ALTER, European Journal of Disability Research 6 (2012) 159–177

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Research Paper

Core concepts of human rights and inclusion of vulnerable groups in the United Nations Convention on the rights of persons with disabilities

Concepts centraux relatifs aux droits de l'homme et à l'inclusion de groupes vulnérables dans la Convention des Nations Unies pour les droits des personnes handicapées

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ARTICLE INFO

Article history:
Received 6 January 2012
Accepted 20 April 2012
Available online 11 July 2012

Keywords:
United Nations Convention on the rights of persons with disabilities
Core concepts of human rights and inclusion of vulnerable groups

ABSTRACT

The Convention on the Rights of Persons with Disabilities (UN CRPD) was adopted by the United Nations General Assembly in 2006 and entered into force on May 3rd, 2008. The UN CRPD is the first legally binding international instrument with comprehensive protection of the rights of persons with disabilities, and sets out the legal obligations on States to promote and protect the rights of persons with disabilities worldwide. *EquiFrame*, a novel policy analysis framework, was used to evaluate the UN CRPD in relation to its commitment to 21 predefined core concepts of human rights and inclusion of 12 Vulnerable Groups. While a number of core concepts and vulnerable groups were found to be absent in the UN CRPD, and other core concepts mentioned only in a specified capacity, the overall quality rating for the UN CRPD when interpreted within the parameters of *EquiFrame's* summary indices was found to be high, placing it amongst the best policy instruments assessed using the *EquiFrame* methodology so far. Suggestions for how shortcomings can be addressed are made.

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1875-0672/$ – see front matter
http://dx.doi.org/10.1016/j.alter.2012.05.005

Mots clés :
Convention des Nations Unies relative aux droits des personnes handicapées
Concepts principaux des droits de l'homme
Droits de l'homme
Groupes vulnérables

RÉSUMÉ

La Convention relative aux droits des personnes handicapées (CDPH) a été adoptée lors de l'assemblée générale des Nations Unies en 2006 et entrée en vigueur le 3 mai 2008. Cette Convention est le premier instrument international contraignant pour protéger les droits des personnes handicapées. Elle énonce les obligations des États vis-à-vis de la promotion et de la protection des droits des personnes handicapées partout dans le monde. Cet article rend compte de l'utilisation d'un cadre d'analyse des politiques publiques relatives au handicap–*EquiFrame*–pour évaluer la Convention au regard de 21 concepts principaux des droits de l'homme et de l'inclusion de 12 groupes vulnérables. Même si certains concepts principaux des droits de l'homme et certains groupes vulnérables manquent au contenu de la Convention, ou ne sont mentionnés que partiellement, la qualité globale de la CDPH, évaluée selon les paramètres des indicateurs synthétiques d'*EquiFrame*, la place en tête des meilleurs instruments de protection des personnes handicapées, analysés avec la méthodologie d'*EquiFrame*. Des propositions sont faites afin de corriger certains défauts.

Introduction

The "human rights approach" to disability advocacy has been classified in recent decades as the single most imperative political development in the effort for equal participation by persons with disabilities (Bickenbach, 2001). Human rights embody universal aspirations to attain justice and realize each individual's human potential; by serving as tools for measuring deficiencies in the experience of particular groups in relation to these objectives, they bear particular weight for the discourse of disability (Baylies, 2002). The issue in disability law and policy across the world does not concern the integrity of our legacy values such as dignity, autonomy, and equality, but rather concerns the manner in which these values are deflected, misapplied, or not applied at all in the context of disability (Quinn, 2009). From a rights-based perspective, disability does not intrinsically render a person vulnerable, but rather it is the lack of access, information and support, which intensifies vulnerability (Lang et al., 2011). Thus, within a rights-based perspective, every individual should have an equal opportunity to access the same services. Some people will require more support to acquire these services and more protection when they are unable to do so (Lang et al., 2011).

Throughout the last two decades, States have adopted explicit instruments that protect and promote the rights of persons with disabilities. Significant landmarks include the World Programme of Action Concerning Disabled Persons (United Nations, 1982), the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991), the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (United Nations, 1993), and the Declaration on the Rights of Disabled Persons (Office of the United Nations High Commissioner for Human Rights, 1975; United Nations Enable, 2008–2011a).

The Convention on the Rights of Persons with Disabilities (UN CRPD) was adopted by the United Nations General Assembly in 2006 and entered into force on May 3rd, 2008 (United Nations, 2006). The UN CRPD is the first legally binding international instrument with comprehensive protection of the rights of persons with disabilities, and sets out the legal obligations on States to promote and protect the rights of persons with disabilities worldwide (United Nations Enable, 2008–2011a). The catalyst for the UN CRPD was a development challenge: approximately 15% of the world's population are persons with disabilities, that is, over one billion people, who may lack the opportunities of the mainstream population (WHO and World Bank, 2011). It was internationally recognized that although

all of the international human rights treaties extend to persons with disabilities, this extensive group of persons continue to suffer discrimination and frequently do not enjoy respect for their human rights on an equal basis with others (Inter-agency, 2008). The UN CRPD was therefore necessary in order to have a clear reaffirmation that the rights of persons with disabilities are human rights and to reinforce respect for these rights (United Nations Enable, 2008–2011a).

While the UN CRPD does not create any new rights or entitlements, it expresses existing rights in a mode that addresses the needs and situations of persons with disabilities (United Nations Enable, 2006). The UN CRPD therefore not only clarifies that States should not discriminate against persons with disabilities, but also outlines the many initiatives that States must employ to create an enabling environment so that persons with disabilities can enjoy equality within a State (United Nations Enable, 2008–2011a). The following articles comprise the first half of the UN CRPD, and are intended to be applied generally to the remainder of the Convention: Article 1 (purpose), Article 2 (definitions), Article 3 (general principles), Article 4 (general obligations), Article 5 (equality and non-discrimination), Article 6 (women with disabilities), Article 7 (children with disabilities), Article 8 (awareness-raising), and Article 9 (accessibility). The specific articles, comprising Article 10 (right to life) and onwards, are therefore intended to be interpreted in a mode consistent with the concepts addressed in Articles 1–9 (Guernsey et al., 2007).

