorization that would be credible across the four project countries, as well as regional and international health policies. However, it was evident that there was also a need for flexibility for the purpose of accommodating any additional country-specific groups, where integration of them into another theme might miss the opportunity to provide valuable information. The vulnerable groups outlined by EquiFrame are provided in Table 2, and resonate with the “Social Determinants Approaches to Public Health” report.⁷⁰

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 (CC) received a score 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.

Table 2: EquiFrame vulnerable groups definitions

Number	Vulnerable Group	Attributes or Definitions
1	Limited Resources	Poor people or people living in poverty
2	Increased Relative Risk for Morbidity	People with one of the top ten illnesses identified by WHO as occurring within the relevant country
3	Mother-Child Mortality	Factors affecting maternal and child health (0-5 years)
4	Female-Headed Household	Households headed by a woman
5	Children with Special Needs	Children marginalized by special contexts, such as orphans or street children
6	Aged	Referring to older age
7	Youth	Referring to younger age without identifying gender
8	Ethnic Minorities	Non-majority groups in terms of culture, race, or ethnic identity
9	Displaced Populations	People who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence
10	Living Away from Services	People living far from health services, either in travel time or distance
11	Suffering from Chronic Illness	People who have an illness requiring continuous care
12	Disabled	Persons with disabilities, including physical, sensory, intellectual, or mental health conditions, and including synonyms of disability

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 (for example, “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 references to core concepts.

Summary indices

The four summary indices of EquiFrame are as follows:

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 (see Mannan et al).⁵⁰

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.

Core concept quality: A policy was examined with respect to the number of core concepts within it that

were rated 3 or 4 out of the 21 core concepts identified; 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 concept.

Each document was given an *overall summary ranking* in terms of it being of low, moderate, or high standing according to the following criteria:

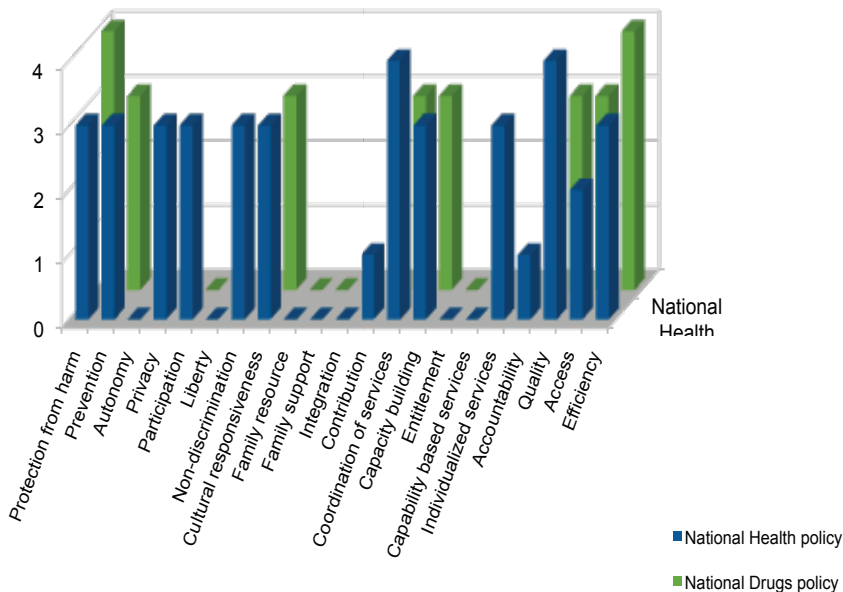
- (i) High = if the policy achieved $\geq 50\%$ on all of the three scores above.
- (ii) Moderate = if the policy achieved $\geq 50\%$ on two of the three scores above.
- (iii) Low = if the policy achieved $< 50\%$ on two or three of the three scores above.

