

Core Concepts of Human Rights and Inclusion of Vulnerable Groups in the Namibian Policy on Orthopaedic Technical Services

Gert VanRooy¹, Elina Amadhila², Hasheem Mannan^{3*}, Joanne McVeigh⁴, Malcolm MacLachlan⁵, Mutamad Amin⁶

1. Research Fellow, Multidisciplinary Research Centre, University of Namibia

2. Post-graduate Research Fellow, Multidisciplinary Research Centre, University of Namibia

3. Senior Research Fellow, Project EquitAble, Centre for Global Health and School of Psychology, Trinity College Dublin, Ireland

4. Researcher, Centre for Global Health and School of Psychology, Trinity College Dublin, Ireland

5. Professor, Centre for Global Health and School of Psychology, Trinity College Dublin, Ireland, and Extraordinary Professor, Centre for Rehabilitation Studies, Stellenbosch University, South Africa

6. Director of Research, Ahfad University for Women, Omdurman, Sudan

ABSTRACT

Purpose: *Despite a highly progressive legislation and clear governmental commitment, living conditions among persons with disabilities in Namibia are systematically lower than among persons without disabilities. This implies that persons with disabilities are denied equal opportunities to participate and contribute to society, and consequently are denied their human rights.*

Methods: *EquiFrame, an innovative policy analysis framework, was used to analyse Namibian Policy on Orthopaedic Technical Services. EquiFrame evaluates the degree of stated commitment of an existing health policy to 21 Core Concepts of human rights and to 12 Vulnerable Groups, guided by the ethos of universal, equitable and accessible health services.*

Results: *A number of Core Concepts of human rights and Vulnerable Groups were found to be absent in the Namibian Policy on Orthopaedic Technical Services, and its Overall Summary Ranking was assessed as Moderate.*

Conclusion and Implications: *The Namibian health sector faces significant challenges in addressing inequities with respect to its policy on Orthopaedic Technical Services. If policy content, or policy 'on the books', is not inclusive of vulnerable groups and observant of core concepts of human rights, then health practices are also unlikely to do so. This paper illustrates that EquiFrame can provide the strategic guidance for the reform of Namibian Orthopaedic*

*Corresponding Author: Hasheem Mannan, Senior Research Fellow, Project EquitAble, Centre for Global Health and School of Psychology, Trinity College Dublin, Ireland. Email: mannanh@tcd.ie

Technical Services policy, leading to universal and equitable access to healthcare.

Key words: *core concepts of human rights, equity, vulnerable groups, Namibian Orthopaedic Technical Services policy*

INTRODUCTION

Although there is a highly progressive legislation and clear governmental commitment, the majority of persons with disabilities in Namibia still do not have access to opportunities for leading an independent life like persons without disabilities do (VSO International, 2010). Despite its classification as a middle-income country, with per capita GDP as much as five times greater than many African countries (Lang, 2008), Namibia exhibits high levels of inequality in income, access to resources, including healthcare, and health outcomes (Zere et al, 2007). Living conditions among persons with disabilities in Namibia are systematically lower than among those without disabilities, implying that persons with disabilities are denied equal opportunities to participate and contribute to society, and consequently are denied their human rights (SAFOD, FFO, & SINTEF, n.d.).

The Namibian Policy on Orthopaedic Technical Services (OTS) was published in 2001 by the Namibian Ministry of Health and Social Services. Enshrined in the policy is the declaration by the government of the Republic of Namibia to strive for the creation of a “Society for All”, encompassing human diversity and the development of all human potential, thereby embodying the human rights instruments of the United Nations (MOHSS, Republic of Namibia, 2001). The government seeks to promote the integration of persons with disabilities in all domains of society, and Community Based Rehabilitation (CBR) is viewed as a critical approach in realising this goal (MOHSS, Republic of Namibia, 2001). The Namibian Policy on OTS is guided by the principle of equity: ‘in accordance with the constitution of the Republic of Namibia, all Namibians shall have equitable access to basic health care and social services provided by the Ministry of Health and Social Services’ (MOHSS, Republic of Namibia, 2001).

