ORIGINAL RESEARCH

Human Rights, Social Inclusion and Health Equity in International Donors' Policies

Arne Henning Eide[1]*, Mutamad Amin[2], Malcolm MacLachlan[3], Hasheem Mannan[4], Marguerite Schneider[5]

1. Chief Scientist at SINTEF Technology and Society, Norway
2. Professor, Director of Research, Afhad University for Women, Sudan
3. Professor, Centre for Global Health & School of Psychology, Trinity College Dublin, Ireland
4. Senior Research Fellow, Centre for Global Health & School of Psychology, Trinity College Dublin, Ireland
5. Research Officer, Department of Psychology, Stellenbosch University, South Africa

ABSTRACT

Background: *Health policies have the potential to be important instruments in achieving equity in health. A framework – EquiFrame - for assessing the extent to which health policies promote equity was used to perform an equity audit of the health policies of three international aid organizations.*

Objective: *To assess the extent to which social inclusion and human rights feature in the health policies of DFID (UK), Irish Aid, and NORAD (Norway).*

Method: *EquiFrame provides a tool for analyzing equity and quality of health policies with regards to social inclusion and human rights. Each health policy was analyzed with regards to the frequency and content of a predefined set of Vulnerable Groups and Core Concepts.*

Results: *The three policies vary but are all relatively weak with regards to social inclusion and human rights issues as defined in EquiFrame. The needs and rights of vulnerable groups for adequate health services are largely not addressed.*

Conclusion: *In order to enhance a social inclusion and human rights perspective that will promote equity in health through more equitable health policies, it is suggested that EquiFrame can be used to guide the revision and development of the health policies of international organizations, aid agencies and bilateral donors in the future.*

Limitations: *Analyses are limited to "policy on the books" and does not measure how effectively vulnerable groups are included in mainstream health policy work.*

***Corresponding Author:** Arne H Eide, Chief Scientist, SINTEF Technology and Society, Oslo, Norway. Email:arne.h.eide@sintef.no

Vol 23, No.4, 2012; doi 10.5463/DCID.v23i4.144

INTRODUCTION

The Millennium Development Goals (MDGs) (UN, 2000) have led to an increased focus on health services for poor and vulnerable groups, and to new binding legal rights legislations such as the Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2008) which is increasingly making donors and national authorities accountable for social inclusion.

Healthcare can be neither universal nor equitable if it is less accessible to some sections of society than to others. To promote equity in health, a strategy for inclusive health is needed that actively incorporates targeted measures to reach the most vulnerable groups (MacLachlan et al, 2011). Individuals with disability should be included as a major sub-population, since they are estimated to comprise 15 % of the world's population or more than one billion persons globally (WHO, 2011). Most low-income countries have been unable to offer access to publicly-funded comprehensive healthcare, and to provide the not-for-profit sector with necessary political, technical and financial support (Unger et al, 2009). A small but growing body of literature has documented and discussed access and quality problems with regard to health services for individuals with disabilities in low-income countries (Eide et al, 2011; WHO, 2011; Van Rooy et al, 2012). International health policy has been identified as a co-factor in the neglect of vulnerable groups, due to the emphasis on disease control rather than comprehensive health services for all (Unger et al, 2009).

International health policy is challenged by globalisation and changes in international relations (Kickbush, 2000). In addition to the increased transfer of health risks and the existing global health inequalities such as the serious shortage of health personnel in low-income countries, the consequence has been a weakening of nation states' capacity to ensure population health and to address important health determinants (op. cit.). There are a number of players involved in international health policy, such as international NGOs, philanthropists and new forms of partnerships including the UN system and others (Global Health Initiatives or GHIs), characterised as a "cross national policy patchwork" (Reinicke, 1998). A new organisational form has emerged within international health, from agency-based to network-based (Castells, 1996), creating a complex web with unclear lines of responsibility and accountability.

