Australia Bali Memorial Eye Centre – Phase II Support Program

AidWorks Initiative Number INJ001

Activity Design Document

February 2010.

Aid Activity Summary

Aid Activity Name	Australia Bali Memorial Eye Centre – Phase II Support Program		
Aid Works initiative number	INJ001		
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Total other $	N/A		
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Implementing Partner(s)	Government of Indonesia		
Country/Region	Bali, Indonesia		
Primary Sector	Health		

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Dr John Menzies was the team leader for the Design Team that consisted of the following members:

- Ms Karen Harmon – Service Planner
- Prof. Frank Billson - Ophthalmology Consultant
- Ms Pamela Cummings - Specialist Eye Nursing Service Advisor
- Dr Stephanus Indradjaya - Indonesian Health Advisor
- Mr Brian Hearn – AusAID Canberra Office.
- Mr. Eldrin Kumendong - Costing Planner.

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Key Abbreviations

AAA	Accra Agenda for Action
ABMEC	Australia Bali Memorial Eye Centre
AIP	Australia Indonesia Partnership
AusAID	Australian Agency for International Development
AVI	Australian Volunteers International
BLUD	Badan Layanan Umum Daerah
BMP	Bali Memorial Package
DinKes	Dinas Kesehatan (Provincial Department of Health)
GoA	Government of Australia
GoB	Government of Bali
GoI	Government of Indonesia
KPI	Key performance Indicator
KRA	Key Result Area
HRD	Human Resource Development
HA	Hospital Administrator
HSA	Health Services Advisor
ISP	Implementing Service Provider
MANDARA	Planned Bali Health Insurance Scheme due to commence early in 2010
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NGO	Non Government Organisation
PCC	Program Coordinating Committee

PERDAMI	Perhimpunan Dokter Spesialis Mata Indonesia (Indonesian Ophthalmologist Association)
PMI	Palang Merah Indonesia (Indonesian Red Cross)
RS	Rumah Sakit (Hospital)
RS Indera	Rumah Sakit Indera (Indera Hospital)
RS Sanglah	Rumah Sakit Sanglah (Sanglah Hospital)
SEKDA	Sekretaris daerah
TNA	Training Needs Analysis
WHO	World Health Organisation

1. Executive Summary

Key background information

Following the tragic bomb blasts in Kuta, Bali in October 2002, the Prime Minister of Australia approved the $10.5 million Bali Memorial Package. The key purposes of the aid package were to help improve health services in Bali and to be a memorial to the people who lost their lives including 88 Australians. One of the three main components of the aid package was the construction and equipping of a new purpose built eye disease treatment centre which was officially opened in July 2007. The new eye centre was named the Australia Bali Memorial Eye Centre (ABMEC).

ABMEC became one campus of the Provincial hospital responsible for the treatment of eye, skin and ear, nose and throat conditions, Rumah Sakit Indera (RS Indera). Under the RS Indera management team, ABMEC / RS Indera provides assessment and diagnosis of patients with general eye disease. Treatment is limited to general eye diseases and speciality care in the disciplines of lens and refraction, cataract surgery, glaucoma, and retinal surgery. Currently, the first two speciality areas are better developed than the latter two. ABMEC / RS Indera was also provided with two mobile clinics which are used to provide certain free eye operations for the poor in rural areas of Bali.

A review of ABMEC undertaken in November 2008 noted that although ABMEC, as a part of RS Indera, was providing effective services, the hospital had not reached its full potential. For ABMEC / RS Indera to achieve its full potential it would be necessary to support further capacity building of staff and enhanced ongoing cooperation between all major parties involved with eye doctor training and service delivery in Bali *viz*., PERDAMI (the Indonesian Professional Association of Ophthalmologists), Rumah Sakit Sanglah, Udayana University Eye Department and ABMEC/ RS Indera . In early 2009, the Australian Government decided to provide a second phase of support to ABMEC/ RS Indera. This design document outlines the elements of aid that will be provided and how it will assist the GoI to improve eye disease service delivery at ABMEC / RS Indera and provide better training for eye surgeons in Bali.

This second phase of assistance to be provided to AMBEC / RS Indera is congruent with the overall Australia Indonesia Partnership Country Strategy (AIP) 2008-2013. In particular, this Program will assist Bali and eastern Indonesia to address the major issue of preventable blindness and eye disease. Data provided by PERDAMI indicate that there is a 12.7% eye morbidity prevalence rate in Bali's 3.1M population. The World Health Organization estimates that 1.5% of Indonesia's population suffers from blindness and cataract is the leading cause of blindness. It has also been noted that there is a strong relationship between poverty and the incidence of blindness with a significantly higher prevalence of blindness amongst the urban and rural poor.

The Proposed Program of Assistance

A three year program of assistance totaling AUD 3M has been proposed. The Program involves two specific phases- i) an initial support and planning phase, expected to start from the date of Program commencement and cover a period of around 6 months depending upon the activities approved by the Program Coordinating Committee (PCC) and iii) the full implementation phase which will run from the end of the initial support and planning phase until the end of the program which is expected to conclude around the end of calendar year 2012.

The Program's goal is that **the population of Bali, particularly for those that are poor, receives best practice tertiary eye care.** The Program of Assistance has been designed with an outcomes / results approach as the basis for achieving the goal. There are two key objectives to be achieved within 3 years,

- assisting ABMEC / RS Indera to deliver best practice tertiary eye services, and
- assisting ABMEC / RS Indera and related eye surgeon training facilities to provide best practice eye surgeon clinical training.

The Program objectives evolved from the main activities, issues and focus initially suggested by key stakeholders in late 2008 and early 2009.

The Program is based upon a set of guiding principles which are:

- Partnership between the GoA and the GoI to improve the eye health of the people of Bali based on ongoing policy engagement and sound governance principles.
- A focus on the improvement of eye health status of men, women and children in Bali through the provision of essential and cost effective eye health services that meet Indonesian best practice standards.
- Assistance to help Bali implement its own plans in accordance with GoI procedures and regulations.
- Support for strengthened governance that emphasize efficiency, effectiveness, quality improvement and stakeholder participation.
- Support to build capacity of local staff providing eye services and the training of eye doctors and clinical support staff to achieve ABMEC / RS Indera eye health objectives in accordance with the needs identified by ABMEC / RS Indera.
- Development that builds upon past and current AusAID assistance where activities are yet not fully self sustaining.
- Strong and continuing focus on monitoring the performance and achievements of the Program of Assistance.
- Promoting engagement with institutions of civil society including the community, NGOs, the private sector and educational institutions in health service provision and training improvement.
- A continuing focus upon the key crosscutting issues of poverty reduction and gender equity.
- Strategic use of Australian resources to address areas where maximum impact can be achieved within local recurrent funding and resources.

It is intended that this second phase of assistance will primarily revolve around training and capacity building for ABMEC / RS Indera personnel, ranging from clinicians and health service delivery staff through to administration and clinical support staff in accordance to the needs identified by Balinese health authorities. Core to this is the engagement of a full time experienced a Health Services Advisor (HSA) as an advisor, coach and mentor to senior ABMEC / RS Indera staff. This advisor will be responsible to the Director of ABMEC / RS Indera, with a representative of the Director being a member of the selection panel. In particular, this advisor position will assist with advice on clinical administrative issues that will allow ABMEC / RS Indera to improve the quality and quantity of clinical services that are offered. This position will be supported by several short term external (both national and international) advisors and trainers who will be recruited for specific tasks to meet the needs which will be identified following a management gap analysis and training needs analysis. These will be undertaken in the first quarter of the first year of assistance.

To assist ABMEC / RS Indera achieve its full potential of providing Indonesian best practice standards of care, some program assistance will be given to improving infrastructure. No new building work will be undertaken, however, an allocation is provided for some minor capital works that will assist with improved efficiency and safety of patient care.

As the new Bali health insurance program will allow for direct referral of eye patients from local community health centres (*puskesmas*) and district hospitals, the current outreach program is to be reviewed. ABMEC has indicated its intention to transport referred rural area patients from *puskesmas* and district hospitals to ABMEC / RS Indera to receive treatment. The Provincial Health Office will select district hospitals and/or *puskesmas* that require skill enhancement and Udayana University will select district hospitals and *puskesmas* where registrars can be placed for training. The equipment and resources in the mobile clinics might then be reallocated to ABMEC / RS Indera and the district hospitals.

Whist much of the capacity building can be provided by the proposed short and long term advisors and trainers, there is a need for an ongoing support mechanism to help ABMEC / RS Indera with the emergent issues that arise. For this reason, a number of 'twinning' arrangements have been proposed. It is recommended that at least two twinning arrangements be established – one within Indonesia and one with an international institution. The relevant institutions should either be dedicated tertiary level eye hospitals or tertiary level general hospitals with major eye

departments. The design acknowledges that for twinning arrangements to succeed there must be benefits for both participants- especially the major facility which will be required to provide most of the assistance. For this reason, funding allocation is made to ensure the cost of twinning is appropriately covered.

To achieve best practice tertiary clinical care there is a need to provide a well planned and phased implementation of new diagnostic and treatment equipment and procedures. Each major new item and procedure will need an accompanying training program for doctors, nurses and support staff.

Approximately AUD 1M has been proposed for equipment. The three main categories are: i) general surgical (operating theatre) equipment for fixed and mobile clinics, ii) general hospital and staff training equipment, and iii) specialised items to enhance the development of the four eye speciality areas approved for ABMEC / RS Indera viz, cataract surgery, lens and refraction, glaucoma and retinal disease.

Capacity building for whole of hospital activities

The Indonesian health system is complex and all hospitals generally have limited recurrent resources to provide their expected quantity and quality levels of service. ABMEC / RS Indera buildings and equipment are amongst the most modern in Indonesia and have features that are not common in similar Indonesian hospitals. In particular, maintenance of modern international standard plant and equipment is a challenge as it requires additional resources to meet the higher and more complex maintenance procedures. In addition, the hospital is expected to provide higher levels of clinical and general administrative support to assist the new or more complex procedures that are performed. One of the priorities of ABMEC/RS Indera is to achieve *Badan Layanan Umum Daerah* (BLUD) status, which would allow the hospital to retain any revenue received from fee paying patients rather than returning the income to Provincial consolidated revenue. The HSA will be expected to play a leading role in assisting the hospital administration meet the BLUD criteria.

To assist the senior and middle management staff at ABMEC / RS Indera, the Program provides substantial capacity building to address the wide array of issues facing a hospital that is providing tertiary level services both internally and to external sites.

Program Management Model

Four models of implementation and management arrangements were considered. The Implementing Service Provider (ISP) model was considered the most appropriate. This model utilises a consultant contractor. It should be relatively cost effective given the size of the Program. The contractor, on request from the Program Coordinating Committee (PCC), will provide specific long and short term consultants, advice, procurement, logistics and other required services which will be paid for on a requested per service basis as approved in the ISP's contract with AusAID.

Program Governance

To ensure that local governance arrangements are in accord with contemporary international aid principles, including the ACCRA Agenda for Action and the Paris Declaration, it is recommended that Program activities should be overseen and implemented by a local Program Coordinating Committee. Key stakeholders will be invited to participate as members. It is suggested that the Jakarta Office of AusAID could be the representative of the GoA and the Bali Provincial Director of Health or his nominee as a GoI representative. The other members would be the Director of RS Sanglah, a representative of the National Executive, or the local Chapter of the Indonesian Ophthalmologists Association (PERDAMI) and the head of the Eye Department of Udayana University. It is proposed that there could also be a representative of a mutually respected Bali eye disability group to represent the community needs. The HSA will also attend as a non voting member to assist with secretariat support. AusAID will facilitate the meetings.

The ISP will procure and make payments for procurement identified by ABMEC / RS Indera and endorsed by the PCC. AusAID will reimburse the ISP on a monthly basis.

Program Issues, Risks and Monitoring and Evaluation

There are a number of issues and risks that must be addressed by the new Program to ensure it achieves its goal and two key objectives. The first issue relates to the transition period from the 2009 level of support to commencement of the new Program. The first program of assistance to ABMEC / RS Indera formally concluded in April 2009. Since that time, AusAID provided some ongoing assistance to ABMEC / RS Indera by supporting inputs from volunteers provided by Australian Volunteers International. The most important was a full time, general hospital administration advisor, a position which concluded in November 2009.