ANALYSIS OF THE NATIONAL HEALTH POLICY OF SUDAN AND DRUG POLICY OF SUDAN

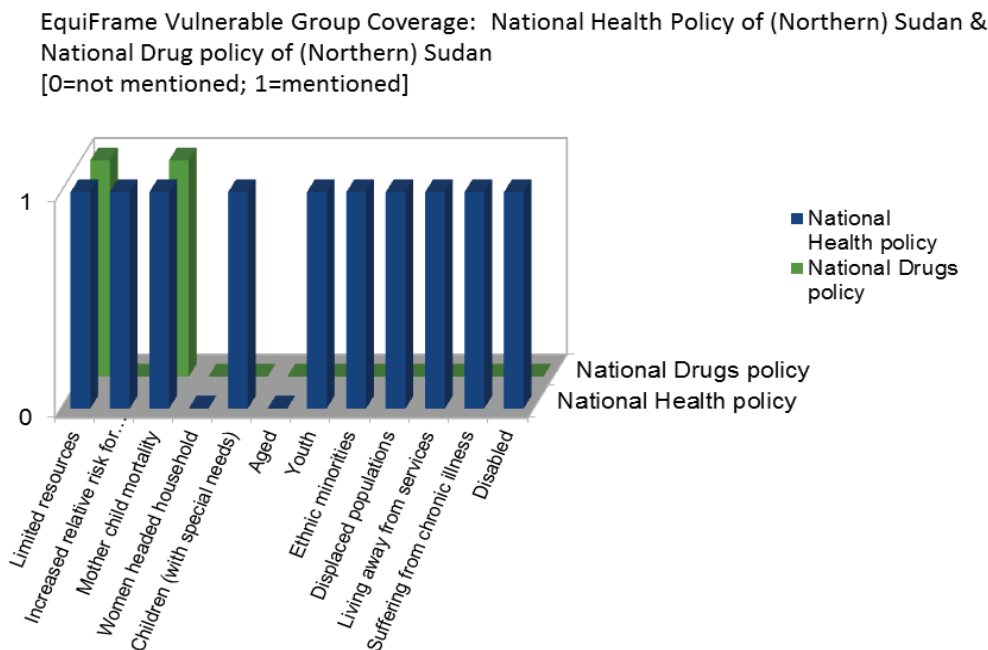
Based on these indices, more than 70 health policies from the four African country partners were assessed with regards to core concept coverage, vulnerable group coverage, and core concept quality and were given an overall summary ranking in relation to core concepts and vulnerable groups. In this paper, we present the analyses of only two policies to illustrate the application of EquiFrame to disparate types of policies. These two policies are the National Health Policy of Sudan and the Drug Policy of Sudan, and they have been chosen because the Sudanese team, based at Ahfad University for Women, led the policy analysis work package that produced the EquiFrame policy analysis framework. For the analysis of all policies, two members of the research team independently applied EquiFrame to analyze each of the policies. Where difference of interpretation occurred

Graph 1: EquiFrame core concept coverage

EquiFrame Core Concept Coverage: National Health Policy of (Northern)Sudan & National Drug Policy of (Northern) Sudan
 [0=Core Concept not mentioned; 1=Concept only mentioned; 2=Concept mentioned and explained; 3=Specific policy actions identified to address the Concept; 4=Intention to monitor the Concept expressed]



Graph 2: EquiFrame vulnerable group coverage



these were addressed by subsequent discussion, until a consensus position was agreed between the raters.

The National Health Policy of Sudan (2007) has been formulated within the context of a comprehensive peace agreement which puts an end to the many years of conflict that disrupted the country's social service institutions, including its health institutions and services. The policy is framed within the remits of the relevant provisions of the interim Constitution of Sudan, from 2005, the Local Government Act from 2003, and the resolute state laws and decrees which have introduced and institutionalized decentralized federalism in the country. Furthermore, the policy draws from and builds on the 25-year health strategy and existing policies relating to reproductive health, child health, HIV/AIDS, the national drugs policy, the essential primary health care package, and the 10-year human resources strategy. It also reiterates national and international commitments, such as the Alma-Ata Declaration and the Health for All strategy, the Millennium Summit Declaration, and other global strategies such as Roll Back Malaria (RBM), Stop TB, and the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, including HIV/AIDS. The General Directorate of Health

Planning and Development (FMOH) took the lead in drafting this document, supported by a drafting committee comprised of national consultants, representatives of UN agencies (WHO and UNICEF), representatives of the General Directorates in the Federal Ministry of Health, and many other individuals who assisted in the work to accomplish this task. A consensus-building workshop was held on May 12 and 13, 2007, in Khartoum to enrich this document. The process began in 2001 and has passed through many phases, essentially iterative, of assessing the situation, reviewing a host of background documents, and at times, collecting empirical data.