While it does not explicitly define disability, according to the UN CRPD persons with disabilities "include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (United Nations, 2006, Article 1). Accordingly, the UN CRPD firmly aligns its classification of disability with the social model of disability (Stein and Lord, 2009). As emphasized by Lord et al. (2010), alongside its function as a human rights instrument, the UN CRPD has an explicit social development dimension, and recognizes that many persons with disabilities experience multiple forms of discrimination based on economic or other status (United Nations, 2006, preamble to the UN CRPD para p), as well as emphasizing the crucial need to address the negative impact of poverty on persons with disabilities (United Nations, 2006, preamble to the UN CRPD para t).

The UN CRPD provides a clear legal, moral and political course for change, encompassing a wide variety of fields and addressing an extensive range of human rights, including civil, political, economic, social and cultural rights (European Foundation Centre, 2010). The UN CRPD has played a seismic role in raising the political profile of disability, which is essentially linked to human rights, to such a degree that has not yet been achieved (Lang, 2009). In part due to the extensive participation of persons with disabilities in the development of the Convention, the UN CRPD has received extensive international support (Stein et al., 2009). As from April 2012, 112 countries have ratified the UN CRPD, and 64 countries have ratified the Optional Protocol. It is estimated that the UN CRPD will prompt, as well as guide the reform of domestic legislation guaranteeing substantive equality and non-discrimination for persons with disabilities (Dimopoulos, 2010; Guernsey et al., 2007). Accordingly, it is of critical importance to establish the degree to which the UN CRPD, in accordance with its affirmed purpose, promotes, protects and ensures the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.

This paper reports on the application of a novel policy analysis framework to the UN CRPD. *EquiFrame* evaluates the degree of stated commitment of a public policy to 21 core concepts of human rights and to 12 vulnerable groups, guided by the ethos of universal, equitable and accessible health services. Accordingly, *EquiFrame* allows the analyst to identify the strengths and weaknesses in current policy according to how strongly or weakly a policy advances core concepts of human rights in healthcare particularly among vulnerable groups. In its current form, *EquiFrame* is directed towards health policy-oriented researchers and policy-makers. While *EquiFrame* has been developed for the purposes of healthcare policy analysis, we believe that its form of analysis can also be usefully applied to other types of planning and guiding documents, and that coverage of core concepts of human rights and inclusion of vulnerable groups is pertinent to a range of diverse documents, including the UN CRPD (Mannan et al., 2011). While the focus of *EquiFrame* is on the analysis of policy documents in the field of health, our approach is not discipline or sector-specific, and is equally applicable to the analysis of a diverse array of fields, including the legal, political, and cultural spheres, education, employment, and social services, and to the analysis of the UN CRPD in relation to the universal and equitable access

of persons with disabilities to these fields. We therefore sought to assess the extent to which the UN CRPD addressed core concepts of human rights and inclusion of Vulnerable Groups, and by extension equitable access to services for persons with disabilities.

Development of *EquiFrame*

There is paucity of literature that outlines and utilizes analytical frameworks for the content of policies "on the books" (Stowe and Turnbull, 2001). There is however a body of research on the process of health policy development (Gilson et al., 2008). A number of frameworks have been devised that address this process, including the "Stages" Models (Exworthy, 2008); Policy Triangle Framework by Walt and Gilson (cited in Walt et al., 2008); Network Frameworks (Tantivess and Walt, 2008); Policy Space Analysis (Crichton, 2008); Multiple Streams Theory (Kingdon, 1984); Punctuated Equilibrium Theory (Exworthy, 2008); Implementation Theory (Walt et al., 2008); and Critical Theory Approach (Duncan and Reutter, 2006). While these approaches focus on the critical importance of how policy is made, they offer only little guidance on evaluating the actual content of policies, or policy "on the books". Regardless of the considerable challenges of policy development and implementation, if policy "on the books" is not inclusive of vulnerable groups, and observant of human rights, then nor are health practices likely to be. Developing and applying a method for analysing the content of policies was the focus of the present research, which was undertaken from the perspective of African low and middle-income countries. *EquiFrame* has been developed as part of a Work Package led by Ahfad University for Women, Sudan, within a larger EU FP7 funded project, EquitAble, which is led by the Centre for Global Health at Trinity College Dublin, with a consortium of international partners (www.equitableproject.org).

The World Health Report, "Working Together for Health" (WHO, 2006), noted that Africa has the greatest disease burden of any continent but has the poorest health services. The four African countries that are the focus of this policy analysis framework each represent distinct challenges in terms of equitable access to healthcare. These four countries allow us to address how access to healthcare systems for vulnerable groups can best be promoted in contexts where a large proportion of the population has been displaced (Sudan); where the population is highly dispersed (Namibia); where chronic poverty and high disease burden compete for meagre resources (Malawi); and where, despite relative wealth, universal and equitable access to healthcare is yet to be attained (South Africa). *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, and is guided by the ethos of universal, equitable and accessible health services.

Core concepts

EquiFrame's 21 core concepts are presented alongside series of key questions and key language, each series tailored to elucidate the specified core concept (Table 1). These 21 core concepts were not positioned in terms of equivalent importance within the framework, but rather were included with a view to representing a broad range of salient concerns in striving for equitable, accessible and universal healthcare. "Core concept" may be interpreted as a "central, often foundational policy component generalized from particular instances (namely, literature reviews, analyses of statutes and judicial opinions, and data from focus groups and interviews)" (Umbarger et al., 2005). *EquiFrame's* core concepts are grounded in international and domestic legal instruments (Appendix 1). Thirteen core concepts are associated with Constitutional principles and ethical principles (Appendix 2). "Each expresses a policy goal; each is directive, hortatory, or aspirational; and each points the way to improving families' quality of life" (Stowe and Turnbull, 2001, p. 208), while a number of core concepts are associated with administrative principles. They concern the implementation of the goal-oriented core concepts, the outcomes of policy as administered. They are concerned with evaluating and subsequently implementing appropriate changes in the service system (Stowe and Turnbull, 2001; Stowe et al., 2005; Turnbull and Stowe, 2001).