Gwatkin et al (2004) called for a concerted effort to ensure that health services reach disadvantaged groups, including revising current priorities and reorienting health systems towards the needs of the poor. International health policy is

regarded as an important factor in reaching comprehensive health services to all (Unger et al, 2009). It is therefore important to examine what health policies actually say and commit to, in terms of equity, social inclusion and human rights (Mannan et al, 2012). There is limited literature on research and frameworks to analyse "policy on the books" (Stowe & Turnbull, 2001), and the literature review of Gilson and Raphaely (2008) further shows the absence of systematic approaches to measure, compare and assess health equity.

This paper presents an analysis of the international health policies of three major donors. The authors have made a novel contribution to the field of health policy analyses by developing a framework – EquiFrame – to analyse social inclusion and human rights in health policies. EquiFrame (Amin et al, 2012) was developed as a tool for analysing the content of health policies with regard to how specific vulnerable groups are treated in the text of policy documents. It is based on the understanding that a number of groups need special attention at policy level, so that systematic efforts are made to ensure universal access to good quality health services. The research team was particularly interested in the extent to which people with disabilities feature in the health policies of donor countries. An understanding of disability in line with CRPD and the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) forms the basis of the analysis, which has a much broader understanding of the concept than may be expected currently at the policy level. When analysing the inclusion of disability and the implications of policies for individuals with disability, it is therefore necessary to bear in mind that a number of vulnerability factors are highly relevant within a broad definition of disability.

The research team focussed on aid agencies in Norway, Ireland and Britain, as it was aware of projects supported by each of these three countries. However the analysis that is reported covers all the vulnerable groups identified within EquiFrame.

Global Health Policies

Three global health policies from government aid agencies in Ireland (Irish Aid), U.K. (DfID) and Norway (NORAD) were analysed and compared. These policy documents are relevant as they are the current steering documents in the area of (global) health for government aid agencies in three industrialised (North-West) European countries. They do, however, differ in format, as one is a policy (Irish Aid), one is a strategy (DfID) and one document is in the form of an internal report (NORAD). The main issue was not to rank the documents according to a standard, but to use the developed methodology of EquiFrame to analyse how vulnerable groups and core concepts of human rights were included in them.

Table 1: International Health Documents analysed

Irish Aid Health Policy. Improving Health to Reduce Poverty (2004).

Irish Aid Health Policy has a comparatively good coverage of vulnerable groups. Although putting most emphasis on issues related to women and children, disability and mental illness are included, as well as more general terms such as marginalised groups and poor people.

Policy objectives:

- Address the determinants of ill-health
- Strengthen health systems to serve the poor more effectively
- Promote health strategies that meet the needs of the poor and marginalised
- Contribute to an effective international response to health needs of the poor
- Ensure a coherent approach to health improvement and health protection in all Irish Aid's work

NORAD Report 1/2003. Health in Development Co-operation. Norwegian Agency for Development Co-operation (2003).

The NORAD document is largely on a systems level and focusing the role of NORAD internationally.

NORAD gives priority to the following:

- That Norwegian support to health in partner countries is seen in a big picture, and based on the countries' own strategies for poverty reduction and achievement of the MDGs.
- Interaction between different actors and funders that contribute to building countries' capacity for planning, funding and documenting.
- Health system and health reform capacity, focusing personnel, medicine, health information systems and health funding
- Capacity about HIV/AIDS, TB, reproductive health (youth and mothers)

Health is Global. A UK Government Strategy 2008 – 2013.