This paper reports on the application of EquiFrame, a novel policy analysis framework, to the OTS policy of the Republic of Namibia. An internationally peer-reviewed framework, based on best practices principles of systematic review, EquiFrame evaluates the degree of stated commitment of an existing health policy to 21 Core Concepts of human rights and to 12 Vulnerable Groups, guided

by the ethos of universal, equitable and accessible services. In its current form, it is directed towards health policy-oriented researchers and policy-makers. The framework has been applied in the analysis of 51 health policies across Namibia, Malawi, South Africa, and Sudan, highlighting some very strong policies, serious shortcomings in other policies, as well as country-specific patterns. Health policies were included if they met the following criteria: (1) Health policy documents produced by the Ministry of Health; (2) Policies addressing health issues outside of the Ministry of Health; (3) Strategies that address health policies; and (4) Policies related to the top 10 health conditions identified by the World Health Organization (WHO) within the respective country. In the Namibian context, 10 health policies were identified and analysed, inclusive of the Namibian Policy on Orthopaedic Technical Services. Orthopaedic Technical Services in the Namibian context constitutes a foremost health service provision consideration marked in terms of scale; in 2004, it was estimated that approximately 85,000 people with disabilities required orthotic and prosthetic appliances in Namibia (Lang, 2008). A qualitative inquiry undertaken in Northern Namibia indicates that there is need for health authorities to consider the unique issues affecting access to healthcare for people living with disabilities (Van Rooy et al, 2012).

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 Organisation (WHO, 2008), that priority is afforded to vulnerable groups, as healthcare founded on equity contributes to the empowerment and social inclusion of such groups. This paper reports on the application of EquiFrame to Namibian Policy on OTS. The objective was to establish the degree to which the Namibian OTS policy protected and promoted universal and equitable access to healthcare.

Development of *EquiFrame*

There is a paucity of literature that outlines and utilises analytical frameworks for the actual content of policies, or policy 'on the books' (Stowe & Turnbull, 2001). There is however, a body of research on the process of health policy development (Gilson et al, 2008). While this body of research focuses on the critical importance of how policy is made, very little guidance is offered on evaluating the actual content of policies, or policy 'on the books'. The focus of the present research was to develop and apply a method for analysing the content of policies. EquiFrame has been devised 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. It is guided by the ethos of universal, equitable and accessible health services. EquiFrame has been developed as part of a Work Package led by Ahfad University for Women, Sudan, within a larger EU FP7 funded project, EquiAble, which is led by the Centre for Global Health at Trinity College Dublin, with a consortium of international partners (see www.equitableproject.org).

The Framework

EquiFrame's 21 Core Concepts are presented alongside a series of key questions and key language, each series tailored to elucidate the specified Core Concept (see Table 1). These 21 Core Concepts represent a broad range of salient concerns in striving for equitable, accessible and universal healthcare. 'Core Concept' may be interpreted as a "central, often foundational policy component generalised from particular instances (namely, literature reviews, analyses of statutes and judicial opinions, and data from focus groups and interviews)" (Umberger et al, 2005). *EquiFrame's* Core Concepts are grounded in international and domestic legal instruments (see Table 2).

Table 1: *EquiFrame* Core Concepts of Human Rights; Key Questions and Key Language

No.	Core Concept	Key Question	Key Language
1.	Non-discrimination	Does the policy support the rights of vulnerable groups with equal opportunity in receiving health care?	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (i.e. Living away from services; Persons with disabilities; Ethnic minority or Aged).
2.	Individualised Services	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective, and understandable services.
3.	Entitlement	Does the policy indicate how vulnerable groups may qualify for specific benefits relevant to them?	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grant.
4.	Capability-based Services	Does the policy recognise the capabilities existing within vulnerable groups?	For instance, peer to peer support among women headed households or shared cultural values among ethnic minorities.

5.	Participation	Does the policy support the right of vulnerable groups to participate in the decisions that affect their lives and enhance their empowerment?	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation, and evaluation.
6.	Coordination of Services	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)?	Vulnerable groups know how services should interact where inter-agency, intra-agency, and inter-sectoral collaboration is required.
7.	Protection from Harm	Are vulnerable groups protected from harm during their interaction with health and related systems?	Vulnerable groups are protected from harm during their interaction with health and related systems.
8.	Liberty	Does the policy support the right of vulnerable groups to be free from unwarranted physical or other confinement?	Vulnerable groups are protected from unwarranted physical or other confinement while in the custody of the service system/provider.
9.	Autonomy	Does the policy support the right of vulnerable groups to consent, refuse to consent, withdraw consent, or otherwise control or exercise choice or control over what happens to him or her?	Vulnerable groups can express "independence" or "self-determination". For instance, person with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice.
10.	Privacy	Does the policy address the need for information regarding vulnerable groups to be kept private and confidential?	Information regarding vulnerable groups need not be shared among others.
11.	Integration	Does the policy promote the use of mainstream services by vulnerable groups?	Vulnerable groups are not barred from participation in services that are provided for general population.
12.	Contribution	Does the policy recognise that vulnerable groups can be productive contributors to society?	Vulnerable groups make a meaningful contribution to society.
13.	Family Resource	Does the policy recognise the value of the family members of vulnerable groups in addressing health needs?	The policy recognises the value of family members of vulnerable groups as a resource for addressing health needs.