The National Health Policy of Sudan addressed 14 of the 21 core concepts outlined by EquiFrame (67%) (see Graph 1). The most frequently occurring concepts included prevention, non-discrimination, coordination of services, capacity-building, and access. A number of concepts were not mentioned in the policy: autonomy, liberty, family resource, family support, integration, entitlement, and capability-based services. Eleven concepts were rated as having a level 3 or 4 quality of commitment, that is, specific policy actions were identified that addressed the concept, or an intent to monitor the concept was expressed.

Table 3: EquiFrame Summary Indices: National Health Policy of (Northern) Sudan and National Drugs Policy of (Northern) Sudan

Policies	VG%	CC%	% of CC Quality Between 3 to 4	Quality of Policy
National Health Policy	83	67	52	High
Drugs Policy	17	38	100	Low

These concepts are protection from harm, prevention, privacy, participation, non-discrimination, cultural responsiveness, coordination of services, capacity-building, individualized services, quality, and efficiency.

All vulnerable groups were mentioned in this document with the exception of two: female-headed households and aged (see Graph 2). The most frequently mentioned vulnerable groups comprised limited resources, increased relative risk for morbidity, ethnic minorities, and disabled. However, most of the concepts were mentioned in a universal way, defined in terminologies such as the whole population, citizens, or people of Sudan, vulnerable and professional, and health institutions. Four vulnerable groups: mother child mortality, children (with special needs), youth, and living away from services, were mentioned only once. The policy scored 83% with respect to vulnerable group coverage; 67% on core concept coverage and 52% on core concept quality. The overall summary ranking of the policy was rated to be high (Table 3).

The National Drug Policy document is based on the 1981 action program on essential drugs (DAP) and the policy aims to provide drugs in a safe, effective, and quality manner; enhance judicious usage of drugs; and provide advanced pharmacological service. The document addressed eight of the 21 core concepts, namely, protection from harm, prevention, cultural responsiveness, coordination of services, capacity-building, quality, access, and efficiency (Graph 1). All concepts that were mentioned were rated at a level 3 or 4 quality of commitment to the concept, that is, specific policy actions were identified that addressed the concept or an intention to monitor the concept was expressed. In terms of quality of commitment to core concepts, the concepts protec-

tion from harm and efficiency received the highest score of 4, that is, an intention to monitor these concepts was expressed. The remaining concepts were mentioned with reference to specific policy actions that addressed the concepts, and were therefore given a quality rating score of 3.

Only two vulnerable groups, namely individuals with limited resources and mother-child mortality, were explicitly mentioned in the document (Graph 2). The Drugs Policy for Sudan scored 17% on vulnerable group coverage; 38% on core concepts coverage; and 100% on core concept quality. The overall summary ranking of the policy was rated to be low (Table 3).

DISCUSSION

The above results are intended to illustrate how EquiFrame can be used to illuminate aspects of human rights and social inclusion in two policies that have quite different foci. While these policies address very broad and quite specific remits, respectively, the application of the EquiFrame methodology has revealed important results relevant to social inclusion and human rights. For instance, the National Health Policy included 83% of vulnerable groups and 67% of core concepts, 52% of which were mentioned at a quality rating of 3 or 4. In contrast, the Drugs Policy of Sudan included only 17% of vulnerable groups, and 38% of core concepts, although all of these concepts received a quality rating of 3 or 4. Accordingly, the National Health Policy and National Drug Policy received an overall quality rating of high and low, respectively. These findings are illustrative of the manner in which EquiFrame can be applied to reveal the disparate quality of health policies, both across and within countries, in terms of commitment to core concepts of human rights and inclusion of vulnerable groups.

Ultimately, EquiFrame allows one to evaluate – to measure – the extent of inclusion and prominence of rights accorded to persons with disabilities and other vulnerable groups in policy and planning documents. This is important as, according to the old adage, “What gets measured gets done.” The framework was developed with regard to health policy documents with the motivation to contribute to enhancing equity in service delivery and access to health care. It is hoped that health policies instituted on the values and importance of equity are more likely to result in health services that are more fairly distributed within the population. This paper has sought to give an introductory overview of the framework and provide some comparative analysis.