Perhaps the most important issue that will need ongoing support and input will be the enhancement of cooperation between all of the providers of tertiary level eye services and eye surgeon training in Bali. As no one institutional entity can by itself provide comprehensive service and training, cooperation between institutions, surgeons and professional groups will be vital. The Program aims to assist in this regard by recommending all key stakeholders have a role to play in the Program by i) participation on the PCC, ii) provision of certain basic diagnostic and treatment equipment that will assist with eye care both in Denpasar and district hospitals that will provide eye surgery, and iii) assistance with training programs in Bali that enhance the skills of all eye surgeons. Other issues and risks are covered in an attached risk matrix.

Careful attention has been given to the issue of sustainability. All the new elements of this Program of Assistance are planned to occur only when they are deemed appropriate by the PCC / local institutions for implementation, and that the prerequisites to support sustainability are in place. This means that no element should commence until it is assessed that, i) a facility is ready to accept a new enhancement, and ii) there will be sufficient funds and other resources to continue a new service, or to support the maintenance of a new piece of equipment, after it has been introduced. This approach has been adopted as some of the proposed new eye surgery procedures and equipment items have considerable maintenance and consumable costs. As the Program will be led by the Balinese health authorities and in accordance with GoI procedures and regulations, rather than being driven by a traditional managing contractor, it is anticipated that sustainability will be enhanced.

The monitoring and evaluation plan is to be developed with two main purposes, i) monitoring of the delivery of outputs and ii) evaluation of program outcomes. The monitoring and evaluation plan will be developed during the initial support and planning phase, and reported upon at each PCC meeting. The plan will need to be revised annually with adjustments made based on lessons learnt from regular ongoing or special evaluations. A number of key performance indicators have been suggested for the Program as a whole, and several examples have been provided as to how specific outcomes can be assessed.

Future Potential

It can be reasonably expected that this Program of Assistance to ABMEC/ RS Indera will achieve its two main objectives and be a major step forward in meeting the Program goal. Importantly, it has been noted by the design team that when the Program is complete, the combined tertiary eye service providers of Bali will be well positioned with all of the enhanced eye services and training facilities, especially those at ABMEC / RS Indera, to offer training to eye surgeons and support staff elsewhere in eastern Indonesia. This region of Indonesia has high prevalence rates of eye disease (including preventable blindness), high rates of poverty and currently limited secondary and tertiary level eye services.

2. Introduction – Analysis and Strategic Context

2.1 Relevant Strategic Background

Following the Kuta bombings in Bali on 12 October 2002, the Australian Government announced a memorial aid package. The key purposes of the aid package were to help improve health services in Bali and to be a memorial to the people who lost their lives – including 88 Australians. One of the three main components of the aid package was the construction and equipping of a new purpose built eye disease treatment centre. The centre also included modern laboratory facilities for training eye surgeons and the provision of two mobile vans in which eye surgery could be performed. Construction of the new eye centre commenced in February 2006 and the Centre was officially opened in July 2007 by the President of Indonesia and the Australian Prime Minister. It was then handed over to the Balinese Government and the doors opened to the public on 1 October 2007. The new eye centre was named the Australia Bali Memorial Eye Centre (ABMEC).

ABMEC is one campus of the existing Provincial hospital in West Denpasar – Rumah Sakit Indera, which is a hospital designated to treat patients with eye, skin and ear, nose and throat conditions. The administration of ABMEC became the responsibility of the RS Indera management team. The Bali health system now refers to ABMEC not as ABMEC, but rather as RS Indera, RS Indera / ABMEC.

A number of events occurred that effected the operation of the facility after it was opened. Two were significant. First, a supporting NGO withdrew its support for ABMEC / RS Indera in April 2008 which meant that the hospital had to fund all of its activities from within its approved provincial health budget. This included the running of the second mobile eye clinic and having to maintain some of the complex eye surgery equipment. Second, in early 2008[1] the Indonesian Government introduced a new whole of nation law called JAMKESMAS which redefined which citizens throughout Indonesia could be officially recognised as poor, and therefore entitled to free eye care and surgery. In 2010 The Balinese government will also introduce a provincial health insurance (MANDARA) scheme that will cover the costs of all Balinese to Class 3 hospital treatment.

ABMEC, as part of Rumah Sakit Indera (Indera Hospital), provides community outreach, assessment, diagnosis, and treatment for patients with many eye diseases. Treatment is limited to general eye diseases and speciality care in the disciplines of lens and refraction, cataract surgery, glaucoma, and retinal surgery. Currently, the first two speciality areas are better developed than the latter two. ABMEC/ RS Indera has a general eye outpatient service, a small overnight ward, two operating theatres with three operating tables and wet laboratory training facilities for training eye surgeons. ABMEC / RS Indera has a pharmacy service but only limited pathology and diagnostic imaging services. It also has two mobile clinics that were used to provide certain free operations to the poor in rural areas but which are currently not used pending a review of the need for such a service.

In November 2008, AusAID undertook a review of the Australia Bali Memorial Eye Centre. The review noted that although ABMEC / RS Indera was providing effective services, the hospital had not reached its full potential and the review team provided a number of recommendations for AusAID if it wished to provide a second phase of assistance. The recommendations in particular indicated that there is a need for further capacity building of staff and enhanced cooperation between all major parties involved with eye doctor training and tertiary eye service delivery in Bali *viz*., PERDAMI (the Indonesian Professional Association of Ophthalmologists), Rumah Sakit Sanglah, Udayana University Eye Department and ABMEC / RS Indera.

2.2 Eye Disease in Bali

Cataract is the leading cause of blindness in Bali. The World Health Organisation estimates that 1.5% of Indonesia's population suffers from blindness. In Bali this translates to around 50,000 people. It has also been noted that there is a strong relationship between poverty and the incidence of blindness with a significantly higher prevalence of blindness amongst the urban and rural poor. Data provided by PERDAMI (Indonesian Ophthalmologists Association) in June 2009

[1] Minister of Health Decree No 125/Menkes/SK/2008 on Guidelines on JAMKESMAS implementation

indicate that there was a 12.7% eye morbidity prevalence rate in Bali's 3.1M population. There is an estimated 24,800 patients awaiting cataract surgery and an additional 3,100 are added to the waiting list each year. PERDAMI indicates that there are 28 eye surgeons in Bali. This is 2.7 % of all eye surgeons in Indonesia to look after the Bali population which is 1.4% of Indonesia's total population. Despite this number of eye surgeons in Bali, there is still a shortfall in the amount of eye surgery that is performed.

In Bali, eye surgery is performed by eye surgeons, and advanced eye doctors in training, working in Balinese public hospitals, private hospitals and in clinics run by NGOs. When it was initially planned, it was expected that ABMEC / RS Indera would help double the number of cataract surgeries performed in Bali from 3,000 per year to over 6,000 by 2010. The extra surgical procedures would be performed in both the fixed ABMEC / RS Indera facilities and the two mobile clinics that visit rural sites around Bali. Currently, ABMEC / RS Indera is performing about 1,000 cataract surgical procedures each year.

2.3 Training of Eye Surgeons

Training of eye surgeons in Indonesia occurs in approved hospitals that work collaboratively with a University Department of Ophthalmology and local members of PERDAMI. The training may occur in several hospitals if one hospital is unable to provide the full array of training and clinical experience that is required in the training curriculum. There are only a couple of hospitals in Indonesia that offer the full array of major eye specialties that are needed to provide comprehensive experience for an eye surgeon in training.

Large eye hospitals, or general hospitals that have large eye departments, are in Jakarta, Bandung and Surabaya. These large eye hospitals are in the public sector and have varying levels of specialist staff, equipment and resources, which in turn means that the standards of care vary between hospitals, and even between departments within one hospital. As occurs around the world, large teaching hospitals in Indonesia have developed different areas of expertise which allows them to offer short courses or periods of supervised training for eye surgeons in their field of expertise.

Most of the large general hospitals around Indonesia, can not offer comprehensive training to Indonesian best practice standards or training requirements. Consequently, young eye surgeons in training often have to travel to a larger centre where they can get the sub-specialty training they need to meet the requirements of the training curricula. After graduation, eye surgeons around Indonesia who want to acquire new skills in a new technique usually have to travel to a larger facility for training. Sometimes Indonesian clinicians, even those from larger facilities, have to travel overseas to gain the training experience that is needed. On some occasions, it is possible to introduce a new skill or procedure into a peripheral hospital by having a national or international surgeon visit for a period of time to provide local in-service training. Most training is provided in the government run hospitals. Currently, new eye surgeons in training in Bali obtain their clinical experience at the main hospital in Denpasar (RS Sanglah) and other hospitals including ABMEC / RS Indera and government hospitals in larger cities on the island of Java.

The vast majority of Indonesian specialist doctors are employed in Indonesian Government (National, Provincial or District) hospitals but have the right to work in private practice after their government duties are complete. Any skills that are gained in training courses can be applied to patient care in both the public and private sector – providing the relevant facility has the necessary equipment, resources and trained clinical support staff.

To achieve the Program objective of enhancing the skills of Bali's eye surgeons to Indonesian best practice standards, there will be a need to engage in a variety of capacity building activities. Most activities can be provided in Bali, or elsewhere in Indonesia, by Indonesian eye surgeons who are already practicing at Indonesian or international best practice standards. In some cases, the necessary expertise will have to be provided in Bali by eye surgeons or staff from international eye training institutions.

2.4 ABMEC / RS Indera Phase II Assistance.

Australia and Indonesia currently enjoy a high level mutual friendly relationship. Indonesia is Australia's biggest and, politically, most important neighbor. There has been considerable investment in supporting Indonesia, particularly in the health sector, in the past decade. Australia,

through its Australia-Indonesia Partnership Country Strategy has articulated both its intention and commitment to continue development support.

To date, over AUD 7M has been provided to improve eye health in Bali through the building and establishment of the Australia Bali Memorial Eye Centre. Australia has also provided technical support in the form of visiting eye professionals and the placement of Australian volunteers to help improve services and standards and to assist the hospital in fulfilling its mandate to improve the eye health of Balinese, especially the poor.

During the course of ABMEC's evolution, issues have arisen which engendered concern for its sustainability over time. Circumstances within Bali have changed in respect of the original concept and premise on which ABMEC was established. For multiple reasons, it is important that ABMEC / RS Indera should be provided with continuing support both as a memory for those killed and injured in the bombings of 2002 and 2005, and also for the future of Bali's blind and visually impaired population. Australia's position on disability as a development focus also provides an imperative to continue the support of the initial activities of ABMEC / RS Indera.

For many reasons, including those already described in the preceding paragraphs, in early 2009, the Australian Government decided to provide a second phase of support to ABMEC / RS Indera. In May 2009, AusAID appointed a design team to prepare a design document for a program of assistance.[2] The Terms of Reference for the design team are attached as Annex A. As part of the preparatory activities, a planning workshop was run in Bali on 18 June 2009. This document outlines the elements of assistance that will be provided and how it will assist the GoI to improve eye disease service delivery at ABMEC / RS Indera and provide better training for eye surgeons in Bali.

2.5 Consistency with AusAID and other donor/multilateral programs

This second phase of assistance to be provided to the Australia Bali Memorial Eye Centre is congruent with the overall Australia Indonesia Partnership Country Strategy (AIP) 2008-2013. The Strategy has as its aim support for sustainable poverty reduction in Indonesia with the goal of working in partnership to develop a more prosperous, democratic and safe Indonesia through support of the Indonesian medium term development plan. In particular, this program builds upon investing in people which is one of the 4 pillars[3] of the program.

This Program is also congruent with the following programs and initiatives.

- Development for All: Towards a Disability-Inclusive Australian Aid Program 2009–2014[4]
- VISION 2020 Mission, Goals, Aims and Objectives[5]
- ACCRA Agenda for Action
- Paris Declaration, and
- Millennium Development Goals

Details of the Program's congruence with each, is outlined in Annex A.

3. Program Description

3.1 Goal and objectives of the Program

The goal of the second phase of assistance to ABMEC / RS Indera is that:

The population of Bali, particularly those that are poor, receives best practice tertiary eye care – both diagnosis and treatment.