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.	Individualized services	Does the policy support the rights of vulnerable groups with individually tailored services to meet their needs and choices?	Vulnerable groups receive appropriate, effective, and understandable services
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 recognize 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 group 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 group are not barred from participation in services that are provided for general population
12.	Contribution	Does the policy recognize that vulnerable groups can be productive contributors to society?	Vulnerable groups make a meaningful contribution to society

Table 1 (*Continued*)

No	Core concept	Key question	Key language
13.	Family resource	Does the policy recognize the value of the family members of vulnerable groups in addressing health needs?	The policy recognizes the value of family members of vulnerable groups as a resource for addressing health needs
14.	Family support	Does the policy recognize individual members of vulnerable groups may have an impact on the family members requiring additional support from health services?	Persons with chronic illness may have mental health effects on other family members, such that these family members themselves require support
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 safe guard
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?	

Vulnerable groups

Definitions for *EquiFrame's* 12 vulnerable groups are provided in Table 2. Vulnerable groups may be defined as "social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality (Flaskerud and Winslow, 1998), and this may include children, the aged, ethnic minorities, displaced populations, people suffering from chronic illnesses and persons with disabilities. Importantly, Eichler and Burke (2006) have recognized 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.

Table 2
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 marginalized by special contexts, such as orphans or street children
6.	Aged	Referring to older age
7.	Youth	Referring to younger age without identifying gender
8.	Ethnic minorities	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

Selection of policies

Health "policies" were defined as "courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health system" (Buse et al., 2005, p. 6). Health policies were included if they met the following criteria:

- health policy documents produced by the Ministry of Health;
- policies addressing health issues outside of the Ministry of Health;
- strategies that address health policies;
- policies related to the top 10 health conditions identified by WHO[1].

A search was carried out to locate available health policies. The relevant ministries, agencies, and libraries were contacted and asked to identify policy documents falling within the scope of our research. The policy documents meeting the inclusion criteria in the four countries were: Malawi: 14; Namibia: 10; South Africa: 11; and Sudan: 16. We sought to assess the extent to which these health policy documents in Malawi, Namibia, South Africa, and Sudan promoted equitable, accessible and inclusive health services.

[1] Malawi: HIV/AIDS; lower respiratory infections; malaria; diarrhoeal diseases; perinatal conditions; cerebrovascular disease; ischaemic heart disease; tuberculosis; road traffic accidents; protein energy malnutrition. Namibia: HIV/AIDS; perinatal conditions; cerebrovascualar disease; tuberculosis; ishaemic heart disease; diarrhoeal disease; malaria; violence; lower respiratory infections; road traffic accidents. South Africa: HIV/AIDS; cerebrovascular disease; ischaemic heart disease: violence; tuberculosis; diarrhoeal diseases; road traffic accidents; diabetes mellitus; chronic obstructive pulmonary disease. Sudan: schaemic heart disease; malaria; HIV/AIDS; diarrhoeal diseases; measles; tuberculosis; cerebrovascular disease; perinatal conditions; war; road traffic accidents.

The framework

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 towards the redrafting of the Malawian National Health Policy. It is hoped therefore that the utility of *EquiFrame* will extend beyond a tool for evaluation of policies to the promotion of equity, human rights and social inclusion in the revision of existing policies and development of new policies. For further details specific to *EquiFrame* and the process of its formulation, including a more detailed discussion of literature sources for core concepts and vulnerable groups, readers are referred to the *EquiFrame* manual (Mannan et al., 2011; Amin et al., 2011; MacLachlan et al., 2012; Mannan et al., 2012a; Mannan et al., 2012b).

Summary indices

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

Core concept coverage

A policy was examined with respect to the number of core concepts mentioned of the 21 core concepts identified; and this ratio was expressed as a rounded up percentage. In addition, the actual terminologies used to explain the core concepts within each document were extracted to allow for future qualitative analysis and cross-checking between raters (Amin et al., 2011; MacLachlan et al., 2012; Mannan et al., 2011; Mannan et al., 2012a; Mannan et al., 2012b).

Vulnerable group coverage

A policy was examined with respect to the number of vulnerable groups mentioned of the 12 vulnerable groups identified; and this ratio was expressed as a rounded up percentage. In addition, the actual terminologies used to describe the vulnerable groups were extracted to allow for qualitative analysis and cross-checking between raters.

Core concept quality

A policy was examined with respect to the number of core concepts within it that were rated 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 to be present, the top quality score received was recorded as the final quality scoring for the respective concept.

Overall summary ranking

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

- high: if the policy achieved more than or equal to 50% on all of the three scores above;
- moderate: if the policy achieved more than or equal to 50% on two of the three scores above;
- low: if the policy achieved less than 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;

Table 3
EquiFrame's summary indices for United Nations Convention on the Rights of Persons with Disabilities.

	Vulnerable group coverage (%)	Core concept coverage (%)	Core concept quality (%)	Overall summary ranking
United Nations Convention on the Rights of Persons with Disabilities	75	95	100	High

- 3 = specific policy actions identified to address the concept;
- 4 = intention to monitor concept was expressed.

If a core concept was not relevant to the document context, it was stated as not applicable.

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

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 UN CRPD (United Nations, 2006), reported here, revealed that, for the Convention, in terms of inter-rater reliability, there was one hundred percent agreement with regards 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 on discussion between raters subsequent to analyzing the document, and the agreement to identify two or more core concepts to a particular segment of the UN CRPD was not found to alter the overall scorings for this document on *EquiFrame's* summary indices.