Both through the process of undertaking this research and feeding the results back to stakeholder workshops in each of the four countries, we have noted several factors that are important to consider when interpreting the results of EquiFrame, 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,” “strategic plans,” or “programs.” 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 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 differ considerably with regard to social inclusion.

In our country feedback workshops, some stakeholders argued that some documents use the term “all,” as in “all people” to be fully inclusive, making it unnecessary to reference specific vulnerable groups. 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, since the use of inclusive terminology does not necessarily address the concerns of specific vulnerable groups.

While EquiFrame has been developed for the purposes of policy analysis, we do believe that its form of analysis can also be usefully applied 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 always be and should always be strengthened by 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.

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.³² 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 exist-

ing 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 checklist of factors for consideration, as well as indicating specific terms and phrasing for use in a policy.

In order to realize the hope that better policies will be associated with better health care, empowerment and social inclusion of vulnerable and marginalized groups must occur in the process of policy development and efforts to implement such policies, as well as in policy documents. The practice of privilege, power, and dominance, in local and national policy contexts, and also in the context of programs supported through international aid, will continue to undermine aspirations for equity.^{28, 72} Without inclusive and effective means of policy development and implementation, “policy on the books” will be inert. Perfectly equitable health policies will only contribute to social inclusion if cognate policies in other sectors embrace similar principles, and if they are translated in measurable actions. While this has not been the target of this paper, it is necessary for the potential benefits of better written policy to become a reality.

The universality of human rights is contested and it may be argued that interpretations are subject to cultural values and contextual realities.⁵¹ As such, any analysis of human rights or social inclusion in health policies is in itself necessarily going to reflect certain cultural and contextual factors. The reflexivity of the analyst – that is, their awareness of their positioning and how this affects their understanding of a policy – is therefore of critical importance. Interpretations do not arise in isolation from who the analysis is done by, for whom and in what context. Although these complex issues are very important, it is equally important to recognize that in many instances the pragmatic reality of lived exclusion is hurtful, often resulting in needless mortality, and frequently all too easy to recognize by the failure to address it in health policies. The number of persons with disabilities is increasing globally, but this is not reflected by the coverage of this group in relevant policies.^{16, 17, 18} By and large, the extensive gap in access to health between disparate groups in low, middle, and high-income countries is well established.¹¹ In the context of low-income countries, where resources are scarce, marginalized 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. 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.⁷³ Equity in health is an astute and feasible political aspiration and our concerns with human rights and vulnerability complement progressive views pertaining to the need for health policies to be placed within a broader ethics framework.⁷⁴ If human rights and social inclusion do not underpin policy formation, however, it is unlikely that equity will be inculcated in service delivery. Through its discernment of policy commitment to core concepts of human rights and vulnerable groups, underpinned by the principle of health care that is universal and equitable, EquiFrame stands to promote the United Nations’ directive of health for all, with its implicit assumption of universal and equitable access to health care.

ACKNOWLEDGEMENTS

This research was funded by the European Commission Framework Programme 7, Project Title: Enabling Universal and Equitable Access to Healthcare for Vulnerable People in Resource Poor Settings in Africa, Grant Agreement No.: 223501.

REFERENCES

1. S. Gruskin, “Is there a government in the cockpit: A passenger’s perspective or global public health: The role of human rights,” in M. Freeman (ed), *The ethics of public health: Volume II* (London: Ashgate Publishing Limited, 2010), pp. 353-373.
2. S. Peckham and A. Hann, *Public health ethics and practice* (London: The Policy Press, 2010).
3. J. M. Mann, L. Gostin, S. Gruskin, T. Brennan, Z. Lazzarini, and H.V. Fineberg, “Health and human rights,” *Health and Human Rights: An International Journal* 1/1 (1994), pp. 6-23.
4. L. Gostin, J. M. Mann, and L. Gostin, “Towards the development of a human rights impact assessment for the formulation and evaluation of public health policies,” *Health and Human Rights: An International Journal* 1/1 (1994), pp. 58-80.