14.	Family Support	Does the policy recognise individual members of vulnerable groups may have an impact on the family members requiring additional support from health services?	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support.
15.	Cultural Responsiveness	Does the policy ensure that services respond to the beliefs, values, gender, interpersonal styles, attitudes, cultural, ethnic, or linguistic aspects of the person?	i) Vulnerable groups are consulted on the acceptability of the service provided. ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, i.e., respectful of the culture of vulnerable groups.
16.	Accountability	Does the policy specify to whom, and for what, services providers are accountable?	Vulnerable groups have access to internal and independent professional evaluation or procedural safeguard.
17.	Prevention	Does the policy support vulnerable groups in seeking primary, secondary, and tertiary prevention of health conditions?	
18.	Capacity Building	Does the policy support the capacity building of health workers and of the system that they work in addressing health needs of vulnerable groups?	
19.	Access	Does the policy support vulnerable groups – physical, economic, and information access to health services?	Vulnerable groups have accessible health facilities (i.e., transportation; physical structure of the facilities; affordability and understandable information in appropriate format).
20.	Quality	Does the policy support quality services to vulnerable groups through highlighting the need for evidence-based and professionally skilled practice?	Vulnerable groups are assured of the quality of the clinically appropriate services.
21.	Efficiency	Does the policy support efficiency by providing a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups?	

Table 2: EquiFrame Core Concepts of Human Rights/Key Legal Instruments

	<i>EquiFrame</i> Core Concepts of Human Rights	Key Legal Instruments
1.	Non-discrimination	African Charter on Human and Peoples' Rights (1986) UN Convention on the Elimination of All Forms of Discrimination Against Women (1981) UN International Covenant on Civil and Political Rights Vienna Declaration and Programme of Action (1993) United Nations Millennium Declaration (2000) Americans with Disabilities Act of 1990
2.	Individualised services	UN Convention on the Rights of Persons with Disabilities (2007) African Charter on Human and Peoples' Rights (1986) UN Convention on the Rights of the Child (1990) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health Protocol of San Salvador (1988) Rehabilitation Act [29 U.S.C. § 722]
3.	Entitlement	UN Convention on the Rights of the Child (1990) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health UN Convention on the Rights of Persons with Disabilities (2007) Charter of Fundamental Rights of the European Union (2000/C 364/01) UN Declaration on Social Progress and Development (1969) UN Convention on the Elimination of All Forms of Discrimination Against Women (1981)
4.	Capability-based services	UN Convention on the Rights of Persons with Disabilities (2007) United Nations Declaration on the Rights of Mentally Retarded Persons (1971) Protocol of San Salvador (1988) Constitution of Venezuela; Art 81 (1999) The Bangkok Charter for Health Promotion in a Globalised World (2005)
5.	Participation	Vienna Declaration and Programme of Action (1993) International Convention on the Elimination of All Forms of Racial Discrimination United Nations Millennium Declaration (2000) Americans with Disabilities Act of 1990 Declaration on the Occasion of the Fiftieth Anniversary of the United Nations Declaration of Alma-Ata, International Conference on Primary Health Care (1978) Developmental Disabilities Assistance & Bill of Rights Act of 2000 [42 U.S.C. §§ 15001 et seq.]