Results

Illustrated in Table 3 are the scorings on *EquiFrame's* summary indices for the UN CRPD. The UN CRPD scored above 50% on each of *EquiFrame's* summary indices. Accordingly, the UN CRPD received an overall summary ranking of "High".

Core concept coverage

Core concept coverage of the UN CRPD was 95%. Access and non-discrimination were mentioned most frequently at 71 times and 67 times respectively. Following access and non-discrimination, most frequently mentioned core concepts comprised Individualized services, contribution, and participation, mentioned 23 times, 19 times, and 17 times respectively. The core concept of efficiency was not mentioned in the UN CRPD. The core concepts of coordination of services, family resource, cultural responsiveness, prevention and quality were amongst those mentioned least frequently, each mentioned fewer than three times in the document.

Core concept quality

Article 33 outlines national implementation and monitoring provisions of the UN CRPD. This article specifies that "States parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention", including the full involvement and participation in the monitoring process of "civil society, in particular persons with disabilities and their representative organizations". As a stipulation to monitor the core concepts of human rights outlined in the UN CRPD is expressed, all core concepts were scored at a level 4 rating regarding quality of commitment to the concepts. Accordingly, core concept quality was scored as 100%. Table 4 illustrates core concept coverage and core concept quality of the UN CRPD.

Vulnerable group coverage

Seventy-five percent of the vulnerable groups covered in *EquiFrame* were addressed in the UN CRPD. Unsurprisingly, the vulnerable group of disabled persons was mentioned most frequently in the document at 141 times. Most frequently mentioned vulnerable groups also included "children with special needs", mentioned 17 times, "women headed households", mentioned 14 times, and "aged", mentioned six times. A number of vulnerable groups were not mentioned in the document, including "persons at increased relative risk for morbidity", "displaced populations", and persons "suffering from chronic illness". The vulnerable groups of "limited resources", "youth", "living away from services", and "ethnic minorities" were amongst those mentioned least frequently, each mentioned less than four times in the document. Vulnerable group coverage of the UN CRPD is outlined in Table 5.

Discussion

An extensive range of core concepts of human rights including civil, political, economic, social and cultural rights are expressly mentioned in the UN CRPD. Article 3 of the UN CRPD, outlining general principles of the Convention, comprises the core concepts of access and non-discrimination. It is unsurprising therefore that access and non-discrimination are among those concepts addressed most extensively throughout the UN CRPD. The UN CRPD in relation to non-discrimination states inter alia that "States Parties shall prohibit all discrimination on the basis of disability" (Article 5). The core concept of Access is defined by *EquiFrame* in relation to three classifications: economic, physical and informational access to services. The UN CRPD emphasizes economic access in Article 20, alongside other articles of the Convention, by stipulating that State parties shall facilitate "access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost". Physical access is outlined inter alia in Article 9 of the UN CRPD in relation to the obligation of States parties to take appropriate measures "to ensure to persons with disabilities access, on an equal basis with others, to the physical environment". Article 9 of the UN CRPD, alongside other articles, outlines the requirement on States to ensure informational access to persons with disabilities: "States parties shall also take appropriate measures to promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information".

The UN CRPD demonstrates extensive coverage of core concepts of human rights. Nonetheless, the UN CRPD does not expressly mention the core concept of efficiency, referring to the provision of a policy of a structured way of matching health system resources with service demands in addressing health needs of vulnerable groups. The core concept of efficiency is indispensable for all policy decisions and all provider systems, whether they are non-specific or particular to disability (Turnbull and Stowe, 2001).

A number of core concepts, namely quality, coordination of services, privacy and cultural responsiveness, while explicitly mentioned, are addressed only in specified and somewhat restricted terms in the UN CRPD. These core concepts are mentioned only within specified articles of the UN CRPD, that is, within Article 10 and onwards. These concepts are however outlined in the literature as critical to

Table 4
Core concepts of Human Rights in United Nations Convention on the rights of persons with disabilities.

No.	Core concept	Frequency	Quality	Terminology for core concepts in the UN CRPD (Article of UN CRPD in parentheses)
1.	Non-discrimination	67	4	States Parties shall prohibit all discrimination on the basis of disability (Art 5)
2.	Individualized services	23	4	States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided (Art 5)
3.	Entitlement	6	4	In order to promote equality and eliminate discrimination, States parties shall take all appropriate steps to ensure that reasonable accommodation is provided (Art 5)
4.	Capability based services	5	4	States Parties undertake to adopt immediate, effective and appropriate measures: to promote awareness of the capabilities and contributions of persons with disabilities (Art 8)
5.	Participation	17	4	In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations (Art 4)
6.	Coordination of services	1	4	States Parties. . . shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels (Art 33)
7.	Protection from harm	14	4	States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law (Art 5)
8.	Liberty	10	4	States Parties shall ensure that persons with disabilities, on an equal basis with others. . . enjoy the right to liberty (Art 14)
9.	Autonomy	10	4	The principles of the present Convention shall be: respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons (Art 3)
10.	Privacy	3	4	No person with disabilities. . . shall be subjected to arbitrary or unlawful interference with his or her privacy (Art 22)
11.	Integration	11	4	Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs (Art 19)
12.	Contribution	19	4	To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market (Art 8)
13.	Family resource	2	4	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 (Preamble to the Convention)
14.	Family support	7	4	To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counseling, financial assistance and respite care (Art 28)
15.	Cultural responsiveness	2	4	Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture (Art 30)

Table 4 (*Continued*)