5. E. Zere, C. Mandlhate, T. Mbeeli, K. Shangula, K. Mutirua, and W. Kapenambili, "Equity in health care in Namibia: Developing a needs-based allocation formula using principle components analysis," *International Journal for Equity in Health* 6/3 (2007).
6. A. Bhuiya, S. Hanifi, F. Urni, and S.S. Mahmood, "Three methods to monitor utilization of healthcare services by the poor," *International Journal for Equity in Health* 8/29 (2009).
7. G. Backman, P. Hunt, R. Khosla, C. Jaramillo-Strouss, B.M. Fikre, C. Rumble, D. Pevalin, D. Acurio Páez, M. Armijos Pineda, A. Frisancho, D. Tarco, M. Motlagh, D. Farcasanu, D., and C. Viadescu, "Health systems and the right to health: An assessment of 194 countries," *Lancet* 372/9655 (2008), pp. 2047-2085.
8. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000). Available at <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En>
9. M. MacLachlan, H. Mannan, and E McAuliffe, "Access to healthcare of persons with disabilities as an indicator of equity in health systems," *Open Medicine* 5/1 (2011), pp. 10-12.
10. D.J. Block, *Healthcare outcomes management: Strategies for planning and evaluation* (Sudbury, MA: Jones and Bartlett Publishers, 2006).
11. T. Ensor and S. Cooper, *Overcoming barriers to health service access and influencing the demand side through purchasing*, Health, Nutrition and Population (HNP) Discussion Paper (Washington, D.C., International Bank for Reconstruction and Development/World Bank, 2004).
12. L. London, "Issues of equity are also issues of rights: Lessons from experiences in South Africa," *BMC Public Health* 7/14 (2007), pp. 1-10.
13. Office of the United Nations High Commissioner for Human Rights and World Health Organization, *The Right to Health* (2008). Available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>.
14. The Bamako Call to Action on Research for Health (2008). Available at <http://www.who.int/rpc/news/BAMAKOCALLTOACTIONFinalNov24.pdf>.
15. World Health Organization, WHO European Ministerial Conference on Health Systems: Health Systems. Health and Wealth, June 25-27, 2008, *The Tallinn Charter: Health Systems for Health and Wealth* (2008).
16. R. Wiman, E. Helander, and J. Westland, *Meeting the needs of people with disabilities – New approaches in the health sector* (Washington, D.C.: World Bank, 2002). Available at <http://bvs.per.paho.org/texcom/cd048370/meeting.pdf>
17. N. Groce, "HIV/AIDS and Disability," *Health and Human Rights: An International Journal* 8/2 (2005), pp. 215-225.
18. M. MacLachlan and L. Swartz, *Disability and international development: Towards inclusive global health* (New York: Springer, 2009).
19. International Conference on Primary Health Care: *Declaration of Alma-Ata*, Alma-Ata, USSR, September 6-12, 1978.
20. P. Braveman and S. Gruskin, "Defining equity in health," *Journal of Epidemiology and Community Health* 57/4 (2003), pp. 254–258.
21. M. Whitehead, "The concepts and principles of equity and health," *Int J Health Serv* 22/3 (1992), pp. 429-445.
22. P. Braveman and S. Gruskin, "Poverty, equity, human rights and health," *Bull World Health Organ* 81/7 (2003), pp. 539-45.
23. G. Tamburlini, "Promoting equity in health," *Health Policy and Development* 2/3 (2004), pp. 186-191.
24. G. Bloom, "Equity in health in unequal societies: Meeting health needs in contexts of social change," *Health Policy* 57 (2001), pp. 205-224.
25. EQUINET, *Taking forward the equity watch in East and southern Africa* (2009). Available at <http://www.equinet africa.org/bibl/docs/EWmtg%20repNov09.pdf>