6.	Coordination of services	UN Convention on the Rights of Persons with Disabilities (2007) United Nations Political Declaration on HIV/AIDS Declaration of Alma-Ata, International Conference on Primary Health Care (1978) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health International Health Regulations (2005) (WHO) Minister of Health v. Treatment Action Campaign (2002) 5 SA 721 (CC) (South Africa)
7.	Protection from harm	UN Convention on the Rights of the Child (1990) UN Convention on the Rights of Persons with Disabilities (2007) European Social Charter International Convention on the Elimination of All Forms of Racial Discrimination United Nations Declaration on the Rights of Mentally Retarded Persons (1971) Charter of Fundamental Rights of the European Union (2000/C 364/01)
8.	Liberty	UN Convention on the Rights of the Child (1990) UN Convention on the Rights of Persons with Disabilities (2007) African Charter on Human and Peoples' Rights (1986) International Covenant on Civil and Political Rights Charter of Fundamental Rights of the European Union (2000/C 364/01) UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003)
9.	Autonomy	International Covenant on Civil and Political Rights European Social Charter Vienna Declaration and Programme of Action (1993) United Nations Political Declaration on HIV/AIDS Declaration on the Occasion of the Fiftieth Anniversary of the United Nations Declaration of Alma-Ata, International Conference on Primary Health Care (1978) Developmental Disabilities Assistance & Bill of Rights Act of 2000 [42 U.S.C. § § 15001 et seq.]
10.	Privacy	UN Convention on the Rights of Persons with Disabilities (2007) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health International Covenant on Civil and Political Rights United Nations Political Declaration on HIV/AIDS Charter of Fundamental Rights of the European Union (2000/C 364/01) UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003)

11.	Integration	UN Convention on the Rights of Persons with Disabilities (2007) European Social Charter Charter of Fundamental Rights of the European Union (2000/C 364/01) UN Declaration on Social Progress and Development (1969) Constitution of Venezuela; Art 81 (1999) Constitution of Albania; Art 59 (1998)
12.	Contribution	UN Convention on the Rights of Persons with Disabilities (2007) European Social Charter International Convention on the Elimination of All Forms of Racial Discrimination United Nations Declaration on the Rights of Mentally Retarded Persons (1971) Charter of Fundamental Rights of the European Union (2000/C 364/01) United Nations Declaration on the Rights of Indigenous Peoples
13.	Family resource	UN Convention on the Rights of the Child (1990) UN Convention on the Rights of Persons with Disabilities (2007) UN Declaration on Social Progress and Development (1969) UN Convention on the Elimination of All Forms of Discrimination Against Women (1981) Protocol of San Salvador (1988) Québec Charter of Human Rights and Freedoms (1975)
14.	Family support	UN Convention on the Rights of the Child (1990) UN Convention on the Rights of Persons with Disabilities (2007) African Charter on Human and Peoples' Rights (1986) International Covenant on Civil and Political Rights European Social Charter United Nations Declaration on the Rights of Mentally Retarded Persons (1971) The Universal Declaration of Human Rights
15.	Cultural responsiveness	UN Convention on the Rights of Persons with Disabilities (2007) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health Vienna Declaration and Programme of Action (1993) Declaration on the Occasion of the Fiftieth Anniversary of the United Nations Charter of Fundamental Rights of the European Union (2000/C 364/01) United Nations Declaration on the Rights of Indigenous Peoples

16.	Accountability	UN Convention on the Rights of Persons with Disabilities (2007) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health Vienna Declaration and Programme of Action (1993) International Convention on the Elimination of All Forms of Racial Discrimination United Nations Political Declaration on HIV/AIDS United Nations Declaration on the Rights of Mentally Retarded Persons (1971)
17.	Prevention	UN Convention on the Rights of the Child (1990) UN Convention on the Rights of Persons with Disabilities (2007) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health European Social Charter United Nations Political Declaration on HIV/AIDS Declaration of Alma-Ata, International Conference on Primary Health Care (1978)
18.	Capacity building	UN Convention on the Rights of Persons with Disabilities (2007) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health United Nations Political Declaration on HIV/AIDS United Nations Political Declaration on Africa's Development Needs UN Declaration on Social Progress and Development (1969) International Health Regulations (2005) (WHO)
19.	Access	UN Convention on the Rights of the Child (1990) Convention on the Elimination of All Forms of Discrimination Against Women (1981) International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (2003) European Social Charter Vienna Declaration and Programme of Action International Convention on the Elimination of All Forms of Racial Discrimination
20.	Quality	UN Convention on the Rights of Persons with Disabilities (2007) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health UN - Keeping the promise: united to achieve the Millennium Development Goals [Resolution adopted by the General Assembly 2010] Durban Declaration and Programme of Action Constitution of the Republic of Ecuador; Art 66 (2008) Constitution of Venezuela; Art 84 (1999)

21.	Efficiency	United Nations Political Declaration on HIV/AIDS Declaration of Alma-Ata, International Conference on Primary Health Care (1978) Constitution of the Republic of Ecuador; Art 66 (2008) Constitution of Colombia; Art 49 (1991) Constitution of Peru; Art 11 (1993) Constitution of the Portuguese Republic; Art 64 (2005)
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Vulnerable Groups may be defined as “social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality” (Flaskerud & Winslow, 1998), and may include children, the aged, ethnic minorities, displaced populations, people suffering from chronic illnesses and persons with disabilities. Importantly, Eichler and Burke (2006) have recognised that the social discrimination and bias that arise based on such categories are the result of social hierarchies: similar exclusionary practices disadvantage and disempower different groups, undermining their human rights and their rights to health, other social services and to social inclusion – to being full participants in society.