No.	Core concept	Frequency	Quality	Terminology for core concepts in the UN CRPD (Article of UN CRPD in parentheses)
16.	Accountability	8	4	In order to prevent the occurrence of all forms of exploitation, violence and abuse, States parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities (Art 16)
17.	Prevention	2	4	States Parties shall provide. . . services designed to minimize and prevent further disabilities, including among children and older persons (Art 25)
18.	Capacity building	7	4	Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities (Art 20)
19.	Access total	71	4	
	General	25	4	The principles of the present Convention shall be: accessibility (Art 3)
	Economic	9	4	Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost (Art 20)
	Physical	12	4	States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment (Art 9)
	Informational	25	4	To promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information (Art 9)
20.	Quality	2	4	States Parties shall. . . provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons (Art 25)
21.	Efficiency	0	0	

a diverse array of fields, including the legal and political spheres, education, employment, and social services. To illustrate, the core concept of quality in relation to services is mentioned solely in Article 25 of the UN CRPD pertaining to "Health": "States Parties shall. . . provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons". We believe that Quality regarding the provision of services for persons with disabilities is a concern not exclusive to the health sector and that the importance of the delivery of quality outputs is unequivocally applicable to a diverse array of sectors, including the educational, employment and legal sectors. With respect to quality education, it has been asserted that children have a right to a quality education (UNICEF, 2000). Improvements in quality of education are often

Table 5
Vulnerable Groups in United Nations Convention on the Rights of Persons with Disabilities.

No.	Vulnerable Group	Frequency
1.	Limited resources	3
2.	Increased RR for morbidity	0
3.	Mother child mortality	5
4.	Women headed household	14
5.	Children (with special needs)	17
6.	Aged	6
7.	Youth	3
8.	Ethnic minorities	1
9.	Displaced populations	0
10.	Living away from services	2
11.	Suffering from chronic illness	0
12.	Persons with disabilities	141

synonymous with inclusion: accessible, quality, responsive learning environments benefit all children, but are particularly imperative for children with disabilities (Save the Children, 2002). As declared by UNESCO (2005), it is highly probable that the achievement of universal participation in education will be dependent on quality of education; for example, how well pupils are taught and how much they learn can have a critical impact on the duration of stay at school and regularity of attendance. With regards to quality employment opportunities for persons with disabilities, the international literature reflects concerns with respect to the lack of legal protection, effectiveness and quality of sheltered work programmes for persons with disabilities (National Disability Authority Ireland, 2009). So too, in terms of quality legal aid for persons with disabilities, Mercer and MacDonald (2007), p. 548 state that 'most disabled people are poor and often have no access to basic services, including rehabilitation and primary care, let alone a sophisticated legal apparatus to ensure their rights'.

Similarly, the UN CRPD is intrinsically cross-sectoral, as it encompasses across its articles a variety of governmental sectors. Even so, the core concept of coordination of services is observed in the UN CRPD only in relation to cross-sectoral coordination: "States Parties. . . shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels" (Article 33). Inter-agency as well as intra-agency coordination of services is therefore not explicitly mentioned in the UN CRPD. Persons with disabilities have requirements that frequently cut across a variety of domains, while services are frequently organized and delivered without acknowledgment to those transecting needs, creating the need for services that are coordinated, professionals that collaborate, and funding streams that are interconnected (Turnbull et al., 2001).

While the UN CRPD has an explicit social development perspective and recognizes that persons with disabilities frequently experience multiple or aggravated forms of discrimination, women with disabilities and children with disabilities comprise the only two sub-groups of persons with disabilities that are explicitly recognized in the UN CRPD. In a variety of contexts however, disability transpires in conjunction with disparate vulnerability factors that may generate susceptibility to multiple disadvantage and double discrimination. While persons with disabilities may present some similar challenges, for their equitable access to services, they also present quite distinctive challenges. Persons with disabilities 'constitute a heterogeneous entity, manifested in a wide range of impairment groups with differing needs and aspirations, which in turn require a range of different policy responses' (Lang et al., 2011, p. 215). The UN CRPD does not explicitly mention displaced populations with disabilities. In events of persecution, violence, conflict, and displacement, persons with disabilities are more vulnerable to losing family or caregivers, are frequently unable to flee alongside their families, or may be stranded in the path of flight; proactive outreach policies are therefore required to safeguard the identification, monitoring and support of this population in a timely manner (Executive Committee of the High Commissioner's Programme, 2007). Persons with disabilities residing in displacement camps have health-related needs, some of which are general and overlap with the needs of the broader population of displaced persons such as primary healthcare and mental healthcare, while other needs are more disability-specific such as curative, preventive and maintenance-based rehabilitation services, technical aids, corrective surgeries and medical treatment for chronic health conditions (Mirza, 2011). Persons with disabilities at increased relative risk for morbidity, including HIV/AIDS, are not explicitly addressed in the UN CRPD. Despite the growing relationship between HIV/AIDS and disability, persons with disabilities have not received adequate attention within national responses to HIV/AIDS; further, existing HIV programmes generally fail to meet the specific needs of persons with disabilities (United Nations Enable, 2008–2011b). Further, persons with disabilities suffering from chronic illness are not explicitly mentioned in the UN CRPD (DeJong and Basnett, 2001).

Both through the process of undertaking this research and providing feed-back of results to stakeholders workshops in different countries, we have observed several factors that are important to consider when interpreting the results of *EquiFrame*. The indices we have used – scores of over 50% for each of our ratings–could be altered to reflect different weighting or sensitivity with regard to human rights, vulnerability or specific actions to address a concept or intention to monitor a concept being expressed. Indeed these latter two categories could be treated separately rather than combined, as we did here. Ultimately *EquiFrame* is a methodology for descriptive analysis that can provide quantitative indices that can be fine-tuned for the required purpose.

Stakeholders including persons with disabilities and their representative organizations during the consultations that took place during the development of *EquiFrame* 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 use of "All", or its synonyms, indicates that documents using such 'all-inclusive' terms, also specify certain vulnerable groups, but not others. Accordingly, we feel it is important to establish which vulnerable groups are included, and which are not, as the use of inclusive terminology does not necessarily address the concerns of specific vulnerable groups.