26. L. Gilson, K. Buse, S. Murray, and C. Dickinson, "Future directions for health policy analysis: A tribute to the work of professor Gill Walt," *Health Policy and Planning* 23/5 (2008), pp. 291-293.
27. J. Frenk, "Comprehensive policy analysis for health system reform," *Health Policy* 32 (1995), pp. 257-277.
28. Overseas Development Institute, *How can the analysis of power and process in policy-making improve health outcomes?* (London: ODI, 2007)
29. N. Ford, A. Calmy, and S. Hurst, "When to start antiretroviral therapy in resource-limited settings: A human rights analysis," *BMC International Health and Human Rights* 10/6 (2010).
30. M.J. Stowe and H.R. Turnbull, "Tools for analyzing policy on the books and policy on the streets," *Journal of Disability Policy Studies* 12/3 (2001), pp. 206-214.
31. M. Exworthy, "Policy to tackle the social determinants of health: Using conceptual models to understand the policy process," *Health Policy and Planning* 23/5 (2008), pp. 318-327.
32. G. Walt, J. Shiffman, H. Schneider, S.F. Murray, R. Brugha, and L. Gilson, "'Doing' health policy analysis: Methodological and conceptual reflections and challenges," *Health Policy and Planning* 23/5 (2008), pp. 308-317.
33. S. Tantivess and G. Walt, "The role of state and non-state actors in the policy process: The contribution of policy networks to the scale-up of antiretroviral therapy in Thailand," *Health Policy and Planning* 23/5 (2008), pp. 328-338.
34. J. Crichton, "Changing fortunes: Analysis of fluctuating policy space for family planning in Kenya," *Health Policy and Planning* 23/5 (2008), pp. 339-350.
35. J.W. Kingdon, *Agendas, alternatives and public policies*. (Boston: Little, Brown, 1984).
36. S. Duncan and L. Reutter, "A critical policy analysis of an emerging agenda for home care in one Canadian province," *Health and Social Care in the Community* 14/3 (2006), pp. 242-253.
37. L. Gilson and N. Raphaely, "The terrain of health policy analysis in low and middle income countries: A review of published literature 1994-2007," *Health Policy and Planning* 23/5 (2008), pp. 294-307.
38. A. Reichard, T.M. Sacco, and R. Turnbull, "Access to health care for individuals with developmental disabilities from minority backgrounds," *Mental Retardation* 42/6 (2004), pp. 459-470.
39. P. Braveman, "Health disparities and health equity: Concepts and measurement," *Annu Rev Public Health* 27 (2006), pp. 167-194.
40. A. Oliver, A. Healey, and J. Le Grand, "Addressing health inequalities," *Lancet* 360/9332 (2002), pp. 565-567.
41. S. Russell and L. Gilson, "Are health services protecting the livelihoods of the urban poor in Sri Lanka? Findings from two low-income areas of Colombo," *Social Science & Medicine* 63/7 (2006), pp. 1732-1744.
42. A. Munthali, H. Mannan, and M. MacLachlan, "Social Inclusion and Health Policies. National Workshop for Health Policy Makers and Policy Analysts," (workshop at Lilongwe, November 8 and 9, 2010).
43. M. MacLachlan, H. Mannan, M. Amin, A. Munthali, G. Van Rooy, L. Swartz, and A. Eide, "Universal access to healthcare and vulnerable populations in resource poor settings" (presentation at Bamako Global Health Ministerial Summit, 2008).
44. A.K. Dube, M. MacLachlan, M. Amin, and H. Mannan, "Equitable Access to Healthcare and Persons with Disabilities" (presentation at African Union Social Affairs Ministerial Summit, Khartoum, November 21-23, 2001).
45. H. Mannan, M. Amin, M. MacLachlan, and S El Tayeb, "EquiFrame: A new framework for evaluating and developing equity and inclusion through health policy research and planning" (presentation at First Global Symposium on Health System Research, Montreux, November 16-19, 2010).
46. B.R. Connell, M. Jones, R. Mace, J. Mueller et al, *The Principles of Universal Design*. (1997). Available at