[2] Terms of Reference Design Mission for Australia Bali Memorial Eye Centre (ABMEC) Phase II, AusAID June 2009

[3] Australia Indonesia Partnership Country Strategy 2008-2013 p8

[4] Development for All: Towards a Disability-Inclusive Australian Aid Program 2009–2014, AusAID 2009 p7

[5] Vision 2020, World Health Organisation and International Agency for Prevention of blindness Global Initiative 2000

The program of assistance has been designed with an outcomes approach as the basis for achieving the goal. The **key objectives** are:

Within 3 years,

- assist ABMEC / RS Indera to deliver best practice tertiary eye services, and
- assist ABMEC / RS Indera and related eye surgeon training facilities to provide best practice eye surgeon clinical training

Underpinning the support proposed in this design is recognition of the relationship between poverty and sight disability. The activities proposed in this program aim to enhance the skills of local clinical staff to prevent and manage eye disease, as well as enhancing the capacity of local management and clinical support staff to plan for new services and to better utilize existing facilities, thereby providing more access to patients who present for care.

The outcome approach used in this design has identified the beneficiaries as the people of Bali who have eye health problems- particularly the poor, and clinicians supporting the alleviation of eye morbidity viz., the ABMEC / RS Indera health facility generally, Bali's main tertiary level eye hospital and training institutions and community based eye specialists. The design has also identified the resources necessary to support the achievement of the objectives. These include the human capital, equipment and financial resources. At each stage when monitoring and evaluation reporting takes place, there will be the opportunity to reflect on lessons learnt and if necessary fine tune the monitoring and evaluation for the next phase of activity.

This Program's objectives evolved from the main activities, issues and focus initially suggested by key stakeholders in late 2008 and early 2009. They were refined following a planning workshop in June 2009[6] during which key stakeholders again emphasised that ABMEC / RS Indera had not yet reached its full potential in helping Balinese people with eye disease.

The stakeholders believed that with further assistance, ABMEC / RS Indera could reach its full potential, but it would also depend upon ongoing and strengthened collaboration with i) the other major Balinese providers of eye disease management (RS Sanglah and members of PERDAMI), ii) the other eye surgeon training organisations (RS Sanglah and Udayana University -Eye Department), and iii) the Provincial and relevant District Health Offices as part of the referral system when the outreach program is ceased.

Unlike specific eye hospitals, or major general hospitals with comprehensive eye departments, ABMEC / RS Indera has limited facilities and staff that only allow it to address general eye care and four specialty fields of eye disease, and some elements of eye surgery training. Until a couple of years ago, the main and only hospital in Bali that had been responsible for all specialist (tertiary level) eye service delivery and eye surgeon training, had been RS Sanglah. The training of young eye surgeons had been done in collaboration with staff of Udayana University - Eye Department, and some community-based members of PERDAMI.

Despite local staff being enthusiastic and supportive of eye surgeon training, and the development of public eye services, the training opportunities in Bali have not been ideal. This has been due to many factors including limited training equipment, limited access to contemporary diagnostic equipment, and limited supervised operating theatre experience with contemporary operative equipment. The creation of ABMEC as part of RS Indera has given Bali new facilities in which patients with many types of eye disease can be managed and some excellent training facilities and opportunities for eye surgeon training.

Consequently, no entity by itself can offer i) comprehensive tertiary eye care services, or ii) comprehensive training for new eye surgeons, or iii) comprehensive facilities and expertise to upgrade skills for existing eye surgeons. This situation has been acknowledged by all key stakeholders who recognise that a cooperative approach is essential if Bali is to provide best practice Indonesian eye doctor training and provision of eye disease services. To date there has been some initial collaborative steps but additional work is required. To encourage this, it is recommended that the key stakeholders participate on the Program Coordinating Committee

[6] Notes on 18 June 2009 AusAID ABMEC / RS Indera Future Support Workshop held by Health Section AusAID, Jakarta Office.

(described below) to encourage ongoing collaboration and to appreciate that ABMEC / RS Indera's success, and more importantly - Bali's success, depends upon a coordinated and progressive development of services. This includes rotation of staff between hospitals to benefit from the different equipment and expertise at each training site. Accordingly, some complementary assistance will need to be given to all of the key stakeholder organisations. In addition, ongoing assistance will depend on individual and collective stakeholder sequential outcomes being achieved.

Significance of the new goal and objectives

The new Program goal and objectives are congruent with the original 2003 objectives for ABMEC and will build upon the work that has been completed to date. The summated objectives for the first ABMEC / RS Indera assistance project were, i) the provision of new fixed buildings, mobile clinics and equipment that would provide eye surgery diagnosis and treatment, ii) provision of eye doctor, nurse and maintenance engineering training, and iii) provision of free cataract and related eye care to poor category patients.

It is intended that the second phase of assistance will be provided for a period of 3 years, and primarily revolve around training and capacity building ABMEC / RS Indera personnel, ranging from clinicians and health service delivery staff through to administration and clinical support staff. Core to this is the recommendation to place a full time experienced health services advisor as an advisor, coach and mentor to senior ABMEC / RS Indera staff. In particular, this position will assist with advice on clinical administrative issues that will allow ABMEC / RS Indera to improve the quality and quantity of clinical services that are offered. This position will be supported by several short term external advisors and trainers who will be recruited for specific tasks to meet the needs which will be identified following a management gap analysis and training needs analysis. These analyses will be undertaken in the first quarter of the first year's assistance. To support these initiatives, skill enhancement is required for the *puskesmas* and district hospitals.

Other key elements of this Program of Assistance include strengthening RS Indera leadership, and Bali's eye surgeon training, through capacity building and building strong partnerships with other institutions. One way this might be achieved is through twinning arrangements with one or more eminent Indonesian tertiary eye hospitals and one International tertiary eye hospital. Twinning could also assist with clinical service improvements.

It is proposed that this Program of Assistance will be overseen by a Program Coordinating Committee (PCC), comprising representatives of the GoA and GoI including key stakeholders from Bali Province. The Program of Assistance management structure is provided in more detail in Section 4.2.

Guiding Program Principles

Whilst the adopted approach addresses several key requirements, it also has a degree of flexibility to deal with emergent issues. To help guide the Program, a number of guiding principles have been adopted. The proposed principles for future assistance are:-

- Partnership between the GoA and the GoI to improve the eye health of the people of Bali based on ongoing policy engagement and sound governance principles.
- A focus on the improvement of eye health status of men, women and children in Bali through the provision of essential and cost effective eye health services that meet Indonesian best practice standards.
- Assistance to help Bali implement its own plans in accordance with GoI regulations and procedures.
- Support for strengthened governance that emphasize efficiency, effectiveness, quality improvement and stakeholder participation.
- Support to build capacity of local staff providing eye services and the training of eye doctors and clinical support staff to achieve ABMEC / RS Indera eye health objectives in accordance with the needs identified by ABMEC / RS Indera.
- Development that builds upon past AusAID assistance where activities are yet not fully self sustaining.
- Strong and continuing focus on monitoring the performance and achievements of the Program of Assistance.

- Promoting engagement with institutions of civil society including the community, NGOs, the private sector and educational institutions in health service provision and training improvement.
- A continuing focus upon the key crosscutting issues of poverty reduction and gender equity.
- Strategic use of Australian funded resources to address areas where maximum impact can be achieved within local recurrent funding and resources.

Specific issues relating to the original objectives for ABMEC and the November 2008 Review

Whilst this new Program is based upon many of the recommendations of the November 2008 Review of ABMEC, a number of the recommendations have required some modification due to i) developments that have occurred since that time, and ii) following greater and more extensive consultation occurring in the preparation of this document.

Major Buildings

The ABMEC / RS Indera facilities are new and have already had a few minor adjustments to improve operational efficiency. No major building work is required at present, and consequently this new program does not propose any additional funding for new building work at ABMEC / RS Indera, apart from allowing a small amount of contingency funding for some minor modifications that may further improve operational efficiency or patient safety.

Mobile Clinics

No major funding is recommended to either substantially refurbish or replace the existing mobile clinics as was previously recommended in the November 2008 ABMEC review. Since that review, ABMEC / RS Indera has suspended mobile clinic eye surgery pending a review after the MANDARA health insurance has been implemented. This will allow patients to be referred directly from *Puskesmas* and/or district hospitals to ABMEC / RS Indera. Surgery may also be performed in operating theatres in designated hospitals within the existing Balinese health system. Providing surgical services in designated district hospitals has three main advantages. It, i) reduces infection control risks that are present in mobile surgical theatres, ii) allows surgical teams to perform more surgical procedures in the same surgical session times, and iii) local doctors can be trained to provide some of the post surgical patient checks that are required following the departure of the visiting surgical team. It is intended that this strategy will be implemented after capacity building at the district hospital level, thus enabling support staff to provide safer clinical and post operative care in the designated district health facilities. This activity will also have flow-on benefits of enhancing general clinical competency / capacity of staff in the selected district hospitals where the eye surgery will be provided.

It is expected that this new strategy will be implemented over the next year. Should it be decided that mobile eye surgery clinics be reinstigated, it is proposed that assistance for the mobile clinics be limited to minor modifications to help reduce infection control risks. There will also be a need to purchase some additional surgical equipment which will help minimise infection control risks. The purchased equipment will eventually be transferred to the district hospitals which will provide the same surgery in their operating theatre suites.

Capacity building will be required to help ABMEC / RS Indera to plan and undertake surgery in the designated district hospitals, and there may be a need to help acquire some relatively inexpensive basic diagnostic and eye surgery equipment for the selected district hospitals to prepare them to take over the eye surgery and associated procedures.

Equipment

Following the November 2008 ABMEC review and inspection of facilities in June 2009 by the design team, there are additional equipment items that should be acquired for ABMEC / RS Indera which would help improve operational efficiency, patient safety and staff capacity building. The additional items are discussed later in this section.

Capacity Building

The majority of the recommendations of the November 2008 ABMEC review related to provision of capacity building activities. Most of them were requested by ABMEC / RS Indera staff. Some

were recommended by the review team. During June 2009, the Design Team was able to confirm that all of the previous identified needs were still valid. In addition, a number of other complementary capacity building requests were received. Some very useful recommendations were also made at the Planning Workshop by the representatives of RS Sanglah, Udayana University-Eye Department, and the local and national representatives of PERDAMI. The later recommendations were particularly focused on ensuring that there was effective collaboration by all of the Balinese providers of tertiary level eye care services and eye doctor and clinical staff training. By addressing these latest suggestions, there would be a greater likelihood that not only would ABMEC / RS Indera be more likely to achieve its full potential, but also all of the GoI providers of speciality eye care would be able to provide best practice Indonesian standards to more of the Balinese and east Indonesian population. The fundamental principle to be followed in capacity building activities will be that it must be driven by the institutions themselves.

3.2 Expected results

As indicated above, the two objectives to be achieved within 3 years are;

- **assist ABMEC / RS Indera to deliver best practice tertiary eye services, and**
- **assist ABMEC / RS Indera and related participating eye surgeon training facilities to provide best practice eye surgeon clinical training**

From these, it is expected that the results which will be demonstrated by the end of the Program of Assistance will include:

- New and practicing ophthalmologists participating in the Program are capable of diagnosing and treating general eye disease and the sub-specialities of cataract, glaucoma, refraction and retinal surgery to Indonesian best practice standards
- All clinicians (Doctors and Nurses) are capable of providing contemporary best practice levels of patient infection control
- Nurses are capable of planning and implementing general policies and procedures in peri-operative procedures, and general eye nursing care procedures
- ABMEC / RS Indera and related eye surgeon training facilities are equipped with the basic diagnostic and essential surgical eye equipment that is approved by the hospital's administration, confirmed by the PCC, and meets PERDAMI standards for the nominated four eye speciality areas
- ABMEC / RS Indera increases the number of poor and vulnerable beneficiaries of eye care treatment trough treating a greater number of referred poor patients.
- Formal partnership arrangements are enhanced and functioning effectively between ABMEC / RS Indera, RS Sanglah, Udayana University- Eye department and local PERDAMI members to lead the coordination of eye surgeon training in Bali
- ABMEC / RS Indera's Patient Information System will be generating reliable data to inform management and clinical decision making
- Administrative staff able to plan, manage and monitor new and existing clinical services
- ABMEC / RS Indera's plant and equipment maintained effectively in accordance with internally developed preventative maintenance plans and repair servicing.