This strategy document focuses largely on broad systems and organisational level issues. Mothers and children are particularly mentioned and there are references to other individual level problems (mental health, injuries). By and large, vulnerable groups are, however, not visible in the text. The strategy sets out five areas for action:

- Better global health security
- Stronger, fairer and safer systems to deliver health
- More effective international health organisations
- Stronger, freer and fairer trade for better health
- Strengthening the way we develop and use evidence to improve policy and practice

EquiFrame

This framework was developed with a view to contribute towards enhancing equity in healthcare (Mannan et al, 2011; Amin et al, 2012). EquiFrame identifies the degree of commitment of a given policy to specified vulnerable groups and to core concepts of human rights. Social inclusion and human rights are seen as key components of equity in the context of service provision, and it is assumed 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 Organisation (2008), that priority is given to vulnerable groups because healthcare founded on equity contributes to the empowerment and social inclusion of such groups. EquiFrame has been developed deliberately to focus on the assessment of "policy on the books". It is not intended as an alternative but rather as complementary to the related and complex processes involved in assessing the development, implementation and evaluation of policy.

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 the Sudan, Malawi, Namibia, South Africa, Norway and Ireland, incorporating universities, research organisations and non-governmental organisations, undertook literature search and discussions with colleagues in the field. This helped to identify key themes around human rights, the right to health, and vulnerability, which were of relevance across a variety of health service delivery contexts and particular health equity challenges. The development of EquiFrame has drawn on several existing approaches, including the core concepts of disability policy as developed by Turnbull and colleagues Reichard, Sacco, & Turnbull, 2004; Stowe and Turnbull, 2001); the right to the highest attainable standard of health; the need to address health inequalities, as well as other current literature in health policy analyses (Stowe & Turnbull 2001; Oliver et al, 2002; Reichard et al, 2004; Braveman, 2006; Russel & Gilson, 2006; Gilson et al, 2008).

Table 2: Core Concepts and Key Questions in EquiFrame

Core Concept	Key Language	Key Question
Non-discrimination	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?
Individualised services	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?
Entitlement	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?
Capability-based Services	For instance, peer-to-peer support among female-headed households or shared cultural values among ethnic minorities	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?
Participation	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultations 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?
Coordination of services	Vulnerable groups know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required	Does the policy support assistance of vulnerable groups in accessing services from within a single provider system (inter-agency) or more than one provider system (intra-agency) or more than one sector (inter-sectoral)?
Protection from harm	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?
Liberty	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?

Autonomy	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 them?
Privacy	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?
Integration	Vulnerable groups are not barred from participation in services that are provided for the general population	Does the policy promote the use of mainstream services by vulnerable groups?
Contribution	Vulnerable groups make a meaningful contribution to society	Does the policy recognise that vulnerable groups can be productive contributors to society?
Family Resource	The policy recognises the value of family members of vulnerable groups as a resource for addressing health needs	Does the policy recognise the value of the family members of vulnerable groups in addressing health needs?
Family Support	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support	Does the policy recognise that individual members of vulnerable groups may have an impact on the family members requiring additional support from health services?
Cultural Responsiveness	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 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?
Accountability	Vulnerable groups have access to internal and independent professional evaluation or procedural safeguard	Does the policy specify to whom, and for what, service providers are accountable?
Prevention		Does the policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?

CapacityBuilding		Does the policy support the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?
Access	Vulnerable groups have accessible health facilities (i.e., transportation; physical structure of the facilities; affordability and understandable information in an appropriate format)	Does the policy support vulnerable groups – physical and information access to health services?
Quality	Vulnerable groups are assured of the quality of the clinically appropriate services	
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?

Table 3: Vulnerable Groups in EquiFrame

Vulnerable Group	**Attributes or Definitions**
Limited Resources	Poor people or people living in poverty
Increased Relative Risk for Morbidity	People with one of the top ten illnesses identified by WHO as occurring within the relevant country
Mother-Child Mortality	Factors affecting maternal and child health (0 – 5 years)
Female-Headed Households	Households headed by a woman
Children with Special Needs	Children marginalised by special contexts, such as orphans or street children
Aged	Referring to older age
Youth	Referring to younger age without identifying gender
Ethnic Minorities	Non-majority groups in terms of culture, race or ethnic identity
Displaced Populations	People who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence

Living Away from Services	People living far from health services, either in time or distance
Suffering from Chronic Illness	People who have an illness requiring continuous care
Persons with disabilities	Persons with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability

METHOD

Content Analyses

A data extraction matrix (checklist) was developed to measure the quality of the analysed policy documents. The EquiFrame Matrix (Amin et al, 2012; Mannan et al, 2011) was constructed with the vertical axis listing the 21 Core Concepts (see Table 2) and the horizontal axis listing the 12 Vulnerable Groups (VGs) (see Table 3). Each Core Concept (CC) received a score on a continuum scale ranging 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.

NA: 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 were assessed for each Vulnerable Group that was identified in the policy. If no Vulnerable Group was mentioned but there was a Core Concept addressing the total population (e.g. "all people"), this was categorised as "Universal". The total number and scores for mentioned Core Concepts and Vulnerable Groups was calculated for each document. Two members of the research team independently applied the EquiFrame Matrix to the set of policy documents. Where there was any disagreement, a consensus decision was reached through discussion with the other team members.

RESULTS

The first step in this analysis was to count and compare the frequency of reference to Vulnerable Groups and Core Concepts in the three documents.

Table 4: Frequency of Vulnerable Groups

Vulnerable Groups	DFID (UK)	Ireland	NORAD (N)
Limited Resources (including "poor")	17	35	--
Mother and Child Mortality	1	3	--
Persons with Disabilities	1	3	--
Youth	--	--	1
Increased Relative Risk of Morbidity	--	--	--
Aged	--	--	--
Displaced Populations	--	--	--
Ethnic Minorities	--	--	--
Living away from Services	--	1	--
Women-Headed Households	--	--	--
Children with Special Needs	--	--	--
Suffering from Chronic Illness	--	--	--
Total	**21**	**54**	**1**

Table 4 reveals a marked difference between the documents, in that the Irish Health Policy and the UK Government Health Strategy mention vulnerable groups explicitly in the text 23 and 21 times respectively, while the NORAD report mentions only one group, just once. It is also seen in Table 4 that the "Limited Resources" vulnerable group scores highest. This is a general concept that covers all direct references to poor people. "Disability" and "Mother and Child Mortality" are mentioned only once in the UK policy and thrice in the Irish policy document.

Table 5: Frequency of Core Concepts

Core Concept	DFID (UK)	Ireland	NORAD (N)	Total
Capacity Building	24	34	22	80
Coordination of Services	23	--	16	39
Accountability	31	20	3	54
Prevention	10	6	8	24
Access	7	13	3	23
Efficiency	7	11	2	20
Participation	--	8	1	9
Quality	1	2	--	2
Non-discrimination	--	12	--	12
Protection from Harm	2	--	--	2
Liberty	1	--	--	1
Cultural Responsiveness	2	--	--	2
Individualised Services	--	--	--	--
Autonomy	--	1	--	1
Capability-based Service	--	--	--	--
Contribution	--	--	--	--
Privacy	--	--	--	--
Entitlement	--	--	--	--
Integration	--	--	--	--
Family Resource	--	--	--	--
Family Support	--	--	--	--
Total	**108**	**121**	**55**	**184**

From Table 5 it appears that in the three documents, core concepts are more frequently mentioned than the vulnerable groups (Table 4). The three most frequently mentioned core concepts are on a systems level, i.e. focussing on key aspects of how health systems operate. Capacity building, coordination and accountability are three different and important aspects of a professional health system; they have been identified in the literature as critical for effective health services in low-income countries. Two of the core concepts mentioned most often, Prevention and Access, are concerned with outcome. It can be seen that the Irish policy document mentions the most number of core concepts, followed by the UK and the Norwegian documents, i.e. the same order as for the inclusion of vulnerable groups.

The quality of the policy documents was first assessed by rating each core concept according to the scale described above.