The World Report on Disability (World Health Organisation & World Bank, 2011) estimates that over one billion people, or approximately 15% of the world’s population, are living with disability; yet many people with disabilities do not have equal access to healthcare, education, and employment opportunities, do not receive the disability-related services that they need, and encounter exclusion from everyday activities (World Health Organisation & World Bank, 2011). Accordingly, the research team was particularly interested 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 healthcare. Definitions for Vulnerable Groups are provided in Table 3.

EquiFrame has been devised with the aim of generating a systematic evaluative and comparative analysis of health policies on technical content and design. The Framework has been presented at a workshop conducted for the Ministry of Health in Malawi, comprising senior policy-makers (Munthali et al, 2011), and has provided guidance in the redrafting of the Malawian National Health Policy. We believe therefore that *EquiFrame*’s utility will extend beyond that of a tool for the evaluation of policies, to the promotion of equity, human rights and inclusion in the revision of existing policies and the development of new ones. For further details specific to *EquiFrame* and the process of its formulation, including a

Table 3: EquiFrame Vulnerable Groups Definitions

No.	Vulnerable Group	Attributes or Definitions
1.	Limited Resources	Referring to poor people or people living in poverty
2.	Increased Relative Risk For Morbidity	Referring to people with one of the top 10 illnesses, identified by WHO, as occurring within the relevant country
3.	Mother Child Mortality	Referring to factors affecting maternal and child health (0-5 years)
4.	Women Headed Household	Referring to households headed by a woman
5.	Children (with special needs)	Referring to children marginalised 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	Referring to non-majority groups in terms of culture, race or ethnic identity
9.	Displaced Populations	Referring to people who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence
10.	Living Away from Services	Referring to people living far from health services, either in time or distance
11.	Suffering from Chronic Illness	Referring to people who have an illness which requires continuing need for care
12.	Disabled	Referring to persons with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability

more detailed discussion of literature sources for Core Concepts and Vulnerable Groups, readers are referred to the EquiFrame manual (Mannan et al, 2011; see also Amin et al, 2011; Andersen & Mannan, 2012; MacLachlan et al, 2012; Mannan et al, 2012a; Mannan et al, 2012b; Mannan et al, 2012c).

METHOD

Summary Indices

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

- (1) **Core Concept Coverage:** A policy was examined with respect to the number of Core Concepts mentioned, from among 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 (Amin et al, 2011; Mannan et al, 2011; Andersen & Mannan, 2012; MacLachlan et al, 2012; Mannan et al, 2012a; Mannan et al, 2012b; Mannan et al, 2012c).
- (2) **Vulnerable Group Coverage:** A policy was examined with respect to the number of Vulnerable Groups mentioned, from among the 12 Vulnerable Groups identified; and this ratio was expressed as a rounded up percentage. In addition, the actual terminologies used to describe the Vulnerable Groups were extracted, to allow for qualitative analysis and cross-checking between raters.
- (3) **Core Concept Quality:** A policy was examined with respect to the number of Core Concepts within it that were rated as 3 or 4 (as either stating a specific policy action to address a Concept or an intention to monitor a Concept) out of the 21 Core Concepts identified; and this ratio was expressed as a rounded up percentage. When several references to a Core Concept were found, the top quality score received was recorded as the final quality scoring for the respective Concept.
- (4) Each document was given an **Overall Summary Ranking** in terms of it being of High, Moderate or Low 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.

Scoring

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

1 = Concept only mentioned.

2 = Concept mentioned and explained.

3 = Specific policy actions identified to address the concept.

4 = Intention to monitor concept was expressed.

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

Each policy document was assessed by two independent raters. For each document, the presence of Core Concepts was assessed for each Vulnerable Group that was identified in the policy. If no Vulnerable Group was mentioned but a Core Concept addressed the total population (e.g. “all people”), the Core Concept was scored as ‘Universal’. The total number and scores for mentioned Core Concepts and Vulnerable Groups was calculated for each document across the four countries.