3.3 Proposed Forms of Aid

The main form of aid will be the enhancement of knowledge, skills and capabilities of staff working at ABMEC/ RS Indera and the associated Balinese facilities proving eye surgeon training and delivery of tertiary eye care services. Accordingly, the following activities feature prominently:

- Capacity building,
- Training,
- Technical assistance, and
- Twinning arrangements.

Funding will also be provided for equipment and service purchases, especially related to eye diagnostic equipment and devices used for training clinical staff in eye disease management.

Some funding will also be provided for some minor capital works associated with ABMEC / RS Indera improvements that will improve patient safety or throughput.

All aid activities are designed to occur within current or expected local recurrent budgets and approved Government service developments and GoI policies and regulations.

3.3.1 Capacity Building

Capacity building will focus on Human Resource Development (HRD) and is seen as essential to achieving the Program objectives. It is based on the concept that education and training lie at the heart of development efforts and that without HRD that meets the identified needs of participating individuals and agencies, most development interventions including the proposed approach in this design, will be ineffective. Capacity building will focus on a series of actions directed at helping identified participants (eye doctors, nurses, health service managers and others); to increase their knowledge, skills and understandings and to develop the attitudes needed to bring about the desired improvements in eye care training and service delivery.

In 1991 UNDP defined 'capacity building' as *the creation of an enabling environment with appropriate policy and legal frameworks, institutional development, including community participation (of women in particular), human resources development and strengthening of managerial systems*, adding that, *UNDP recognizes that capacity building is a long-term, continuing process, in which all stakeholders participate"* [7] To this end, beneficiaries will be involved in identifying capacity gaps and strategies to achieve competency standards. These activities will primarily occur during the first quarter of the first year, but some preliminary work may commence prior to Program commencement.

The key capacity building role will lie with the Health Services Advisor position described below. However, all advisors and experts contracted to participate in the Program of Assistance will have a responsibility to provide skill transfer and develop a capacity building plan for their respective counterparts.

For capacity building within the framework of this Program of Assistance to be sustainable and effective, other elements need to be included such as agreed training, technical assistance to provide skill transfer and twinning arrangements.

Training

Training is an important element of capacity building and within this proposed program of assistance, the training components are intended to strengthen staff capabilities through the development of technical skills and expertise. In most instances, training will take the form of experiential on-site skill transfer, supported by other learning elements from technical experts who will provide single and multiple inputs over the Program's duration. In addition, training sub contractors will be engaged to provide specific training programs following developed scopes of service to meet training needs identified by the training needs analyses. Training activities will comprise competency based curricula, with pre and post skill assessments to determine impact and effectiveness of the training. The type and nature of training will be identified by the recipient institution and endorsed by the PCC.

Technical assistance

Technical assistance will be provided where a skill is currently lacking or requires support by experienced advisors until local staff and services are developed to provide the activity. When technical assistance is provided, it will have defined timelines and will complement capacity building programs that enhance local skills.

[7] United Nations Development Program, Geneva,1991

Twinning Arrangements

Twinning is the development of formal relationships between institutions / agencies which have comparable mandates. It is usual that this relationship is developed between a stronger, more developed institution / agency and one which will benefit from the other's experience, skills and stronger position. Twinning aims to promote institutional development and provide the recipient with a broad range of competence development and services through the selected 'twinned' organisation. There must be a strong commitment to achieve practical results and longer lasting development.

The twinning arrangement must be flexible and have both short and long term support activities, in order to respond to changing circumstances and recipient growth. The arrangement must also acknowledge that there are costs involved for the larger institution and the budget must include some allowance for this e.g. travel costs of visiting lecturers and trainers and provision of policy and procedure manuals.

Twinning is not aimed at operational intervention, but rather the development of human capital. Suitable twinning arrangements should ideally be developed with well credentialed Indonesian tertiary eye hospitals where clinicians currently interact, and to which complex patients are referred. Whilst national twinning arrangements are cost effective, it has been indicated by local Balinese eye surgeons and the national PERDAMI president, that it would also be advantageous to have at least one link with an international, well credentialed eye hospital that could assist with some training elements and development experience that is not readily available in Indonesia.

In order for the Program to achieve its objectives, capacity building must not be limited to professional technical training of doctors. It is imperative that the needs of all staff, nurses, engineering support and maintenance staff, administrators and managers be addressed.

Specific Capacity Building Issues

The ABMEC/ RS Indera senior administrative staff has recognised the additional issues that have arisen with the provision of the new eye centre and have sought assistance to help build their administrative capacity. The senior staff has indicated that a number of them have benefited from local courses and training and the currently provided Australian volunteer administrative coaching, but there is much more that they still need to learn if ABMEC / RS Indera is to deliver its full potential as a modern specialist eye hospital and training facility. In particular, they have sought assistance with clinical administration skill development and further general hospital administrative capacity building, so that ABMEC can offer clinical services that are at best practice Indonesian and/or international standards.

Specifically, additional capacity building is required in the following areas:-

- data gathering, analysis and preparation of financial and operational plans,
- implementation and monitoring of approved plans and projects with emphasis on change management and clinical service improvement,
- effective programming of preventive maintenance for major plant and equipment,
- data collection, analysis and reporting to support evidence based decision making, and
- planning and implementation of clinical quality assurance activities with a focus on infection control.

Activities

To achieve this wide set of requirements, it is proposed that a long term Health Services Adviser be appointed. The Health Services Advisor (HSA) must have demonstrated experience and skills in general and clinical service administration of a hospital providing tertiary level services. An example of Suggested Terms of Reference is attached as Annex B to illustrate the skills and experience required of the position. Funding will be allocated for the full three year period. Although a three year placement is anticipated, it is hoped that the length of the input can be reduced as local management capacity and expertise is enhanced.

The extension of the term of the HSA from year to year should be conditional upon annual assessments by the PCC to ensure that key performance indicators (set at the outset and revised annually) are met. An important indicator will be the impact and effectiveness of the capacity building and skills transfer. Further inputs must be justifiably required and supported by the PCC.

It is intended that the HSA, as the key technical advisor within the Program of Assistance, will be supported in providing the more specialised elements of capacity building by short term inputs from experts. Examples of such expertise might include eye surgeons from the associated twinned hospitals assisting with clinical quality assessment programs.

It is proposed that available and appropriate scholarships and Fellowships will be accessed. However, as much as is possible, training will be on site, and conducted as competency based programs with experiential elements using adult learning principles. It is anticipated that most of this formal training will be from accredited training institutions within Indonesia under contract arrangements. Training should be recognised as far as possible by the appropriate authorities.

Expected outcomes

The expected achievements at the end of the program of assistance will include:

i) Enhanced capability of clinical administration staff to plan, manage and monitor the delivery of quality eye care in line with Indonesian best practice standards and allocated budgets. This would include the production of consultatively developed strategic and business plans in areas such as Human Resource Management and Development, Financial Planning for Clinical Services and Risk Management, with plans matched to available budgets and subsequently implemented.

ii) Enhanced ability of senior medical and nursing staff to plan, implement and monitor clinical improvement activities.

iii) At an institutional level, all providers of tertiary level eye care and eye surgeon training, working collaboratively to plan, deliver and monitor services that require cooperation between multiple parties.

iv) Clinical and administrative staff have additional skills to plan and deliver more cost effective services for all categories of patients that present – especially the poor either at ABMEC / RS Indera and the yet to be designated district hospitals around Bali that will provide eye surgery.

v) Production of quality useful reports that assist clinicians and administrators with planning and review of patient related activities that depend on good demographic and clinical data.

3.3.2 Equipment and service purchases

Following the assessment of current equipment status, as identified in the 2008 ABMEC report, and future needs to meet the program of assistance outcomes, a number of new equipment items will be required. They have been identified and fall into three main categories:-

- General surgical (operating theatre) equipment for fixed and mobile clinics
- General staff training and hospital equipment, and
- Items to enhance the development of the 4 eye speciality areas

Equipment in each of the first two categories can be obtained, following PCC approval at any time from the beginning of the Program of Assistance as it will not require specialised training to use it. Equipment in the third category, i.e. items to enhance the development of the four eye speciality areas, require special arrangements. Procurement of specialised equipment should occur in a phased manner, giving time to ensure those staff who will initially be recognised in the subspecialty, have demonstrated competencies in their diagnostic and patient management skills, followed by microsurgical skills including surgical expertise. In relation to anaesthetic support, ABMEC / RS Indera has a good anaesthetic machine for general anaesthesia and more complex eye procedures require only minimal additional anaesthetic and monitoring equipment.

It is likely that each eye specialty area will develop in a phased manner. Complexity will increase from one phase to the next during the program's three years. In each phase there will generally be

a need for both diagnostic and surgical equipment. Progress from one phase to the next should only occur when ABMEC / RS Indera and the eye specialists of Bali together are confident that competence has been achieved in the particular level and it is appropriate to progress to the next level. The formal ratification of this assessment will be made by the PCC, which in turn can authorise progress to the next phase of implementation.

As each phase is commenced, there will be a need to match capacity building training with new equipment purchases. It is expected that the development of services will be in line with PERDAMI published standards and recommendations, and in accordance with Department of Health requirements. An assumption has also been made that the Balinese eye surgeons in the tertiary level facilities will want to continue developing eye services in a similar manner as occurs elsewhere in Indonesia, and internationally, to achieve Indonesian best practice standards.

As it was not possible to predict with certainty which equipment items should be acquired, and the timing when they would be required, the technical consultants produced a table of possible equipment requirements in a three phase sequence (each phase being at least one year) of likely service and training enhancements. This is attached as Annex C. Most of the equipment will be required at ABMEC / RS Indera but some diagnostic items that are needed for the effective training of young eye surgeons will need to be placed at other Bali training facilities including RS Sanglah.

Approximately AUD 1M has been proposed for new equipment and services which are likely to be progressively required over the three year period of this Program. Specific allocations have not been made as it is likely that the development rate in each sub-speciality will vary depending upon local staff availability and interest, and availability of recurrent expenditure to support the procedures. Towards the end of the Program of Assistance, if greater progress is made than expected, there may be a need to seek funds from other sources to develop some of the more complex and expensive eye procedures.

With the proposed diagnostic and surgical equipment and the already existing training equipment at ABMEC /RS Indera, the combined tertiary level eye service providers of Bali have the potential to provide eye health workforce training not only for clinicians in Bali Province but ultimately for most of east Indonesia. This would be achieved by sharing staff expertise, equipment and other resources. This would be a major beneficial outcome for Indonesia, as east Indonesia has a lower rate of ophthalmologist to population ratio than the rest of Indonesia. When additional recurrent funding is available, ABMEC / RS Indera with its additional equipment and trained staff will also be in an ideal position to consider expansion to a full 24 hour specialist eye service.

All equipment items are readily available in Indonesia. The cost allocations generally include at least one year of warranty maintenance. The staff of ABMEC /RS Indera will need to decide if ongoing maintenance is more cost effective by using maintenance contract extension or other internal maintenance arrangements that may be developed.

Expected outcomes

i) Practicing eye surgeons, and eye surgeons in training, will have access to essential equipment to support the correct diagnosis and safe delivery of eye care which meets Indonesian best practice standards. This can be measured against the published PERDAMI standards.

ii) Nurses and general clinical support staff will have access to general training equipment that allows them to upgrade or maintain their skills at best practice Indonesian standards. This can be measured by quality of care audits with advice from other health institutions in Bali and Indonesia.

iii) By assisting with some new equipment purchases to help establish eye surgery in DinKes approved district hospitals, Bali eye surgeons will be able to provide eye surgery to more of the population, especially the rural poor who can not attend the major eye hospitals in Bali.

iv) ABMEC / RS Indera, its staff and affiliated PERDAMI consultants will be able to offer clinically safer care to patients who present to the current mobile clinics until such time as they are decommissioned.

v) Staff at the district hospitals around Bali where eye surgery is performed will have improved general operating theatre skills following the training provided by ABMEC / RS Indera in preparing the facilities for eye surgery. This can be measured by the number of post operative complications, including infections, and numbers of patients treated in district hospitals by eye diagnostic category.