The application of *EquiFrame* to the UN CRPD has yielded a number of compelling findings in terms of the absolute and legitimate alignment of the UN CRPD with its affirmed purpose: "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities". Not all core concepts of human rights are explicitly mentioned in the UN CRPD, while a variety of core concepts, pertinent to a much broader range of fields, are referred to only within specified articles of the UN CRPD. Further, a number of sub-groups of persons with disabilities are not explicitly expressed in the UN CRPD, potentially compromising the recognition and incorporation by signatory States of the specific needs and aspirations of these heterogeneous populations in legislative and policy responses. Yet, these deficits are conceivably partially reconciled by an extensive range of core concepts of human rights including civil, political, economic, social and cultural rights that are comprised in the UN CRPD. The analysis of the UNCRPD indicates the inclusion of 20 core concepts of human rights and nine Vulnerable Groups "on the books"; now that signatory countries are presenting their country reports on the situation of persons with disabilities, we believe that country reports that are submitted towards monitoring of the UNCRPD should report on these core concepts and vulnerable groups. As affirmed by Mercer and MacDonald (2007), there can be little doubt that the UN CRPD is a progressive step for persons with disabilities in general. As declared by Lang (2009), it is the first time in history that persons with disabilities, their representative organizations and other civil society institutions will have a legal redress to hold to account their governments for the protection and enforcement of disability rights. Burgeoning international support for the UN CRPD implies that, if effectively implemented, the UN CRPD can on an increasingly global scale fortify the political profile of disability, reinforce a paradigm shift in political conceptions of disability, and above all establish the legal obligations on signatory states to promote and protect the human rights of persons of disabilities worldwide.

Appendix 1. *EquiFrame* core concepts of Human Rights: Key legal instruments

EquiFrame 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 (1966) Vienna Declaration and Programme of Action (1993) United Nations Millennium Declaration (2000) Americans with Disabilities Act of 1990
2. Individualized services	UN Convention on the Rights of Persons with Disabilities (2006) 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 (2006) 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)

Appendix 1 (*Continued*)

EquiFrame core concepts of Human Rights	Key legal instruments
4. Capability based services	UN Convention on the Rights of Persons with Disabilities (2006)
	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 Globalized World (2005)
5. Participation	Vienna Declaration and Programme of Action (1993) International Convention on the Elimination of All Forms of Racial Discrimination (1965) 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 (2006)
	United Nations Political Declaration on HIV/AIDS (2011) 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 (2006) European Social Charter (1961, 1996) International Convention on the Elimination of All Forms of Racial Discrimination (1965) 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 (2006) African Charter on Human and Peoples' Rights (1986) International Covenant on Civil and Political Rights (1966) 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 (1966) European Social Charter (1961, 1996) Vienna Declaration and Programme of Action (1993) United Nations Political Declaration on HIV/AIDS (2011) 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 (2006) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health (2000) International Covenant on Civil and Political Rights (1966) United Nations Political Declaration on HIV/AIDS (2011) 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 (1961, 1996) 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)

Appendix 1 (*Continued*)

EquiFrame core concepts of Human Rights	Key legal instruments
12. Contribution	UN Convention on the Rights of Persons with Disabilities (2006) European Social Charter (1961, 1996) International Convention on the Elimination of All Forms of Racial Discrimination (1965) 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 (2007)
13. Family resource	UN Convention on the Rights of the Child (1990) UN Convention on the Rights of Persons with Disabilities (2006) 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) Quebec 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 (2006) African Charter on Human and Peoples' Rights (1986) International Covenant on Civil and Political Rights (1966) European Social Charter (1961, 1996) United Nations Declaration on the Rights of Mentally Retarded Persons (1971) The Universal Declaration of Human Rights (1948)
15. Cultural responsiveness	UN Convention on the Rights of Persons with Disabilities (2006) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health (2000) 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 (2007)
16. Accountability	UN Convention on the Rights of Persons with Disabilities (2006) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health (2000) Vienna Declaration and Programme of Action (1993) International Convention on the Elimination of All Forms of Racial Discrimination (1965) United Nations Political Declaration on HIV/AIDS (2011) 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 (2000) European Social Charter (1961, 1996) United Nations Political Declaration on HIV/AIDS (2011) Declaration of Alma-Ata, International Conference on Primary Health Care (1978)
18. Capacity building	UN Convention on the Rights of Persons with Disabilities (2006) CESCR General Comment No. 14. The Right to the Highest Attainable Standard of Health (2000) United Nations Political Declaration on HIV/AIDS (2011) United Nations Political Declaration on Africa's Development Needs (2008) 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 (1961, 1996) Vienna Declaration and Programme of Action (1993) International Convention on the Elimination of All Forms of Racial Discrimination (1965)

Appendix 1 (*Continued*)

EquiFrame core concepts of Human Rights	Key legal instruments
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 (2000) UN - Keeping the promise: united to achieve the Millennium Development Goals [Resolution adopted by the General Assembly 2010] Durban Declaration and Programme of Action (2001) Constitution of the Republic of Ecuador; Art 66 (2008) Constitution of Venezuela; Art 84 (1999)
21. Efficiency	United Nations Political Declaration on HIV/AIDS (2011) 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)

Appendix 2. Taxonomy for core concepts in relation to underlying principles

No.	Core concept	Principle
1.	Non-discrimination	Constitutional/ethical
2.	Individualized services	Administrative
3.	Entitlement	Administrative
4.	Capability based services	Administrative
5.	Participation	Constitutional/ethical/administrative
6.	Coordination of services	Administrative
7.	Protection from harm	Constitutional/ethical
8.	Liberty	Constitutional/ethical
9.	Autonomy	Constitutional/ethical
10.	Privacy	Constitutional/ethical
11.	Integration	Constitutional/ethical/administrative
12.	Contribution	Constitutional/ethical
13.	Family resource	Constitutional/ethical/administrative
14.	Family support	Constitutional/ethical/administrative
15.	Cultural responsiveness	Constitutional/ethical/administrative
16.	Accountability	Administrative
17.	Prevention	Constitutional/ethical
18.	Capacity building	Administrative
19.	Access	Ethical
20.	Quality	Administrative
21.	Efficiency	Administrative

References

Amin, M., MacLachlan, M., Mannan, H., El Tayeb, S., El Khatim, A., Swartz, L., et al. (2011). *EquiFrame*: A framework for analysis of the inclusion of human rights and vulnerable groups in health policies. *Health and Human Rights: An International Journal*, *13*(2), 1–20.