Inter-rater reliability was established through the comparison of evaluations by raters subsequent to separately analyzing a relevant policy document. To illustrate, the application of EquiFrame to the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006) revealed that for this document, in terms of inter-rater reliability, there was one hundred percent agreement with regard to the scores assigned to the Core Concept Quality of the document (i.e. level 1 (Concept mentioned); level 2 (Concept mentioned and explained); level 3 (specific policy actions identified to address the Concept); level 4 (intention to monitor expressed)). In terms of Core Concept Coverage however, there was a one in ten instance of a dissimilar identification of Core Concepts by raters for a particular segment of the UN CRPD. For example, in Article 22(2) of the UN CRPD relating to ‘Respect for Privacy’ it is stipulated that “States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others”. For this segment, the Core Concept of Privacy was identified by both raters, while one rater also identified the Core Concept of Non-discrimination. The dissimilar identification of Core Concepts for a given segment of the UN CRPD was resolved by discussion between raters subsequent to analysing the document, and the agreement to identify two or more Core Concepts for a particular segment of the UN CRPD was not found to alter the overall scorings for this document on EquiFrame’s summary indices.

RESULTS

The Orthopaedic Technical Services Policy of Namibia scored 50% for Vulnerable Group Coverage; 66% for Core Concept Coverage; and 48% for Core Concept Quality. The Overall Summary Ranking for Namibian OTS Policy was therefore scored as Moderate (see Table 4).

Table 4: EquiFrame Summary Indices for Namibian Policy on Orthopaedic Technical Services

	Vulnerable Group Coverage	Core Concept Coverage	Core Concept Quality	Overall Summary Ranking
Orthopaedic Technical Services Policy of Namibia	50%	66%	48%	Moderate

Vulnerable Group Coverage

The following Vulnerable Groups (VGs) were not explicitly mentioned in the policy: Increased relative risk for morbidity, Mother child mortality, Women headed households, Aged, Ethnic minorities, and persons Suffering from chronic illness.

The VG that appeared most often was Persons with Disabilities (cited 17 times). Also cited in the policy were the VGs of Children with special needs (cited 3 times), Living away from services (cited 3 times), Limited resources (cited twice), Youth (cited once), and Displaced populations (cited once).

The VG of Persons with Disabilities was referred to using terms such as “*people with disabilities (PWD)*” and “*people with impaired limbs*”. The VG of Children with special needs was addressed in terms such as “*children with disabilities*”, and “*child with physical disability*”. Phrases like “*Disabled population (living) in rural areas*” and “*distances that need to be covered by orthopaedic patients to the service facilities*” were used with reference to the VG of Living away from services. The VG of Limited resources was indicated by terms such as “*Limitation of means*”, and the VG of Youth was referred to as “*young adults*” and “*disabled young person*”. Finally, the terminology used for the VG of Displaced populations was “*disadvantaged regions*” and “*underserved communities*”.

Core Concept Coverage

The Core Concepts (CCs) of Protection from harm, Privacy, Liberty, Family resource, Family support, Contribution, and Accountability were not explicitly mentioned in the policy.

The CC that was mentioned most often was Access (cited 26 times), followed by Coordination of services (cited 17 times), Integration (cited 13 times), and Quality (cited 11 times). Other Core Concepts also cited were: Prevention (cited 6 times), Cultural responsiveness (cited 6 times), Capability based services (cited 3 times), Efficiency (cited 3 times), and Individualised services (cited twice). The CCs that were least often mentioned: Autonomy, Participation, Non-discrimination, Capacity building, and Entitlement (each cited once).

The CC of Access was cited in the policy in terms such as *“physical accessibility”*, and *“societal limitations (including) limitation of funds and culture (that) affect accessibility”*. Terminology alluding to the CC of Coordination of services included *“multi-disciplinary/multi-sectoral approach”*, and *“coordination of OTS with Community Based Rehabilitation services to address community problems related to OTS”*. With regard to the CC of Integration, references included *“integration of people with health problems into mainstream socio-economic life”*. Terminology referring to the CC of Quality included *“good quality services”* and *“upgrading and ensuring quality of the Orthopaedic Technical Services”*. The Core Concept of Non-discrimination was alluded to in terms of adherence to the human rights instruments of the United Nations, by *“encompassing human diversity”* and *“equal consideration of people with disabilities for employment and education”*.