- http://www.ncsu.edu/www/ncsu/design/sod5/cud/about_ud/udprinciplestext.htm.
47. S. Stevens, "Equity and choice: Can the NHS offer both? A policy perspective," in A. Oliver (ed), *Equity in health and health care: Views from ethics, economics and political science*. (London: The Nuffield Trust, 2003), pp. 65-69.
48. H.R. Turnbull, G. Beegle, and M.J. Stowe, "The core concepts of disability policy affecting families who have children with disabilities," *Journal of Disability Policy Studies* 12/3 (2001), pp. 133-143.
49. H.R. Turnbull and M.J. Stowe, "A taxonomy for organizing the core concepts according to their underlying principles," *Journal of Disability Policy Studies* 12/3 (2001), pp. 177-197.
50. H. Mannan, M. Amin, M. MacLachlan and the EquiAble Consortium, *The EquiFrame manual: A tool for evaluating and promoting the inclusion of vulnerable groups and core concepts of human rights in health policy documents* (Dublin: Global Health Press, 2011).
51. M. MacLachlan, *Culture & health: A critical perspective towards global health*, 2nd ed. (Chichester: Wiley, 2006).
52. World Health Organization, *25 Questions & Answers on Health & Human Rights*. (Geneva: WHO, 2002) Available at http://www.who.int/hhr/activities/en/25_questions_hhr.pdf.
53. T. Ensor and S. Cooper, "Overcoming barriers to health service access: Influencing the demand side," *Health Policy and Planning* 19/2 (2004), pp. 69-79.
54. M. Goddard and P. Smith, "Equity of access to health care services: Theory and evidence from the UK," *Social Science and Medicine* 53/9 (2001), pp. 1149-62.
55. S.B. Rifkin, "A framework linking community empowerment and health equity: It is a matter of CHOICE," *Journal of Health, Population and Nutrition* 21/3 (2003), pp. 168-180.
56. A. Sen, *The idea of justice* (London: Allen Lane, 2009).
57. World Health Organization, *Equity, social determinants and public health programmes* (Geneva: World Health Organization, 2010).
58. World Health Organization, *A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2: Debates, Policy & Practice, Case Studies*. (2010). Available at <http://www.ossyr.org.ar/pdf/bibliografia/131.pdf>.
59. Pan American Health Organization, *Human rights and health: Persons with disabilities*. (Pan American Health Organization, 2008). Available at http://www.paho.org/english/dd/pub/10069_Disabilities.pdf.
60. P. Hunt and G. Backman, "Health systems and the right to the highest attainable standard of health," *Health and Human Rights: An International Journal* 10/1 (2008), pp. 81-92.
61. World Health Organization and Public Health Agency of Canada, *Health equity through intersectoral action: An analysis of 18 country case studies* (2008). Available at <http://www.phacaspc.gc.ca/publicat/2008/hetia18-esgai18/pdf/hetia18-esgai18-eng.pdf>
62. World Health Organization, *The case for change*. Background paper for the conference Better health, better lives: Children and young people with intellectual disabilities and their families (World Health Organization Regional Office for Europe, 2010).
63. M. MacLachlan, "Rehabilitation psychology and global health," in P. Kennedy (ed), *Oxford Handbook of Rehabilitation Psychology* (Oxford: Oxford University Press, 2011).
64. World Health Organization, Regional Office for South-East Asia, *Convention on the Rights of Persons with Disabilities: Roles and Responsibilities of the Health Sector: Information for Policy-Makers*. (World Health Organization, 2010).
65. V. La Rosa-Salas, and S. Tricas-Sauras, "Equity in health care," *Cuadernos de Bioética* 19/66 (2008), pp. 355-68.
66. R. Jacobs, P.C. Smith, and A. Street, *Measuring efficiency in health care: Analytical techniques and health policy*. (New York: Cambridge University Press, 2006).
67. M.J. Roberts, and M.R. Reich, "Ethical analysis

in public health,” *Lancet* 359/9311 (2002), pp. 1055-1059.

68. S.A. Hurst, “Vulnerability in research and health care: Describing the elephant in the room?” *Bioethics* 22/4 (2008), pp. 191-202.

69. N. Kenny and M. Giacomini, “Wanted: A new ethics field for health policy analysis,” *Health Care Analysis* 13/4 (2005), DOI: 10.1007/s10728-005-8123-3

70. E. Blas, J. Sommerfeld, and A.S. Kurup, *Social determinants approaches to public health: From concept to practice* (Geneva: World Health Organization, 2011). Available at http://whqlibdoc.who.int/publications/2011/97892241564137_eng.pdf.

71. M. MacLachlan, C. Khasnabis, and H. Mannan, “Inclusive Health,” *Tropical Medicine and International Health* (2011), DOI:10.1111/j.1365-3156.2011.02876.x

72. M. MacLachlan, S.C. Carr, and E. McAuliffe, *The aid triangle: Recognizing the human dynamics of dominance, justice and identity* (London: Zed, 2010).

73. M. Marmot, “Achieving health equity: From root causes to fair outcomes,” *Lancet* 370/9593 (2007), pp. 1153-1163.

74. M. Giacomini, N. Kenny, and D. DeJean, “Ethics frameworks in Canadian health policies: Foundation, scaffolding, or window dressing?” *Health Policy* 89 (2009), pp. 58-71, DOI:10.1016/j.health-pol.2008.04.010