POSITION STATEMENT

An organising framework for addressing equity in access to eye care

June 2020

The Fred Hollows Foundation

ACN 070 556 642

POSITION STATEMENT

This position presents The Fred Hollows Foundation's (The Foundation) preferred definition of equity in eye health care and an organising framework for addressing inequities through our programming. It seeks to ensure that a human rights approach to addressing inequities is embedded and operationalised in our work.

Principles for addressing equity in access to eye care

Equity and Eye Health

The World Health Organization (WHO) defines equity as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification".[1]

Addressing health inequities is critical to ensuring that all people can realise their fundamental human right to good health and attaint their full health potential. In eye health, this means that all people can access the eye health information and support services they need to prevent vision loss or manage vision impairment.

Some people require more support to address their eye health needs than others, for example people living with a disability, those living in remote communities and those who are economically disadvantaged. Providing equal services for all is not enough, "the underlying issues and individual needs of underserved and vulnerable populations must be effectively addressed".[2] This includes addressing attitudinal and physical barriers to make eye health accessible to all.[3]

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- **The Fred Hollows Foundation (The Foundation) believes good eye health and access to eye health care is part of every human's fundamental right to good health and wellbeing.** This means that all people should have access to quality, efficient, and affordable eye health care.
- The Foundation is committed to ensuring that our programs consider the needs of the poorest and most marginalised in the places where we work, including the complexities relating to issues of inequity in access to eye health care and appropriate responses. To fulfil this commitment, we have adopted the **GAPSED+ equity organising framework.**
- **We will use the GAPSED+ organising framework to understand who is most marginalised and excluded** in terms of access to eye care and ensure that our work targets the needs and respects the human dignity of these specific groups and communities. We will actively engage with those groups and communities, and their representatives, in decisions about their eye health to support their empowerment.
- **All new projects, programs and initiatives will be required to use the GAPSED+ equity organising framework** during the conduct of situational analyses and project development to ensure issues of inequity are effectively identified and addressed. Project review and approval processes will be used to ensure this occurs, and that considerations of equity are balanced in our decision making with considerations of value for money programming and how to optimise our contribution to ending avoidable blindness and vision impairment, the local context, and the needs and circumstances of our implementing partners.
- The Foundation is committed to assessing and implementing ways to mainstream equity and inclusion across our projects and supporting advocacy strategies that increase equity of access for all people. We will monitor the impact of our programming in reducing eye health inequity across the GAPSED+ domains, and adjust our program portfolio, program design and approval processes as required.
- **The Foundation considers eye health as a human right for all.** We will promote the use of rights-based language for eye health programs and services. However, we understand there are some contexts where it is not appropriate to explicitly use the language of rights and rights-based approaches. In these circumstances, it may be possible to use equity and inclusion more broadly in the way The Foundation has articulated in its public-facing strategy.
- **We support country and implementing teams to make decisions about which marginalised and excluded groups to target on a case-by-case basis**, with support from global technical teams to review available evidence, mobilise targeted funding and evaluate impact. The Foundation acknowledges that marginalisation and exclusion of different groups is context specific and will support our country offices and partners in addressing local barriers to equitable eye health.
- **The Foundation will continue to invest in advocacy efforts at the local and global level to empower vulnerable and marginalised groups** – including women, people with disabilities, people living in rural & remote areas and indigenous peoples – to share their experience and engage in decisions to address their eye health needs.
- **We will actively learn from our partners, country offices and others in the international development sector who are championing and leading work on equity**. Where it is needed, The Foundation will develop partnerships with new organisations to deliver localised and targeted services to marginalised groups, such as Women's organisations, Disabled Peoples Organisations (DPOs), Indigenous led organisations, community-controlled organisations etc
- **The Foundation commits to using an equity lens in making decisions that impact our programming and organisation structure.**

GAPSED+

The Foundation is committed to addressing and embedding equity in our organisational policies, internal processes and procedures.

The Foundation has adopted the **GAPSED+ equity organising framework.** This organising framework is based on a comprehensive assessment of existing evidence on health and equity (see Appendix A). It prioritises domains of equity to help understand the landscape of inequity in countries where we work.

Being aware that issues of inequity shift across space, place and time, the GAPSED+ domains provide a looking glass and not a prescription for identifying relevant domains in all contexts. Decisions on which domains to focus and/or prioritise should align with country context and The Foundation's capacity for delivering impact.

GAPSED+

Gender/sex

Age

Place of residence

Socio economic status

Ethnicity/indigeneity/race/culture

Disability

Plus (+) - Other factors of marginalisation and exclusion (migrant status, LGBTQI+) as determined by context-specific situational analyses

In addition, we will continuously strengthen our internal approaches to mainstream equity work with local communities and partners, and will develop new tools, processes and policies as needed.

This includes:

- **Human Rights, Gender Equity and Disability Inclusion Policy**
- **Safeguarding People Policy** – Incorporating Code of Conduct and Child Protection
- **Gender Equity and Inclusion Framework 2019-2023**
- Our organisational values of: **Integrity, Collaboration, Empowerment** and **Action** that guide our ways of working.
- Our **Indigenous Australia Program (IAP) principles**, which are informed by the United Nations Declaration on the Rights of Indigenous Peoples, the National Aboriginal and Torres Strait Islander Health Plan and the Aboriginal Peak Organisations Northern Territory principles. These principles uphold the right of Aboriginal and Torres Strait Islander Peoples to self-determination, and guide the way The Foundation works in Australia.
- The Foundation's **Reconciliation Action Plan 2019-2022**, which includes key commitments to increase recruitment and retention of Aboriginal and Torres Strait Islander staff.