3.3.3 Minor Capital Works

As previously mentioned, this new Program does not require any major capital works. There will however, be some minor works required to help improve service delivery and patient safety to be identified after further studies during the initial six months of the Program. As an example, ABMEC / RS Indera may wish to modify its small pathology area so that some basic pathology tests can be provided on site. A small contingency fund has been allocated for minor capital works.

3.4 Estimated program budget and timing

It is proposed that the Program of Assistance commence in the first quarter of 2010 and then continue for a three year period. A notional budget of AUD 3M is recommended including AusAID administrative costs. During the first quarter of the third year of the Program, an assessment will be made of what funds are likely to remain unexpended and any savings that will be made due to the possible early phase out of the HSA. A recommendation will be made to transfer such funds to the subsequent disbursement for approved PCC activities or retention by AusAID.

4. Implementation Arrangements

4.1 The proposed overall Program Management Model

Four models of implementation and management arrangements were considered and are identified below. The fourth model which utilises an Implementing Service Provider is the model believed to be most appropriate and strongly recommended.

Traditional managing contractor. This method has the advantages that it provides professional in country management of a project and can reassure the client that all elements are delivered to the standards that are required including audit and financial standards. Its main disadvantage is that is expensive and may be seen as overly burdensome for a program as small as this one. Additionally, it could also be seen by some as inconsistent with the principles of the Accra Agenda for Action.

AusAID management. Whilst this program is small and most of the elements of the program will be known at the time of commencement, it will necessitate the purchase of many equipment items and capacity building services. It is possible that the activities could all be purchased / acquired / arranged by in country AusAID staff. The main disadvantage of this method is the resource demands made upon AusAID staff. It would also place all risks of the activity upon AusAID.

Management by an in-country NGO. This method would involve a reasonably resourced and experienced neutral NGO managing the project on behalf of AusAID for a fee that may be lower than a Managing Contractor model. A NGO would have to be respected by all stakeholders and have the necessary infrastructure and experience to carry out the required activities. Unfortunately, suitable organisations such as PERDAMI are unlikely to have the experience or infrastructure to complete the task. There may also be local resistance to this model given the significant evolutionary history of ABMEC / RS Indera and perceived conflicts of interest.

Implementing Service Provider (ISP) Model. (Recommended Model)

This model utilises a consultant contractor (ISP) working on a procurement fee basis for the Program's duration. It should be relatively cost effective given the size of the Program. The Contractor, on request from AusAID will procure specific short term consultants, training logistics and other required services. AusAID will thus have an implementation support capacity that is responsive and flexible for planned and emergent needs and minimises ongoing management overheads. AusAID will reimburse the ISP on a monthly basis for all procurement undertaken in the previous month on receipt of valid invoices.

This model also places greater emphasis on engagement and performance by local entities in implementation and monitoring and evaluation of program activities, and is consistent with the Accra Agenda for Action. In particular, the implementation model encourages ABMEC / RS Indera to take an active role in leading and encouraging all beneficiaries to achieve milestones that allows progress towards more complex levels of surgical eye care and higher clinical standards. Such an approach also provides for specific risk assessments to be done against achievement of specific outcomes.

4.1.1 The role of the Implementing Service Provider (ISP).

The ISP responsibilities will include:

- Assist with the preparation of Terms of Reference and position descriptions for both long and short term advisors as identified by RS Indera and endorsed by the PCC.
- Preparation of contracts for recruited personnel
- Logistics associated with mobilisation and demobilisation of recruited personnel
- Payroll of long term advisors / contracted staff

Other ISP responsibilities include:

- When requested, procurement of equipment and medical supplies from national and international sources
- Development of scope of work of services for sub contracted trainers
- Contracting of sub contractors
- Payment for all procured goods and services
- Carrying out *ad hoc* activities requested by AusAID relating to the Program.

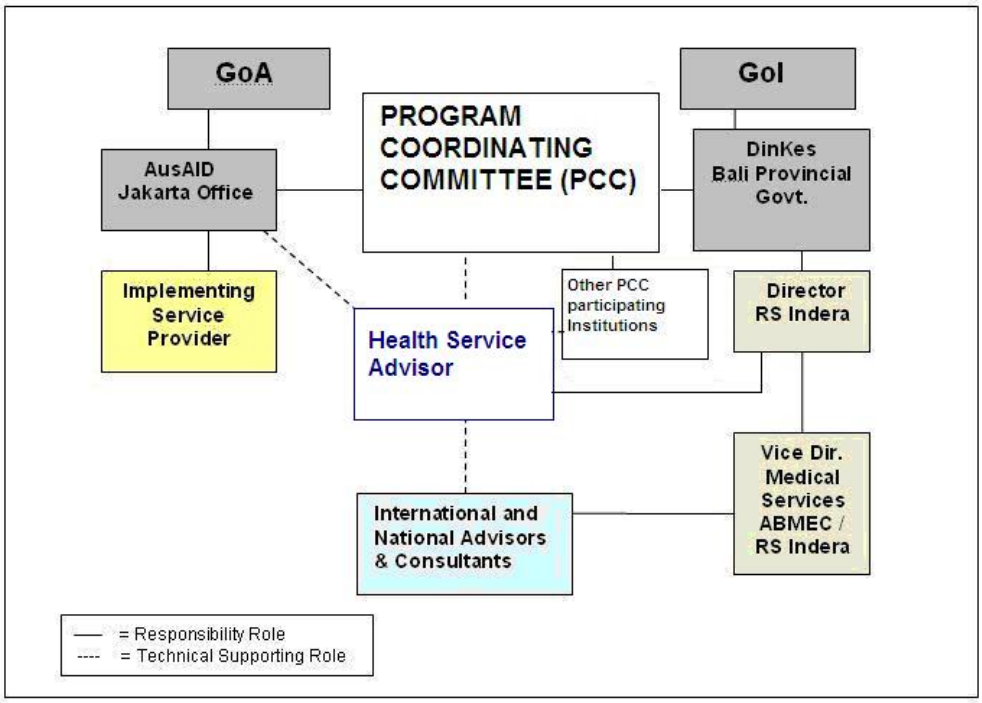
4.2 Local governance and administration

Implementation and management of the Program of Assistance will be a partnership arrangement between the GoA (represented by AusAID), and the GoI, (represented by the Provincial Health Office - DinKes). Relationships and lines of responsibility are diagrammatically represented in Diagram 1. Each party will have important roles and responsibilities to fulfil. In keeping with the Program's philosophy of support to assist Bali to improve the eye health of the Province's population, it will be the task of AusAID and the Provincial Health Office to ensure that appropriate management arrangements are implemented. These arrangements will allow ABMEC / RS Indera and other Balinese health facilities to fulfil the Program's objectives.

For each of the objectives, the Director of RS Indera will lead the activity. Program resources and advisors will be provided to support the Director to carry out the specified activities. ABMEC / RS Indera will be responsible for the agreed implementation elements on commencement of the Program and these will be progressively increased as ABMEC / RS Indera capacity is demonstrated.

Diagram 1.

Suggested lines of responsibility.



As well as providing general hospital administration and management advice, coaching and mentoring for the senior executive staff at ABMEC / RS Indera, the long term HSA will also assist with the management support of some program elements – including secretariat coordination for the PCC (see below). The HSA will be assigned a key counterpart from ABMEC / RS Indera in order to strengthen effective relationships and most importantly, ensure succession planning, capacity building, and coordination of activities beyond those that will be undertaken under the auspices of the Program.

The HSA will also be available to provide periodic advice to other members of the PCC relating to PCC implementation issues involving their institution.

4.2.1 The Program Coordinating Committee (PCC)

To ensure that the numerous tasks required in this Program of Assistance are effectively administered, and to involve all key stakeholders in planning and monitoring of activities, it is proposed that a Program Coordinating Committee (PCC) be established. The PCC will be the ultimate authority for the program under a Subsidiary Arrangement between GoI and GoA. The PCC will apply principles of sound governance that will be necessary to achieve the objectives of the Program and to meet Government reporting requirements.

The PCC will be established and have its first meeting within four weeks of the commencement of the Program. The PCC will:

- Establish and provide strategic directions and priorities for the Program.
- Ensure the strategic objectives for the Program link with the priorities outlined in the Renstras of the Provincial Health Department (DinKes) and ABMEC / RS Indera.
- Approve the Monitoring and Evaluation Framework and use it to monitor progress and performance of the Program.
- Provide guidance and direction to the long term HSA and other advisors engaged on the Program,

- Define the nature and extent of the reporting required for the Program.
- Establish and maintain a continuous quality improvement focus.
- Develop eligibility criteria for the activities to be funded under the Program, including the purchase of goods (equipment) and services
- Review and approve annual Program plans and budgets and an annual Program of Assistance review
- Review any technical standards, protocols and guidelines developed by the Program
- Encourage a culture of collaboration, innovation and high performance
- Attempt resolution of differences and conflicts between the Program stakeholders to maximum mutual benefit.

4.2.2 Composition and functioning of the PCC

Suggested Terms of Reference for the PCC are provided in Annex D. Membership of the PCC will include the Director of ABMEC / RS Indera, a nominated Jakarta based AusAID Officer, the Provincial Director of Health or his nominee, the Director of RS Sanglah or his nominee, a senior representative of the National Executive, or the Bali Chapter, of PERDAMI and the Professor or a senior representative of Udayana University – Eye Department. The PCC could also invite a mutually respected Balinese visual disability support group to be a member. Secretariat coordination and support services will be provided by the HSA and the resources of ABMEC / RS Indera.

The PCC will meet at least 3 times each year and may find it necessary to meet more regularly especially during the first year of the program. The PCC may enlist the services of other high level technical expertise as *ad hoc* members when, and if, it is deemed necessary.

4.3 The significance of the Long Term HSA Role

The Health Services Advisor (HSA) is the key position to assist with capacity building and coordination of training for the Program of Assistance. It is proposed that this position be counter-parted with the AMBEC / RS Indera Vice Director of Medical Services and report to the Director of RS Indera. This position will also have accountability to the Jakarta Office of AusAID, through regular reporting against performance indicators and to the PCC through quarterly reports. Although it is not expected, this position may require support or performance intervention from the ISP.

4.4 Implementation Plan

Prior to the Program being implemented, there will be a need for AusAID to complete the necessary pre-tender planning and tender preparation activities. It is likely the new Program will commence early in 2010. When the Program commences it will run for three years, and it is proposed that it will be implemented in two phases. The first will be the initial support and planning phase. The second and final phase will be full implementation.

4.4.1 The initial support and planning phase.

This phase is expected to start from the date of Program commencement and run between two and six months depending upon the activities approved by the PCC. The more important activities to be undertaken include:

- The HSA and senior executive of ABMEC /RS Indera undertake all remaining training need analyses.
- The PCC to endorse the first six month operational plan developed by the Executive of ABMEC / RS Indera assisted by the HSA, and including input from the participating eye surgeon training institutions.
- The ISP procures any short term advisors, training and equipment approved for the initial six months of operation.

- The HSA and Executive staff of ABMEC / RS Indera develop the essential operational policies and procedures that are required to support routine program activities. These policies and procedures should be in accordance with current GoI requirements.
- The HSA, in cooperation with ABMEC/ RS Indera, develop a monitoring and evaluation plan that will be endorsed by the PCC. Discussions commence to arrange twinning arrangements with suitable national and / or international eye hospitals or institutions.
- The HSA and the senior executive of ABMEC / RS Indera develop a capacity building plan for the three years of the Program.
- Commencement of phased approach to develop the four eye sub-speciality areas at ABMEC / RS Indera
- Develop formal cooperative arrangements between ophthalmologists at ABMEC / RS Indera, RS Sanglah, Udayana University- Eye Department and PERDAMI.

4.4.2 Full implementation Phase

This phase will run from the end of the initial support and planning phase until the end of the Program, completing three years of assistance. The more important activities to be undertaken during the first year include:

First six month period

- Commencement of regular reports by HSA to PCC for AusAID
- Endorsement by PCC of forthcoming six month operational plan.
- PCC to review monitoring and evaluation reports
- Authorisation by PCC of equipment, services and training
- PCC review of expenditure reports
- Continuation of ongoing capacity building and support by the long term HSA for ABMEC / RS Indera senior staff
- Recruit and contract any periodic advisors for Nursing, Management, Engineering and Biomedical Engineering
- Commencement of periodic short term training and support in approved areas such as nurse education, general hospital maintenance and health information system support
- Regular liaison between ABMEC / RS Indera and approved twinned institutions
- Further development of preventative and breakdown maintenance plans for ABMEC / RS Indera
- Support and implementation for the complementary training elements of eye surgery that need to be undertaken at other Bali tertiary level training institutions
- Health Information Management strategies developed
- Assistance offered by HSA to other PCC member stakeholders that require assistance with the introduction of PCC approved activities in their institution.