Table 6: Quality of Core Concepts mentioned per policy

Core Concept	Only mentioned	Mentioned and explained	Specific policy actions identified to address concept	Intention to monitor concept addressed
Accountability	N			UK/Irel/
Capacity building			UK/N	Irel
Non-discrimination			Ire/	
Autonomy		N	Ire/	
Access		N	UK/Ire/	
Coordination of services			UK/N	
Prevention		Ire/N	UK	
Efficiency			UK	
Quality	UK/Ire			
Protection from harm		UK		
Cultural				
Responsiveness		UK		
Contribution	UK			
Efficiency	UK	N		
Liberty	UK			

In the first place, only 2 of the concepts have been given the highest rating, i.e. explicit intention to monitor development. This concerns Accountability in two of the documents and Capacity building in one. Then, 6 core concepts were given the second highest rating, i.e. specification of policy action. Further, 8 core concepts were mentioned and explained, while 2 were only mentioned, and 7 were not mentioned at all in any of the three documents.

Table 7: The overall Quality Assessment of Policies analysed

Policy	VG % N/12x100	CC % N/21x100	% of CC quality 3 or 4 N (3 + 4)/21x100
UK Government Strategy	25	41	29
Irish Aid Health Policy	33	43	24
NORAD Health Report	8	33	10
Ranking scale: High quality = if the policy achieved ≥50% on all of the 3 quality scores Moderate quality = if the policy achieved ≥50% on two of the three quality scores Low quality = if the policy achieved ≤50% on 2 or 3 of the quality scores			

Table 7 shows the overall quality assessment of the three selected policy documents. None of the policies reached a high quality level, which in this analysis was set to => 50 %, on any of the quality scores. The highest scores were obtained for core concepts. The UK policy and the Irish policy score higher than the Norwegian policy, on both the core concepts and the overall quality scores.

DISCUSSION

EquiFrame has been developed as a tool for analysing health policies with regard to equity in health for population groups in danger of being excluded from services. The framework aims at providing a basis for analysing the quantity and quality of a set of vulnerable groups and core concepts that may influence how policies contribute to equity in health. While disability is included in the framework as one of the vulnerable groups, it is argued that the conceptual understanding of disability in international health policies differs from the current broad and ICF-based framework as applied in CRPD and the World Disability Report (WHO, 2011). Incorporating activity limitations and restrictions in social participation into the understanding of disability has direct bearing on how disability is handled, for instance, in health policies. The conceptual obscurity that lies in the distinction between a narrow and often impairment-based understanding, and a broad understanding of disability may thus lead to further problems in assessing the relevance for disability of health policies. While disability may be treated, or rather not treated, as a separate issue in policies, it is argued here that vulnerability and vulnerable groups are the key to understanding the relevance of policies for individuals within a broad definition of disability. EquiFrame's utility is reinforced because many of the core concepts are directly and indirectly

relevant to a range of contextual factors that may create disability, for instance discrimination, participation and protection from harm.

EquiFrame's focus is on 'policy on the books', not on the equally important areas of policy development, implementation or evaluation. While the framework identifies the commitment to social inclusion and human rights, it does not however measure how effectively vulnerable groups are included in mainstream health policy work.

One objection to the use of EquiFrame on International Donors' health documents could be that these are not "real" policy documents, but are more general documents that influence the direction of aid and support to national level development of health and health services. It is however argued that it is necessary to include equity and human rights at all levels in the chain of health policies, as the international documents not only direct critical decision-making by major donors, leading to the flow of funding to low-income countries, but also exert influence on national health policies and their implementation. Equity, human rights and social inclusion may be treated on different levels of specificity. Lack of attention to these issues in the relevant international policy documents for low-income countries will eventually result in reduced attention at the national levels.