Core Concept Quality

In total, ten Core Concepts were scored as 4. An intention was expressed to monitor the following Concepts: Prevention, Non-discrimination, Cultural responsiveness, Integration, Coordination of services, Capacity building, Entitlement, Capability based services, Individualised services, and Access. The Concepts of Quality and Efficiency were each only mentioned and explained. Finally, the Concept of Participation was only mentioned in the policy.

DISCUSSION

The Namibian health sector faces significant challenges in addressing the inequities that are present with respect to its policy on Orthopaedic Technical Services. Only half of the Vulnerable Groups were explicitly included in the

policy. The Vulnerable Group of Women headed households was not addressed. As documented by the 'Living conditions among people with activity limitations in Namibia' survey conducted by SINTEF, Namibian women were found to be worse off than men with respect to standards of living (Eide et al, 2003). The study highlighted that differences regarding age, disability profile, and family life emphasised the need for a gender perspective on disability and policy for improvement of the lives of persons with disabilities in Namibia (Eide et al, 2003). The Vulnerable Group of Suffering from chronic illness was not explicitly mentioned in the policy, though malaria is a major issue in the north and central regions of Namibia (Lang, 2008). Further, Namibia has one of the highest HIV prevalence rates in the world, affecting an estimated 15.3% of the adult population (WHO, 2009). The increasing connection between HIV/AIDS and disability is an emerging issue of concern as persons with disabilities are at higher risk of exposure to HIV, and persons living with HIV/AIDS are also at risk of acquiring disabilities due to their condition (United Nations Enable, 2011).

Disability disproportionately affects vulnerable populations, including women, older people, and children from ethnic minorities (World Health Organisation & World Bank, 2011). In several contexts, not explicitly addressed by the Namibian OTS policy, the experience of disability interplays with other vulnerability factors that may generate susceptibility to double discrimination and multiple disadvantage [women with disabilities (Barnes, 2001; Council of Europe, 2005; United Nations, 2006; United Nations Economic and Social Council, 2003; United Nations Enable, 2011; World Bank, 2004, World Bank, 2010; World Health Organisation & UNFPA, 2009); ethnic minorities with disabilities (Castellino, 2002; Council of Europe, 2005; Elliott, Utyasheva, & Zack, 2009); aged populations with disabilities (United Nations Economic and Social Council, 2003); persons with disabilities suffering from chronic illness (DeJong & Basnett, 2001); maternal/child mortality for persons with disabilities (UNICEF, 2008; World Bank, 2010; World Health Organisation & UNFPA, 2009); persons with disabilities at increased relative risk for morbidity, in particular HIV/AIDS (Dube, 2009; Dutch Coalition on Disability and Development, 2008; Elliott, Utyasheva, & Zack, 2009; Grant, Strode, & Hannass-Hancock, 2009; Groce, 2003; Rohleder, Swartz, & Philander, 2009; The Africa Campaign, 2008; United Nations Enable, 2011; United Nations Human Rights, WHO, & UNAIDS, 2009; World Bank, 2004; World Bank, 2010; Yousafzi & Edwards, 2004)]. While persons with disabilities may present similar challenges for their equitable access to healthcare, various subpopulations of persons with disabilities may present distinctive challenges. For example, as

emphasised by Haveman et al (2011), healthcare providers and policy-makers must recognise that many people with intellectual disabilities have special needs that may necessitate the modification of standard healthcare practices and service models, and that such needs arise with advancing age. As a further illustration, Emerson and Hatton (2007) indicate that a substantial share of the inequalities in health status experienced by children and young people with intellectual disabilities may simply be due to between-group differences in socioeconomic position, specifically to the increased risk of exposure to poverty and social disadvantage experienced by children with intellectual disabilities. Until specific mechanisms of exclusion and detailed needs and aspirations of subgroups of persons with disabilities are explicitly recognised and addressed, the Namibian Policy on Orthopaedic Technical Services will fall short of its equity objectives.

Only two-thirds of the Core Concepts are explicitly mentioned in the policy. The Core Concept of Accountability is not explicitly mentioned. According to the UN Economic and Social Council (United Nations Economic and Social Council, 2000), the national health strategy should be founded on the principle of accountability: any person or group that is a victim of an infringement of the right to health should have access to effective judicial or other suitable remedies at both national and international levels. Further, all victims should be entitled to sufficient reparation, in the variety of restitution, compensation, satisfaction, or certification of non-repetition (United Nations , 2000). Without accountability, policies that claim to address equity and empowerment engender minimal confidence and credibility (Rifkin, 2003). The Core Concepts of Contribution and Privacy are not explicitly mentioned in the policy. According to the UN Economic and Social Council (2000), the right to health is closely associated with, and dependent upon, the realisation of other rights as promoted in the International Bill of Rights, including the right to work and the right to privacy; these and other rights and freedoms address essential components of the right to health (United Nations Economic and Social Council, 2000).