Subsequent periods:

- Regular PCC meetings overseeing Program activities
- Annual assessment by PCC of HSA performance
- Subsequent six month operational plans prepared (using lessons learnt from previous periods), and endorsed
- Presentation of audit and monitoring and evaluation reports to PCC meetings
- Training and capacity building continues, based on training and capacity building plans

- Health Information Management reports generated and used to support decision making

It is intended that following the first year of implementation, annual planning will describe the subsequent year's activities. This will ensure that the Program remains flexible and responsive to emerging needs. In addition, progress against the achievement of performance measures can be assessed and changes to program activity will be considered in order to address issues identified in the monitoring and evaluation reports.

4.5 Specific start-up and transition activities

The first program of assistance to ABMEC / RS Indera formally concluded in April 2009. Since that time, AusAID has provided some ongoing assistance to ABMEC / RS Indera by supporting inputs from volunteers provided by Australian Volunteers International. In particular, a full time, general hospital administration advisor was provided. This position concluded in November 2009. It was recommended that the incumbent, as part of his exit planning activity, could assist with some data gathering activities such as pre training skills auditing to identify skill gaps to help in preparation for the new Program. It was also important for the incumbent to ensure that appropriate support activities were in place to help conclude the implementation of the new patient information system provided by AusAID. Data generated by the new system will help with the planning and eventual evaluation of some of the new Program initiatives.

During the brief hiatus of AusAID assistance, it will be important that a senior ABMEC / RS Indera staff member be identified as the Program implementation leader and that person and key stakeholders are regularly updated on activities being undertaken to implement the new Program. During this period, an important activity will be the involvement of the Director of ABMEC / RS Indera in the selection of the ISP and HAS.

4.6 Financial Management, Procurement Arrangements and Financial Transparency

A range of options for the financial management and procurement arrangements were considered by the design team. Consistent with current AusAID policy, it is desirable that a mechanism is identified where Australian support is led by the Director of RS Indera, who may select an executive team member to be the Program manager, under the guidance of the PCC, and integrated into Government of Indonesia (GOI) management and accountability systems to the maximum extent possible. This approach is consistent with the Paris Declaration and the Accra Agenda for Action.

It is intended that the model proposed will utilise ABMEC / RS Indera's management and implementation systems, with oversight through the PCC. This is clearly intended to improve ABMEC / RS Indera systems and strengthen them where weaknesses are identified.

4.6.1 Goods and service procurement

Consideration was given to paying for procurement according to Financial Regulations 168 and 169 of 2008. However, it was assessed that this risked delays in procurement. This posed risks of very significant delays in accessing goods and services. In addition the implementing partners during consultations on the design expressed a strong desire that the ISP undertake all procurement of goods and services under the Program. A strong wish was also expressed that as far as possible all goods and services be procured within Indonesia. ABMEC/ RS Indera, being a Provincial hospital, is currently not responsible for procurement, as this function is the responsibility of the Provincial Governor's Office. Accordingly, it is recommended that the ISP should be responsible for all procurement of goods and services endorsed by the PCC and ensure that all procurement achieves Value for Money through transparent tender processes. Procurement will be reviewed annually by an AusAID approved external auditor. The ISP will be responsible for developing a Procurement Manual in the first three months of the Program, which will be endorsed by the PCC.

4.6.2 Payment of services to be provided by the ISP.

All equipment and services required for this Program will be acquired by the procurement processes of the ISP on instruction from AusAID following PCC endorsement, in accordance with the contract with AusAID. Payment for ISP services will be on a procurement fee basis as detailed in the Basis of Payment, which will reflect the ISP's tender financial proposal. AusAID will reimburse the ISP for all procurement on a monthly basis and pay the ISP procurement fees also on a monthly basis. The ISP, as a provider of services to AusAID, would be required to meet, under their AusAID contract, the Program specific audit requirements.

The ISP will be required to provide payroll services for short and long term advisors.

The expected volume of procurement is at Annex C.

4.7 Monitoring and Evaluation Plan

The Program's monitoring and evaluation (M&E) plan will have two main purposes, i) monitoring of the delivery of outputs and ii) evaluation of program outcomes. In essence, the main goals of the monitoring are to satisfy stakeholder accountability requirements, to demonstrate whether the Program of Assistance has been able to deliver interventions and activities identified in the planning process, and to account for resources that have been used.

The Program of Assistance evaluation will seek to answer questions about processes employed, outcomes (whether objectives have been met) and impacts. For this particular Program, which seeks to ultimately demonstrate an improvement in eye health status of the Balinese population, and ABMEC /RS Indera clinicians providing Indonesian best practice eye services, it should be noted that significant change is not likely to be evidenced in a short time span of just three years. However, through the use of both quantitative and qualitative assessments, it will be possible to identify what progress has been made, the level of sustainability, and how future outcomes can be supported and validated.

The monitoring and evaluation plan will be developed by the HSA in consultation with ABMEC / RS Indera during the initial support and planning phase, and reported upon at each PCC meeting. The plan should be revised annually, and when indicated, adjustments made based on lessons learnt from ongoing or special evaluations. Quantitative reports validating outcomes will be reliant upon good data collection, analysis and timely presentation. For this reason, the Program includes support for developing and utilising the newly installed Patient Information System which will help produce a number of the important patient and operational reporting statistics. The assessment of achieving Indonesian best practice eye care and service delivery will be referenced to the published PERDAMI recommended standards. Qualitative reporting can be accomplished through beneficiary narratives and knowledge exercises provided pre and post training, patient satisfaction surveys, capacity building reflective practice journals and interviews with key informants. By using to the greatest extent possible the current GOI endorsed reporting requirements used by ABMEC / RS Indera, the Program M&E arrangements will strengthen the M&E systems of ABMEC / RS Indera.

Table 1.

Proposed objectives, and associated expected outcomes and means of validation.

Objective	Output	Outcome	Means of Outcome Verification
Assist ABMEC / RS Indera to deliver Indonesian best practice eye services	Ophthalmologists and training eye surgeons trained to PERDAMI recommended standards in the diagnosis and treatment of cataract, glaucoma, refraction and retinopathy diagnosis and treatment	Bali trained ophthalmologists and training eye surgeons able to diagnose and treat cataract, glaucoma, refraction and retinal problems to PERDAMI recommended standards	Pre and post training skill assessments demonstrating improvement in diagnosis and treatment of cataract, glaucoma, refraction and retinopathy.
	All ABMEC doctors, nurses and clinical support staff trained and up skilled in infection control practice	Clinicians practice infection control to Indonesian hospital prescribed standards	Decrease in hospital acquired infection rates evidenced by trends in locally collected data that is compared to national data
	Nurses trained in peri operative procedures, development and implementation of general policies and procedures, and nursing standards	Nursing standards, policies and procedures are in place for all major clinical activities	Nursing policies, procedures, protocols and standards developed and being used in daily practice.
	Basic diagnostic and essential surgical equipment for tertiary level eye care procured and available for staff use.	The procured diagnostic and surgical equipment routinely used by clinical staff to provide PERDAMI prescribed levels of diagnosis and care	External assessments by visiting specialists. Eye surgeons in training having training log books evidencing that they had access to equipment that meet PERDAMI and University training requirements. Pre and post training skill assessments demonstrating improvement following new equipment commissioning and skill update courses.
	Staff trained to effectively use the patient information system to produce regular and reliable data for hospital management	Staff generate routine and special reports from the installed Patient Information System to assist general and clinician managers with service assessment, planning and decision making.	Production of reports to the PCC, DinKes and ABMEC management that meet GoI reporting standards and assist with monitoring of service volume and quality

Objective	Output	Outcome	Means of Outcome Verification
	Development and implementation of preventative and breakdown maintenance plans to maintain and repair all plant and equipment.	All ABMEC plant and equipment maintained in good working order	All major plant and equipment inventoried, and included in current preventative and breakdown maintenance plans. Maintenance occurring in accord with scheduled programs. Timely repairs and maintenance.
Related objective activities	Enhanced skill of selected *puskesmas* and district hospitals.	Improved referral system for vulnerable people in rural areas.	Number of poor patients referred to ABMEC.
	Staff skills enhanced to produce whole of entity and specific department strategic and operational plans for new / enhanced services, and to effectively measure and monitor existing services to standards required by GoI entities.	Relevant ABMEC staff able to prepare plans for new tertiary level eye services. ABMEC senior staff routinely monitoring clinical services to assess quality of service delivery.	Number and quality of plans and reports routinely prepared by staff for the PCC and local GoI authorities.
Assist ABMEC / RS Indera and related eye surgeon training facilities to provide best practice Indonesian eye surgeon clinical training	Established and enhanced formal partnership arrangements between ABMEC / RS Indera, RS Sanglah, Udayana University and local chapter of PERDAMI to prepare integrated programs for eye surgeons in training using all of Bali's tertiary eye training facilities	Eye surgeons in training rotating through Bali's eye tertiary institutions to gain maximum exposure to supervised diagnostic and surgical training. Partnership agreements formalised between the tertiary level eye hospitals providing eye surgeon training.	Formal rotating training rosters in place. Number of Bali eye surgeons in training rotating through the tertiary institutions and meeting PERDAMI standards for training
	Staff skills enhanced to develop plan for implementing and using ABMEC's training facilities for training courses / activities for training and practicing eye surgeons and clinical support staff.	Training facilities are utilised more often to provide training opportunities for new and experienced eye surgeons in Bali and eastern Indonesia.	Number and type of training courses undertaken in ABMEC facilities.

4.8 Sustainability Issues

The foundation of sustainability is that the Program envisages using and thereby strengthening Indonesian Government systems rather than imposing external systems. The standards to be reached are those standards established by the relevant GOI authority, and the systems to be strengthened are those used by ABMEC / RS Indera. Further, all the new elements of this program of assistance are planned to occur only when they are deemed appropriate by the PCC / local institutions for implementation. This means that no element should commence until it is

assessed that, i) a facility is ready to accept a new enhancement, and ii) there will be sufficient funds and other resources to continue a new service or to support the maintenance of a new piece of equipment after it has been introduced. This approach has been adopted as some of the proposed new eye surgery procedures and equipment have considerable maintenance and consumable costs.

A major focus of capacity building will be in the financial management area. It will be important that capacity is strengthened in the area of strategic and operational planning against budget allocations. Ability to negotiate and support budget claims will require a sound understanding of rational resource allocation. Evidenced based planning will be supported through the development of the Health Information System (HIS) reporting mechanism and its intrinsic relationship to planning. This focus of activity is aimed at ensuring reliability and confidence in accessing recurrent funding and developing strong justification for future financial claims. This will assist RS Indera meet the criteria for achieving BLUD status.

The engagement of both a biomedical and hospital engineer to help ABMEC staff develop preventative maintenance plans and training in early interventions of equipment problems will also support the longevity of the equipment and the opportunity for greater cost effectiveness in equipment and capital maintenance.

A key role of the HSA will be to help local executive and middle managers with capacity building of skills in business case planning for new and expensive eye procedures that are required to provide Indonesian best practice standards as outlined in PERDAMI recommendations. Whilst the senior staff of ABMEC / RS Indera should be able to develop and implement sustainable business proposals for new services, there is one significant risk factor. As mentioned throughout this design, the success of this program depends upon the cooperation of many parties, not just the staff at ABMEC / RS Indera.

No one service in Denpasar, by itself, has the necessary equipment and staff to provide the complete training and backup that is required to offer best practice Indonesian standards. Achievement of the standards will depend upon all relevant surgeons and trainers having access to the combined tertiary hospital eye diagnostic and treatment facilities. If the goodwill and support that has occurred to date can continue to grow and be nurtured by ABMEC / RS Indera, together with the resources provided by this Program, then there is no reason why the new services can not be sustainable in the long term and deliver the expected benefits.

The Program has potential to offer significant economic benefits. Four cost components of disease treatments will be reduced with the implementation of the program of assistance.