Three global health policies, from government aid agencies in Ireland, UK and Norway, were analysed. They differed in format and purpose, but have been used to demonstrate how equity and human rights are dealt with in documents used by major donors in the field of international health. Although some of the vulnerable groups are mentioned, a general impression is that specific vulnerable groups are not included, and the most frequently mentioned ones are typically also general. These policies therefore provide very limited guidance or incentive to include specific vulnerable groups, as for instance individuals with disability, in the planning and development of health services. There is a limited mention of poor people and children, and they are all categorised as having "low quality" as defined in EquiFrame The content is, to a large extent, not specific in identifying groups that need particular attention to reach equity in health. Disability is barely mentioned, and several groups are not mentioned at all. Based on the EquiFrame indices, the quality of all three policies is assessed as low.

The three policies focus more on the core concepts which, to a large degree, are at the systems level. This is to be expected from documents which aim to paint a

broad picture of international health. All the three policies place emphasis on a small number of core concepts, i.e. Capacity Building, Coordination of Services, Accountability, Prevention, Access, and Efficiency. Some of these are easily recognised as key priorities and problem areas within international aid during the last decade. A number of the core concepts which appear infrequently or are absent in the documents are typically more individual in nature, and may simply reflect that these policy documents currently are more occupied with overall systems level factors rather than the content and quality of services for specific vulnerable groups.

It is argued that inclusion of vulnerable groups in international health policies is critical. Many of these groups need special attention to ensure access and sufficient quality of health services. Disability is one example of a vulnerable group that is largely ignored, both as a specific sub-population and due to the high relevance of vulnerability and vulnerable groups to disability. Inclusion in international health policies will not in itself solve the problem of discrimination, but a much-needed tool would be in place for people working on the ground and with national health policies. In contexts where resources are scarce and where professional systems, administrative structures and human rights are weak and/or fragile, influence through international health policies can be crucial. Analyses of the core concepts in EquiFrame may therefore contribute to reveal the ability of health policies to address a range of disabling factors. Also, these government aid agencies are particularly influential in relation to a number of organisations which implement the policies in collaboration with national partners.

CONCLUSION

On the basis of this analysis, it can be concluded that the three policies from these high-income countries' government aid organisations do not effectively address the needs and rights of individuals with disability and a number of vulnerable groups for adequate health services. While a more general and non-specific terminology is often associated with human rights and equity, none of the policies achieve overall high quality. With regard to contextual and/or potentially disabling factors, the performance is somewhat better.

As these policies are not developed in isolation, this analysis could be relevant to a broader range of policies at this level. Apparently, a general approach to health issues is unable to include specific strategies to cover the particular needs of vulnerable groups. Poverty and inequity will remain as long as large groups are

not targeted specifically. Therefore there is a need to influence international health policy to include specific strategies for vulnerable groups and their particular needs. While this is clearly also the case for disability, the particular conceptual challenges and the relevance of vulnerability for a broad definition of disability needs to be addressed in health policies and in analyses of health policies. To secure such inclusions EquiFrame, or similar policy analysis frameworks, could be used in "equity audits" during revision of existing health policies, in the development of new health policies, and in monitoring the implementation of the UN Convention on the Rights of Disabled People or other international policy instruments.

Acknowledgement

EquiFrame was developed by the Equitable Team, comprising researchers from Sudan, Malawi, Namibia, South Africa, Ireland and Norway, collaborating on an EU FP 7 funded multi-country study on access and quality of health services for vulnerable groups. The entire team has contributed to the development of EquiFrame.

REFERENCES

Amin M, MacLachlan M, Mannan H, El Tayeb S, El Khatim A, Swartz L, Munthali A, van Rooy G, McVeigh J, Eide A, Schneider M (2012). EqiuFrame: A framework for analysis of the inclusion of human rights and vulnerable groups in health policies. Health & Human Rights; 13(2): 1 – 20.

Braveman P (2006). Health disparities and health equity: Concepts and measurements. Annu Rev Public Health; 27: 167–194. http://dx.doi.org/10.1146/annurev.publhealth.27.021405.102103. PMid:16533114.