The Core Concept of Protection from harm is not explicitly cited in the document. According to the UN Economic and Social Council (2000), violations of the obligation to protect proceed from the failure of a State to enforce all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. The Core Concepts of Family Resource and Family Support are also not explicitly mentioned in the document. Posited as the natural and fundamental group unit of society, the family is entitled to protection

by society and the State; persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities (United Nations, 2006). Liberty is another Core Concept not explicitly mentioned. Every person has the right to liberty and security of person; no one shall be subjected to arbitrary arrest or detention; no one shall be deprived of liberty except on such grounds and in accordance with such procedures as are established by law (United Nations, 1966). With respect to Core Concept Quality, it is notable that only ten of the fourteen Core Concepts cited in the policy were mentioned with a stated intention to monitor. The establishment of accessible, transparent and effectual mechanisms for monitoring health systems and the right to health is a priority (Backman et al, 2008).

As a result of this research, and by providing feedback to stakeholders' workshops in different countries, several factors were observed that should be considered when interpreting the results of EquiFrame. During the consultations that took place throughout the development of EquiFrame, stakeholders including persons with disabilities and their representative organisations, argued that some documents use the term "all", as in "all people" to be fully inclusive and therefore reference to specific vulnerable groups is not necessary. Indeed, subsidiary analysis of the term "all" or its synonyms, indicates that documents using such 'all-inclusive' terms also specify only certain vulnerable groups, not others. Therefore, it is important to establish which vulnerable groups are included and which ones are not, as the inclusive terminology used does not necessarily address the concerns of specific vulnerable groups.

While EquiFrame has been developed for the purposes of policy analysis, the authors believe that this form of analysis can also be applied to other types of planning and guiding documents, and that the coverage of Core Concepts of human rights and inclusion of Vulnerable Groups is pertinent to a range of diverse guiding documents too. Fuller understanding of the content of such documents can and should always be strengthened by understanding 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 also a vital one, if documents that are most likely to support human rights and promote greater inclusion in health service provision are to be recognised and developed. Though considerable enterprise and deliberation have been employed in the development of EquiFrame to authenticate the Core Concepts and Vulnerable

Groups described, it is not suggested that these are universally applicable. Rather, the process of deriving these core concepts and vulnerable groups is put forward as one that can be used in other settings and contexts to achieve similar ends.

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 (Walt et al, 2008). Thus, while the analysis of current Namibian OTS policy has been outlined in this paper, it is hoped that the utility of EquiFrame as a policy analysis tool will extend beyond its application as a framework for evaluation, to the development of new policy documents and to the revision of existing ones. By highlighting high-quality health policy documents, EquiFrame can steer policy-developers towards some superior examples of human rights coverage and vulnerable group inclusion. It can also provide a check-list of factors for consideration, as well as indicate specific terms and phrasing for use in a policy. Finally, it is important to note that since this framework was used to perform what was inherently a content analysis, it is bound by the limitations of using such a methodology, including the expertise required to perform this type of analysis. Further, the framework requires the use of two independent raters, to generate some scope for divergent interpretations of the material analysed.

The Namibian policy on OTS is guided by the principle of equity: 'in accordance with the constitution of the Republic of Namibia, all Namibians shall have equitable access to basic health care and social services provided by the Ministry of Health and Social Services' (MOHSS, Republic of Namibia, 2001). The principle of equity in healthcare is an economically astute, feasible, and morally vigilant political aspiration. The Namibian policy on Orthopaedic Technical Services may be commended for its endeavour to promote these tenets. A considerable number of vulnerable groups are not however explicitly mentioned in this policy. Explicitly naming some vulnerable groups and not naming others in health policies is categorically inequitable – doing so actually perpetuates the inequities that are envisioned to be diminished. If policy 'on the books' is not inclusive of vulnerable groups and observant of core concepts of human rights, then neither are health practices likely to do so. This paper illustrates that EquiFrame can provide the strategic guidance to make Namibian Orthopaedic Technical Services policy reform conducive to universal and equitable access to healthcare. By and large, by discerning health policy inclusion of vulnerable groups and commitment to core concepts of human rights that have particular relevance to low and middle-

income countries more extensively, it is anticipated that its application and value may be of greater reach.

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