1. The direct costs of preventable eye disease will decline as the population has easier access to eye health care. As preventive care becomes more available through district health facilities, trained personnel, and quality essential medical supplies and basic diagnostic equipment, the eye health status of the population will improve and disease prevalence and morbidity rates should decline.
2. The incidental costs of eye disease, including personal travel and transport costs to and from health facilities, will decrease as the Program improves access to eye health service, both at the district and provincial levels.
3. The indirect costs of disease will be reduced as the eye health status of the population is improved by the provision of eye care that focuses on preventive services. A lower incidence of eye disease and disability means those who have been, or may be, affected will make greater productivity contributions to their own families and their communities. Accordingly, there will be an improvement in the diminished productivity due to eye health disability.
4. The psychological costs, including the pain and suffering associated with disease, disruption of normal routines, etc., will also decrease as the eye health status of the population is enhanced, and disease incidence declines.

The focus of the Program of Assistance on whole of population, but particularly the poor and vulnerable, will lead to improvements in both general and eye health status of children and adults by decreasing morbidity and, in some cases mortality. In particular, improvement in the eye health status of the population will lead to: increases in the future productivity of the workforce; decreases in curative health care expenditures; decreases in future absenteeism rates in school and subsequent higher returns to education; and increases in the future savings rate due to

averted health expenditures. Preventive eye health care and early treatment of eye disease can lead to savings in future health care expenditures, especially surgery for cataract and glaucoma.

Capacity building the local workforce will be the greatest investment towards ensuring a long term sustainable impact of this program of assistance. Through i) the appropriate selection of beneficiaries for participation in formal and experiential training, ii) establishing initial engagement and developing enduring relations with 'twinning' partners and iii) supporting strong leadership, there is a confident expectation that improvements in the standards of eye care treatment and rehabilitation will be maintained. A focus on preventative measures to avoid poor eye health and inculcate health promotion into all eye care and wider general health issues will also reduce the burden of eye care at the intervention and treatment level (secondary and tertiary care).

The Program's recommended phased approach to technical assistance and training, the use, as much as possible, of local institutions and the development of strong partnerships at the provincial and national level of health services and training institutions, will contribute to sustainable activity and outcomes.

4.9 Overarching policy issues

4.9.1 Gender

According to Victoria Sheffield, President, International Eye Foundation, "Globally, women bear a greater burden of blindness than men … clear evidence from developing countries shows that women receive fewer eye care services in part because eye care programs are not tailored to meet the needs of women and second, cultural and social barriers exist at the community level."[8]

The Australian Government's Gender and Development Policy states that an essential condition of sustainable development is for women to have a full and equal place in the development cooperation program, as decision-makers in every aspect of the program and as participants in and beneficiaries of all activities. The Program's design process has included broad consultation with women as both health care providers and as policy makers. It will be essential that data collection processes are designed to be sex disaggregated in order to demonstrate equality of access and treatment of eye health issues.

Gender issues will be mainstreamed through the Program's planned activities. This does not mean that a 'woman's component' or even a 'gender equality component' should be included but rather that there is an increase in opportunities for both men and women by bringing the experience, knowledge, and interests of women and men to bear on the development agenda.

It may entail identifying the need for changes as the program of assistance unfolds. In response to issues identified in the monitoring and evaluation reporting, there may be a need for changes in strategies or actions so that both women and men can influence, participate in, and benefit from assistance provided. It is important to recognise that the goal of mainstreaming gender equality is to transform unequal social and institutional structures into equal and just structures for both men and women.

4.9.2 Poverty Reduction

Health care is a basic right of all Balinese, and indeed, Indonesians, and has strong political and community support. The Program of Assistance is designed to ensure that rural communities also benefit through improved access to eye heath service health services, eye health interventions and eye health information. The Program of Assistance will focus on being available to all affected populations including women, and the most vulnerable. This will be made possible through the skill enhancement of selected *puskesmas* and/or district hospitals and the ability of patients to be referred directly to ABMEC / RS Indera.

Cost benefits of improving eye health and related health issues are relevant not only to the actual provision of eye health services but also to the population as a whole, particularly the poor and the vulnerable. Improving the eye health of poor people is central to development. Poor people suffer worse eye health and subsequent disability due to untreated vision problems than

[8] Seeing women: A Movement is Born, Conference, Washington, USA 05.05.09

population members who are more affluent. Family and community livelihoods depend on the maintenance of good eye health. When poor people become disabled, their entire household may become trapped in downward spiral of lost income, low productivity, and reduced participation in community life and high healthcare costs.

4.9.3 Anti corruption

The Program of Assistance will develop transparent tender and procurement arrangements for goods and services. Proposals, selection and contractual arrangements will be endorsed through the PCC. The HSA will help ABMEC / RS Indera ensure necessary policies and procedures meet Indonesian government standards. Through capacity building strategies, the development, expenditure and reporting of budgets will support accountable fiscal management, and strengthen local governance.

4.9.4 Child Protection

The ISP will be required to have a child protection policy in place. Extending the opportunities for improving eye health will support vulnerable children in achieving their life potential, especially in the area of education. The enhancement of local eye surgeon skills to treat eye disease in children will be a major advantage for vulnerable children.

4.10 Compliance with Environment and Biodiversity Conservation Act

The proposed program of assistance is impact negative in respect of the environment or biodiversity.

4.11 Critical Risks and Risk Management Strategies.

A schedule of risks and suggested management strategies was prepared for consideration.[9] Key assumptions and acknowledgments underpinning the program of assistance design include:

1. GoI and Province of Bali want to continue achieving measurable eye health improvement of the population.
2. GoI and AusAID are committed to the full three year program of assistance to the proposed development of ABMEC / RS Indera.
3. GoI and the Bali Provincial Health Office are aware of the economic constraints facing eye health services and are prepared to prioritise resource allocation decisions.
4. The service improvements introduced under the program of assistance will be maintained by GoI / GoB / PHO.
5. There is continuing and enhanced cooperation of all tertiary level providers of eye surgery and eye surgeon training, as no one entity by itself can provide a comprehensive program.
6. The PCC will function effectively to plan, implement and monitor the program elements.
7. Minimum staffing levels for ABMEC / RS Indera and district health services are available to utilise the provided equipment and capacity building interventions.

Whilst it will not be possible to eliminate all of the risks, there are three important risk minimization strategies.

1. The role of the HSA.

   This position is critical. If a suitable, clinically experienced, hospital and health service administration advisor is appointed, that advisor will not only assist with the delivery of the major capacity building activities for ABMEC / RS Indera senior staff but also provide the

[9] Notes on Program Risk Management ABMEC Phase II Support held by Health Section AusAID, Jakarta Office.

necessary support and encouragement for the PCC to function effectively (including risk management) and to encourage cooperation between all of the contributing stakeholders. It is for this reason that a realistic funding level has been allocated to attract the best applicants.

2. The role of the ISP.

   Whilst this is a relatively small program in a monetary sense, and the ISP management model is most appropriate, there are many possible complications that may arise. Whilst, risk minimisation strategies are likely to be effective, it is important that the ISP has the capability of reacting quickly when requested by AusAID to assist with emergent issues.

3. The Role of the Program Coordinating Committee (PCC).

   The structure of the Program of Assistance has been designed to be flexible thus enabling an evolving approach to Bali's eye disease needs and its training of eye care staff. The PCC will play a vital role in overseeing the establishment and implementation of the program and in turn, understand and address many of the risks. Risk Management will be a standard agenda item on each PCC meeting to ensure that the PCC can address known and emergent risks. On a day to day basis, it will be the responsibility of the Health Services Advisor to assist the management team at ABMEC / RS Indera to proactively identify risk and risk management approaches.

4. The phased allocation of funding for equipment.

   In this Program approximately AUD 1M is allocated for highly technical, tertiary level surgical equipment. It is not possible for an entire surgical team / facility to become competent in the use and maintenance of the equipment in a short time frame. Expertise depends upon many preliminary factors being in place before introducing a new procedure or item of equipment e.g. staff training, funding for consumables and maintenance, and support / backup from colleagues in the event of a complication arising. It is for this reason that it is proposed that purchase of specialised surgical equipment should only occur on a phased / outcome achieved basis. Endorsement will be by the PCC when it considers all the preliminary achievements have been met.

Annex A.

Example of Suggested Terms of Reference- Long Term Health Services Advisor

Location:

Based at the Australia Bali Memorial Eye Centre, RS Indera, Denpasar, Bali

Counterparts:

The key counterpart to this Advisor will be the Clinical Director ABMEC/RS Indera,

Duration:

The position is allocated for a maximum period of 36 months, but it is hoped that it will be for a period less than this as local counterparts gain skills and expertise in tertiary eye hospital planning, implementation, management and monitoring of activities. The position will be expected to be full time for 12 Months and reviewed by the PCC in years 2 and 3.

Reports to:

The position primarily reports to the Executive Director of RS Indera. The position also has a responsibility to provide regular and periodic reports to the Jakarta Office of AusAID and PCC.

Overall Responsibilities:

This long-term position of HSA will provide wide-ranging hospital management planning, clinical governance and management advice, mentoring, training and systems development assistance to the Executive of the ABMEC / RS Indera as requested. The position will provide health services management mentoring and advice to the Executive staff of other PCC member stakeholders that require assistance with the introduction of PCC approved activities in their institutions. This position will also provide assistance to RS Indera to fulfil the requirements in preparation to become a BLUD status hospital (Badan Layanan Umum Daerah / Public Service Board) that will enable it to retain its revenue.

Qualifications and Experience:

- Tertiary qualifications in health service management / hospital management.
- Senior hospital management experience or as a consultant to tertiary level hospitals in-country for at least 5 years. Experience in successfully assisting in achieving BLUD status an advantage.
- A clear understanding of Indonesian health administration and Regulations and understanding of the advisory role in a development co-operation project and experience in acting in the role of mentor.
- The individual must also have excellent communication skills and be able to converse with a wide range of health professionals, government officers and the community.
- Language Skills in Bahasa Indonesia are essential

Duties:

Strategic

The position will be expected to provide advice and guidance on options in terms of the integration / linking mechanisms between the current planning processes and changes in the way business is conducted at ABMEC / RS Indera. The model to be developed would consider, but not be limited to, the following key elements:

- Development of the ABMEC / RS Indera's Business Plans.
- Budget Plans
- Service Plans
- Hospital Area Management
- Minimum Service Standards
- Development of Plan for RS Indera to achieve BLUD status
- Linkage of operational plans to budget allocations.
- Development of a reporting framework on:
    - Quality and Safety
    - Outcomes of Continuum of Care
    - New service delivery
    - Performance Management

Operational

In addition to the responsibilities outlined under Strategic Context, the position would be expected to assist ABMEC/ RS Indera put into operation the Strategic Plans and provide mentoring and advice to management staff on a day to day basis to further sustainability. The HSA will foster the implementation of further appropriate quality assurance and quality improvement mechanisms (by changed of mindset, improved organisational management, customer oriented philosophy, governance and clinical leadership) and ABMEC / RS Indera policies, standards and protocols. This should include:

- Develop and improve management and supervisory skills and processes.
- Assist ABMEC / RS Indera in the preparation of BLUD application and help RS Indera make the required changes.
- Assist ABMEC / RS Indera identify short-term advisor needs, and training services to achieve the objectives of the Program;
- Assist ABMEC / RS Indera and PCC partners in prioritising medical equipment to be procured by the ISP.
- Assist with the strengthening of effective and efficient supplies and inventories management, including distribution and control within the hospital.
- Develop a twinning program with Indonesian hospitals and an international hospital
- Assist ABMEC / RS Indera and PCC develop a monitoring and evaluation framework for the Program.
- Complete a comprehensive Exit Report at the conclusion of the long term input

The HSA will support the PCC by:

- Implementing relevant PCC directions and resolutions.
- Serve as a focal point for assisting the coordination of the various PCC functions.
- Assist ABMEC / RS Indera with preparation of budget, monitoring and other documents and activities needed to support the functioning of the PCC.
- Coordinate reporting required by the PCC.
- Make recommendations to the PCC on allocation of resources for capacity building and the procurement of medical equipment according to the prioritisation criteria agreed by the PCC
- Assist with reviews of business processes of the Program.
- Assist with monitoring and reporting of performance.
- Assist with risk minimisation strategies.
- Provide secretariat services to the PCC

Annex B.