Castells M (1996). The rise of network society. Malden MA, Blackwell.

Eide AH, Loeb ME, Nhiwatiwa S, Munthali A, Ngulube TJ, van Rooy G (2011). Living conditions among people with disabilities in developing countries. In: A H Eide & B Ingstad. Disability and Poverty.A Global Challenge. Bristol: The Policy Press.

Gilson L, Buse K, Murray S, Dickinson C (2008). Future dimensions for health policy analysis: A tribute to the work of professor Gill Walt. Health Policy and Planning; 23(5): 291–293. http://dx.doi.org/10.1093/heapol/czn025. PMid:18664525.

Gilson L, Raphaely N (2008). 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): 294–307. http://dx.doi.org/10.1093/heapol/czn019. PMid:18650209 PMCid:2515407.

Gwatkin DR, Bhuiya A, Victora CG (2004). Making health systems more equitable. Lancet; 364: 1273–80. http://dx.doi.org/10.1016/S0140-6736(04)17145-6.

Kickbush I (2000). The development of international health policies – accountability intact? Social Science & Medicine; 51: 979–989. http://dx.doi.org/10.1016/S0277-9536(00)00076-9

MacLachlan M, Khasnabis C, Mannan H (2011). Inclusive Health.Viewpoint. Tropical Medicine and International Health.

Mannan H, Amin M, MacLachlan M & The EquitAble Consortium (2011). The EquiFrame Manual. Dublin; Global Health Press.

Mannan H, Amin M, MacLachlan M (2012). Non-communicable disease priority actions and social inclusion. Lancet; 379(9812): e17-e18. http://dx.doi.org/10.1016/S0140-6736(12)60106-8

Oliver A, Healey A, Le Grand J (2002). Addressing health inequalities. Lancet; 360(9332): 565–567. http://dx.doi.org/10.1016/S0140-6736(02)09713-1.

Reichard A, Sacco TM, Turnbull R (2004). Access to health care for individuals with developmental disabilities from minority backgrounds. Mental Retardation; 42(6): 459–470. http://dx.doi.org/10.1352/0047-6765(2004)42<459:ATHCFI>2.0.CO;2.

Reinicke W (1998). Global public policy: Governing without government? Washington DC: Brooking Institution Press.

Russel S, Gilson L (2006). Are health services protecting the livelihoods of the urban poor in Sri Lanka? Findings from two low-income areas of Colombo. Social Science and Medicine; 63(7): 1732–1744. http://dx.doi.org/10.1016/j.socscimed.2006.04.017. PMid:16766105.

Stowe MJ, Turnbull HR (2001). Tools for analysing policy on the books and policy on the streets. Journal of Disability Policy Studies; 12(3): 206–214. http://dx.doi.org/10.1177/104420730101200306.

Unger J-P, Dessel PV, Sen K, Paepe PD (2009). International health policy and stagnating maternal mortality: is there a causal link? Reproductive Health Matters; 17(33): 91–104. http://dx.doi.org/10.1016/S0968-8080(09)33460-6.

United Nations (2000). Resolution adopted by the General Assembly 55/2, UN Millennium Declaration. New York: United Nations.

United Nations (2008). Convention on the Rights of Persons with Disabilities. New York. Available: www.un.org/disabilities/convention/facts.shtml

Van Rooy G, Amadhila EM, Mufune P, Swartz L, Mannan H, MacLachlan M (2012). Perceived barriers to accessing health services among people with disabilities in rural northern Namibia. Disability and Society; 1–15. http://dx.doi.org/10.1080/09687599.2012.686877.

World Health Organisation (2011). World Report on Disability. Geneva: World Health Organisation.

World Health Organisation, Regional Office for Europe (2008). The Tallinn Charter: Health Systems for Health and Wealth. WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth". Tallinn, Estonia, 25-27 June 2008.