Baylies, C. (2002). Disability and the notion of human development: questions of rights and capabilities. *Disability and Society*, *17*(7), 725–739.

Bickenbach, J. E. (2001). Disability human rights, law, and policy. In G. L. Albrecht, K. D. Seelman, & M. Bury (Eds.), *Handbook of disability studies* (pp. 565–584). USA: Sage Publications, Inc.

Buse, K., Mays, N., & Walt, G. (2005). *Making Health Policy (Understanding Public Health)*. UK: Open University Press.

Crichton, J. (2008). Changing fortunes: analysis of fluctuating policy space for family planning in Kenya. *Health Policy and Planning*, *23*(5), 339–350.

DeJong, G., & Basnett, I. (2001). Disability and Health Policy: the role of markets in the delivery of health services. In G. L. Albrecht, K. D. Seelman, & M. Bury (Eds.), *Handbook of Disability Studies* (pp. 610–632). USA: SAGE Publications.

Dimopoulos, A. (2010). *Issues in human rights protection of intellectually disabled persons (Medical Law and Ethics)*. England: Ashgate Publishing Ltd.

Duncan, S., & Reutter, L. (2006). A critical policy analysis of an emerging agenda for home care in one Canadian province. *Health and Social Care in the Community*, *14*(3), 242–253.

Eichler, M., & Burke, M. A. (2006). The BIAS FREE framework: a new analytical tool for global health research. *Canadian Journal of Public Health*, *97*(1), 63–68.

European Foundation Centre. (2010). Study on challenges and good practices in the implementation of the UN Convention on the Rights of Persons with Disabilities VC/2008/1214: Final Report. Retrieved April 27, 2011. from http://www.study-uncrpd.eu/files/repository/20110201165756_VC20081214_FINAL_REPORT_web_010211.pdf.

Executive Committee of the High Commissioner's Programme (2007). The Protection of Older Persons and Persons with Disabilities. Retrieved August 09, 2011. from http://www.unhcr.org/cgi-bin/texis/vtx/home/opendocPDFViewer.html?docid=4666d9602&query=persons%20with%20disabilities.

Exworthy, M. (2008). Policy to tackle the social determinants of health: using conceptual models to understand the policy process. *Health Policy and Planning*, *23*(5), 318–327.

Flaskerud, J. H., & Winslow, B. J. (1998). Conceptualizing vulnerable populations health-related research. *Nursing Research*, *47*(2), 69–78.

Gilson, L., Buse, K., Murray, S., & Dickinson, C. (2008). Future directions for health policy analysis: A tribute to the work of professor Gill Walt. *Health Policy and Planning*, *23*(5), 291–293.

Guernsey, K., Nicoli, M., Ninio, A. (2007). Convention on the Rights of Persons with Disabilities: Its Implementation and Relevance for the World Bank. The World Bank. Retrieved August 09, 2011. from http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-papers/Disability-DP/0712.pdf.

Inter-agency (2008). Convention on the Rights of Persons with Disabilities: Advocacy Toolkit. Retrieved May 01, 2011. from http://www.unhcr.org/refworld/docid/497f04592.html.

Kingdon, J. W. (1984). *Agendas, Alternatives and Public Policies*. Boston: Little, Brown.

Lang, R. (2009). The United Nations Convention on the right and dignities for Persons with Disability: a panacea for ending disability discrimination? *ALTER: European Journal of Disability Research*, *3*(3), 266–285.

Lang, R., Kett, M., Groce, N., & Trani, J. F. (2011). Implementing the United Nations Convention on the Rights of Persons with Disabilities: principles, implications, practice and limitations. *ALTER: European Journal of Disability Research*, *5*(3), 206–220.

Lord, J., Posarac, A., Nicoli, M., Peffley, K., McClain-Nhlapo, C, Keogh, M. (2010). Disability and international cooperation and development: a review of policies and practices (SP Discussion Paper: No. 1003). The World Bank.

MacLachlan, M., Amin, M., Mannan, H., El Tayeb, S., Bedri, N., Swartz, L., Munthali, A., Van Rooy, G., & McVeigh, J. (2012). Inclusion and Human Rights in Health Policies: Comparative and Benchmarking Analysis of 51 Policies from Malawi, Sudan, South Africa and Namibia. *PLoS One*, *7*(5) [e35864. doi:10.1371/journal.pone.0035864]

Mannan, H., Amin, M., MacLachlan, M., & the EquitAble Consortium. (2011). *The EquiFrame Manual: a tool for evaluating and promoting the inclusion of vulnerable groups and core concepts of Human Rights in health policy documents*. Dublin: Global Health Press.

MannanH., Amin, M., MacLachlan, M., & the EquitAble Consortium. (2012a). Non-communicable disease priority actions and social inclusion. *Lancet*, *379*(9812), 17–18.

Mannan, H., McVeigh, J., Amin, M., MacLachlan, M., Swartz, L., Munthali, A., Van Rooy, G. (2012b). Core concepts of Human Rights and inclusion of vulnerable groups in the disability and rehabilitation policies of Malawi, Namibia, Sudan and South Africa. Journal of Disability Policy Studies, http://dx.doi.org/10.1177/1044207312439103.

