EquiFrame: A framework for analysis of the inclusion of human rights and vulnerable groups in health policies

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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 identifying 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.

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.