HEALTH EQUITY vs EQUALITY

Equality

The assumption is that **everyone benefits from the same supports**. This is equal treatment.

Equity

Everyone gets the supports they need (this is the concept of "affirmative action"), thus producing equity.

Justice

All 3 can see the game without supports or accommodations because **the cause(s) of the inequity was addressed**. The systemic barrier has been removed.

APPENDIX A: KEY EQUITY ISSUES

Gender / Sex

- **55% of the world's blind are women** and most live in middle to low income countries.[10]
- Globally, there is often **inequitable access to and use of health care** between men and women and boys and girls – in most places **females are less likely to receive the eye health care they need** because of a range of cultural, geographical, gender role and cost-related factors including: family responsibilities, financial dependence, restricted access to transport, limits on freedom of movement, limited decision-making power, low literacy rates, low self-esteem and lack of self-confidence.[12] Lack of privacy or confidentiality, and biased or unsympathetic attitudes of providers can also reduce access to services.[13]
- **Despite increasing awareness of gender inequity** in blindness and eye disease, and a recognition that these rates have remained static in the last ten years, there is **little evidence of the impact** of healthcare strategies and interventions to address this gender imbalance.

Age

- 86% of the global population of people who are blind or vision impaired are aged 50 years or over with more than half over the age of 70. **Ageing is the primary risk factor for many eye conditions.**[11]
- Biological ageing is an inherent factor of life and is therefore correlated with an unavoidable inequality in health outcomes. However, there is no typical 'older person' and these assumptions have led to a dearth of research and data on the relationship between ageing and inequality.
- **Older people tend to use eye care services less frequently**, often considering a reduction in vision as part of the normal ageing process, and unaware that many eye conditions can be treated or that rehabilitation may improve their functioning.[5]

Place of Residence

- A person's place of residence can have significant impacts on their capacity to access health services when and where they need them. **Inequality in outcomes due to geographic location** can be found between and within continents, countries, regions, and cities within those regions.
- There is limited data to make direct comparisons on prevalence of blindness and vision impairment between urban and rural populations. **Generally, people who live in lower-income countries and locations** (predominately rural settings) **suffer poorer eye health outcomes**.[5]
- Increasing rates of urbanisation and inequality within urban areas is also an area of concern. **More than half the world's population live in urban areas** and by 2050, this is projected to increase to 70%. There are few studies that assess the relationship between urbanisation, urban slums and eye health, despite the fact that one-third of the urban population in developing countries (close to 1 billion people) live in informal settlements or slums.[14]

Socioeconomic Status

- **Poverty, income, employment status, education level** and other **socioeconomic factors** are key determinants of a person's ability to access and afford treatment to prevent avoidable blindness and vision impairment.
- Blindness and vision impairment have been inversely correlated with higher socioeconomic status measured by higher income, higher educational status, or non-manual occupational social class. Overall, **the prevalence of blindness is higher in impoverished communities around the world** and in lower-income countries overall.[1]

Ethnicity, Indigeneity and Culture

Indigenous and Tribal Peoples

- Despite limited data, blindness and vision loss has been shown to disproportionately impact Indigenous and Tribal Peoples around the world.
- Generally speaking, Indigenous and tribal peoples around the world suffer from poorer health and socio-economic outcomes, and ultimately die younger than their non-Indigenous counterparts. viii While the 370 million Indigenous Peoples make up five per cent of the global population, they account for about 15 per cent of the world's poor.[15, 16] They also make up about one-third of the world's 900 million extremely poor rural people.[15]
- A recent study by the Lancet-Lowitja Institute Global Collaboration found significant and varying disparities among 28 Indigenous populations from 23 countries against several health and social indicators when compared with benchmark populations.[15]

Ethnicity

- Cultural attitudes, issues of racism and discrimination based on ethnicity all impact individuals' experience of health services and ability to seek treatment for eye health issues when needed.

Disability

- The United Nations Convention on the Rights of Persons with disabilities (UNCRPD) states that 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'
- The World Health Organization estimates that around **15% of the world's population have some form of disability, 80% of whom live in developing countries**.[17] People with disabilitiesface greater challenges in accessing eye health services and participating fully in society.
- A focus on accessibility and affordability of health services is needed to eliminate these barriers and ensure people with disabilities can unlock their full potential and lead fulfilling lives, as well as attitudinal/stigma change.[3]
- **Disability and blindness reinforce other areas of social and political inequity and discrimination**: people living in poverty, women, and the elderly are all more likely to suffer from disabilities, including blindness and vision impairment.[5]

Plus

A number of other social, cultural and environmental factors have been linked to marginalisation and exclusion of certain groups in accessing health services, including:

- Internally displaced persons, asylum seekers and refugees
- Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex, plus (LGBTQI+) communities
- People living in conflict affected and fragile states

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Document control

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