Mercer, S. W., & MacDonald, R. (2007). Disability and human rights. *Lancet*, *370*(9587), 548.

Mirza, M. (2011). Unmet Needs and Diminished Opportunities: Disability, Displacement, and Humanitarian Healthcare (New Issues in Disability Research: Research Paper No. 212). Switzerland: United Nations High Commissioner for Refugees. Retrieved August 08, 2011, from http://www.unhcr.org/cgibin/texis/vtx/home/opendocPDFViewer.html?docid=4e0dbdb29&query=disability.

Munthali, A., Mannan, H., MacLachlan, M. (2011). Social Inclusion and Health Policies. National Workshop for Health Policy-Makers and Policy Analyst. Lilongwe, 8-9 November.

National Disability Authority Ireland. (2009). From Sheltered to Open Employment for People with Disabilities in Ireland. Retrieved August 09, 2011. from http://www.nda.ie/Website/NDA/CntMgmtNew.nsf/0/35B752678B255AEA8025787F004789BD/$File/Policy_Advice_Paper_on_Sheltered_Employment_Services.pdf.

Office of the United Nations High Commissioner for Human Rights. (1975). Declaration on the Rights of Disabled Persons. Retrieved August 05, 2011. from http://www2.ohchr.org/english/law/res3447.ht.

Quinn, G. (2009). The United Nations Convention on the Rights of Persons with Disabilities: Toward a new international politics of disability. *Texas Journal on Civil Liberties and Civil Rights*, *15*(1), 33–52.

Save the Children(2002). Schools for ALL Including Disabled Children in Education. UK: Save the Children. Retrieved August 09, 2011. from http://www.savethechildren.org.uk/en/docs/schools_for_all.pdf.

Stein, M. A., & Lord, J. E. (2009). Future Prospects for the United Nations Convention on the Rights of Persons with Disabilities. In O. M. Arnardóttir, & G. Quinn (Eds.), *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian Perspectives. Volume 100 of International Studies in Human Rights* (pp. 17–40). Netherlands: BRILL.

Stein, M.A., Stein, P.J.S., Weiss, P., Lang, R. (2009). Health Care and the UN Disability Rights Convention. Faulty Publications. Paper 1135. Retrieved April 27, 2011. from http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=2166&context=facpubs.

Stowe, M. J., & Turnbull, H. R. (2001). Tools for analyzing policy on the books and policy on the streets. *Journal of Disability Policy Studies*, *12*(3), 206–214.

Stowe, M. J., Turnbull, H. R., & Umbarger, G. T. (2005). Connections among the core concepts of health policy and the core concepts of disability policy. *Journal of Disability Policy Studies*, *16*(2), 74–83. http://dx.doi.org/10.1177/10442073050160020601

Tantivess, S., & Walt, G. (2008). The role of state and non-state actors in the policy process: the contribution of policy networks to the scale-up of antiretroviral therapy in Thailand. *Health Policy and Planning*, *23*(5), 328–338.

Turnbull, H. R., Beegle, G., & Stowe, M. J. (2001). The core concepts of disability policy affecting families who have children with disabilities. *Journal of Disability Policy Studies*, *12*(3), 133–143.

Turnbull, H. R., & Stowe, M. J. (2001). A taxonomy for organizing the core concepts according to their underlying principles? *Journal of Disability Policy Studies*, *12*(3), 177–197.

Umbarger, G. T., Stowe, M. J., & Turnbull, H. R. (2005). The core concepts of health policy affecting families who have children with disabilities. *Journal of Disability Policy Studies*, *15*(4), 201–208. http://dx.doi.org/10.1177/10442073050150040201

UNESCO. (2005). Understanding Education Quality. Retrieved August 09, 2011. from http://www.unesco.org/education/gmr_download/chapter1.pdf.

UNICEF. (2000). Defining Quality in Education. New York: United Nations Children's Fund. Retrieved August 09, 2011. from http://www.unicef.org/education/files/QualityEducation.PD.
United Nations (1982). World Programme of Action Concerning Disabled Persons. Retrieved August 05, 2011. from http://unstats.un.org/unsd/demographic/sconcerns/disability/A-RES-37-52.htm.
United Nations (1991). The Protection of Persons with Mental Illness and the Improvement of Mental Health Care. Retrieved August 05, 2011, from http://www.un.org/documents/ga/res/46/a46r119.htm.
United Nations (1993). Standard Rules on the Equalization of Opportunities for Persons with Disabilities. Retrieved August 05, 2011, from http://www.un.org/documents/ga/res/48/a48r096.htm.
United Nations (2006). Convention on the Rights of Persons with Disabilities. Retrieved August 05, 2011, from http://www.un.org/disabilities/convention/conventionfull.shtml.
United Nations Enable (2006). Convention on the Rights of Persons with Disabilities: Why a Convention? Retrieved April 25, 2011, from http://www.un.org/disabilities/convention/questions.shtml.
United Nations Enable (2008-2011a). Frequently Asked Questions Regarding the Convention on the Rights of Persons with Disabilities. Retrieved April 25, 2011, from http://www.un.org/disabilities/default.asp?navid=23&pid=151#iq4.
United Nations Enable. (2008-2011b). Disability and HIV/AIDS. Retrieved August 05, 2011, from http://www.un.org/disabilities/default.asp?id=156.
Walt, G., Shiffman, J., Schneider, H., Murray, S. F., Brugha, R., & Gilson, L. (2008). 'Doing' health policy analysis: Methodological and conceptual reflections and challenges. *Health Policy and Planning*, *23*(5), 308–317.
WHO. (2006). Working Together for Health. The World Health Report 2006. Available: http://www.who.int/whr/2006/whr06_en.pdf. Accessed: April 30, 2012.
WHO and World Bank (2011). World Report on Disability. World Health Organization. Retrieved December 12, 2011, from http://whqlibdoc.who.int/hq/2011/WHO_NMH_VIP_11.01_eng.pdf.