New Program of Assistance Consistency with AusAID and other Donor / Multilateral Programs.

This second phase of assistance to be provided to the Australia Bali Memorial Eye Clinic (AMBEC) is congruent with the overall Australia Indonesia Partnership Country Strategy (AIP) 2008-2013. The Strategy has as its aim to support sustainable poverty reduction in Indonesia with the goal of working in partnership to develop a more prosperous, democratic and safe Indonesia through support of the Indonesian medium term development plan.

The AIP Strategy is built on 4 pillars[10] :

1. Sustainable growth and economic management
2. Investing in people
3. Democracy, justice and good governance
4. Safety and peace

This assistance program will focus on Pillar 2 -Investing in People with a focus on better health access and systems and a particular emphasis on health system strengthening.

The AIP has identified strengthening priorities as:

- Policy support
- Evidenced based planning and budgeting
- Stronger feedback between all levels of government – national, provincial and district
- Technical Assistance (TA) to build capacity
- Funding for training
- Data collection systems, analysis and reporting
- funding gaps in essential equipment and service delivery[11]

The majority of these will be addressed in the second phase of support for AMBEC.

Underpinning the support proposed in this design is recognition of the relationship between poverty and sight disability. The activities proposed in this program aim to i) enhance the skills of local clinical staff to prevent and manage eye disease, and ii) enhance the capacity of local management and clinical support staff to plan for and better utilize existing facilities thereby providing more access to patients who present for care.

Development for All: Towards a Disability-Inclusive Australian Aid Program 2009–2014 [12]

This represents Australia's goal for developing approaches to addressing issues of disability in the development sector, with an emphasis on the most vulnerable, the poor, women and children and those without a voice. This document is seen as providing significant guiding principles for inclusion in the second phase of support to AMBEC. It is particularly important that those with disabilities are not only afforded access to interventions and rehabilitation, but also are represented in the decision making aspects of policy development. Accordingly, it is proposed that

[10] Australia Indonesia Partnership Country Strategy 2008-2013 p8

[11] Ibid p13

[12] Development for All: Towards a Disability-Inclusive Australian Aid Program 2009–2014, AusAID 2009 p7

there should be a representative of a blind or blindness support organization on the Program of Assistance Coordinating Committee which is described in Section 4.3.

VISION 2020 Mission, Goals, Aims and Objectives[13]

The overarching mission of Vision 2020 is to eliminate the main causes of avoidable blindness by the year 2020 by facilitating the planning, development and implementation of sustainable national eye care programs based on the three core strategies of cost effective disease control, human resource development and infrastructure and technology, incorporating the principles of primary health care. This mission is underpinned by a vision which aspires to eliminate needless blindness in those with unavoidable vision loss in order that they can achieve their full potential. The objectives are:

- Increase awareness, within key audiences, of the causes of avoidable blindness and the solutions to the problem;
- Advocate for and secure the necessary resources to increase prevention and treatment activities; and
- Facilitate the planning, development and implementation of national VISION 2020 programs in all countries.

The Indonesian Vision 2020 goal is congruent with the WHO goal. The local Indonesian ophthalmologist association (PERDAMI) is taking the lead in ensuring that initiatives are in place and actioned in line with the agreements made at the Vision 2020 – Right to Sight task force meeting held in Jakarta in 2002[14]

ACCRA Agenda for Action

This Program of Assistance is also congruent with the ACCRA Agenda for Action[15] (AAA). The key points agreed in the Accra Agenda for Action include:

Predictability – donors will provide 3-5 year forward information on their planned aid to partner countries.
Country systems – partner country systems will be used to deliver aid as the first option, rather than donor systems.
Conditionality – donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.
Untying – donors will relax restrictions that prevent developing countries from buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.

In particular, this proposed program of assistance supports Accra in that, as much as possible, Indonesian systems will be utilised and Indonesian personnel and suppliers will be used to support the achievement of the program's objective in congruence with wider Indonesian eye health objectives.

Paris Declaration:

The program of assistance is also congruent with the Paris Declaration[16] which identifies the following as key underpinning features of any development assistance program:

[13] Vision 2020, World Health Organisation and International Agency for Prevention of blindness Global Initiative 2000

[14] Vision 2020 – right to Sight Report of Inter-country consultations on Development of Regional Strategies, Jakarta 14-17

[14] The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, 2000

[15] Third High Level Forum on Aid Effectiveness hosted by the Government of Ghana in Accra, 2-4 September 2008.

Ownership - Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
Alignment - Donor countries align behind these objectives and use local systems.
Harmonisation - Donor countries coordinate, simplify procedures and share information to avoid duplication.

Results - Developing countries and donors shift focus to development results and results get measured.
Mutual Accountability - Donors and partners are accountable for development results,

This proposed program of assistance has accordingly been designed to allow local ownership, supported through training and capacity building. It will feature support based on mutuality between governments and institutions and put in place transparent fiscal accountability measures. Assessment of success will be evidence based by measuring outcomes against key performance indicators.

Millennium Development Goals (MDGs):

This program of assistance supports at least four of the eight MDGs by providing prevention, early intervention and rehabilitation for those living with visual disability.

MDG 1. Eradicate poverty and extreme hunger

It is a fact that disability contributes to poverty which in turn hinders those living with a disability to challenge the poverty cycle they find themselves living in. Efforts of the program of assistance to intervene in the disabilities associated with blindness and poor vision will provide a more enabling environment for beneficiaries to improve their socio economic circumstance.

MDG 2. Achieve universal primary education

While the main causes of blindness and poor vision in Bali are related to mature onset disease, there remain a small proportion of children who are living with visual disability which prevents them from reaching their education and learning potential. (The commonest form of childhood blindness relates to neonatal blindness of prematurity). Many adults who have lived with visual disability either from birth or early childhood have been prevented from accessing formal education.

MDG 3. Promote gender equality

Women are amongst the most vulnerable group affected by visual disability. Many women, as well as men, are prevented from equal participation in society and suffer injustices to their human rights as a result of their disability. Providing access to services, which intervene through treatment or rehabilitation, to targeted groups of disadvantaged women and men will promote equality and equity in participation in society, the workforce, families and community

MDG 8 Develop global partnerships for development

Partnership engagement between the GoI, Bali Provincial Government and GoA through the program of assistance will support sustainable development. In particular, by entering into twinning arrangements with eye health institutions and services, there will be forged longer term development relationships with advantage for all parties involved.

[16] The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators

Annex C.

Potential Equipment Items and Phasing Needed by the Facilities Providing Tertiary Level Eye Surgeon Training and Eye Service Delivery in Bali.

Eye sub - speciality	Phase	Equipment and associated activities
CATARACT SURGERY	1	Diagnostic Binocular Indirect All Pupil Wireless Ophthalmoscopes X3 Additional diagnostic lenses for existing slit lamps Auto refraction Keratometer IOL Master x1 New operating microscope (This will be used for other sub-speciality disciplines) Surgical JAG Laser
	2-3	Diagnostic Pentacam (Relevant for Cornea & Glaucoma) Surgical Nil
GLAUCOMA MANAGE-MENT	1	Diagnostic Additional lens for slit lamp to aid diagnosis Applanation tonometer Surgical Nil
	2	Diagnostic OCT to image Retinal nerve fibre thickness x2 Pachymetry Hand Held Pentacam (Relevant for Cornea & Glaucoma) (HFA) Humphrey Field Analyser Latest Software x2 Surgical Nil
	3	Diagnostic and Surgical Nil

RETINAL DISEASE & SURGERY	1	Diagnostic Glass Superfield 120^0 Glass 3 mirror peripheral retina examination device Glass Goniolens Sussman Additional lens for operating microscopes. Surgical Additional attachments for ZEISS operating microscope for vitro retinal surgery
	2	Surgical Nil
	3	Diagnostic Nil Surgical Combined Vitrectomy Phaco-emulsification unit for posterior approach & Vitrectomy combined This should only be considered if recurrent funding is available. GYC Green Photo Coagulator Solid state 2watts (532w.l) Laser. Can be used In Operating Theatre or on clinic Slit Lamps with adapter
CORNEA & REFRACTIVE SURGERY	1	Diagnostic Suggested that establishment of a small **Microbiology laboratory** be considered, but will depend upon a technician (salary) being available Surgical Corneal scrapes for culture Nil additional equipment ,
	2	Diagnostic Pentacam (Same device as listed under Cataract above) If a microbiology laboratory has been established, consideration could be given to establishment of an eye and tissue bank. In addition to capital costs would also need staff salaries. Surgical
	3	Diagnostic Established in phase I Surgical In this phase corneal transplantation could occur, but it will only occur if a microbiology laboratory function is available. It also requires considerable recurrent costs for disposable equipment. (Funding not available unless funds saved from other program elements). Excimer Laser for corneal corrective refractive corneal surgery could also be considered in this phase. (Funding not available unless funds saved from other program elements).

Annex D.

Suggested Terms of Reference - Program Coordinating Committee (PCC).

The Program Coordinating Committee (PCC) will be the ultimate authority for the Program and will make decisions in keeping with the Subsidiary Arrangement. It will undertake all of monitoring and evaluation activities required to ensure the program is running effectively and delivering the desired objectives and outcomes. The PCC will apply principles of sound Governance that will be necessary to achieve the objectives of the program and to meet Government reporting requirements. Membership includes all of the major stakeholding institutions that will benefit from the Program.

Responsibilities of the PCC will be:

- Establish and provide strategic direction and priorities for the Program.
- Ensure the strategic objectives for the Program link with the priorities outlined in the strategic and business plans of the Provincial Health Department (DinKes) and ABMEC / RS Indera.
- Approve the Monitoring and Evaluation Framework and use it to monitor progress and performance of the program.
- Provide guidance and direction to the L/T HSA and other Advisors and experts engaged on the program,
- Define the nature and extent of the reporting required for the program.
- Establish and maintain a continuous quality improvement focus.
- Develop eligibility criteria for the activities to be funded under the program, including the purchase of goods (equipment) and services
- Review and approve annual program plans and budgets and an annual program of assistance review;
- Monitor progress and performance of the Program;
- Review any technical standards, protocols and guidelines developed by the program;
- Encourage a culture of collaboration, innovation and high performance;
- Resolve differences and conflicts between the program partners to the maximum mutual benefit.

Membership of PCC

Membership of the PCC will include the Executive Director of ABMEC / RS Indera, a nominated Officer AusAID Jakarta, the Provincial Director of Health or his senior nominee, the President Director of RS Sanglah or his senior nominee, a senior representative of the National Executive or the Bali Chapter of PERDAMI, the Professor or a senior representative of Udayana University – Eye Department. If possible, there could be a member representing a mutually respected Balinese visual disability support group. Each of these should have a designated alternate to cover any absences. The PCC may enlist the services of other high level technical expertise as *ad hoc* non voting members when and if it is deemed necessary. The HSA will attend meetings as a non voting member.

AusAID will facilitate initial meetings of the PCC. The Chair of the PCC will be decided by the PCC. A quorum will be at least four voting members including ABMEC / RS Indera, AusAID and PHO representatives. Secretariat services will be provided by the HSA .

The PCC will meet at least 3 times each year and may find it necessary to meet more regularly during the first year of the program.

The PCC will be established and have its first meeting within 4 weeks of the commencement of the Program. To be effective, the PCC must be delegated the authority to make binding decisions on behalf of the GOI and AusAID for the requirements of the Program.

The specific duties of the PCC members are listed below.

AusAID Representative

The AusAID representative will be responsible for:

- Representing the views and requirements of the AusAID
- Instructing ISP to carry out PCC endorsed implementation activities

Government of Indonesia Representative

The Government of Indonesia representative is Head of Bali Provincial Health Department or a senior DinKes officer. The GOI representative will be responsible for:

- Representing the views and requirements of the Provincial Department of Health
- As far as possible, the structure and function of program arrangements will follow the GoI / Province of Bali management structures and organisational relationships.

ABMEC / RS Indera Representative

The Executive Director will represent the views and requirements of ABMEC / RS Indera

- The Director will be responsible for the implementation of the Program in ABMEC/RS Indera area of responsibility, assisted by Program Technical Advisors.
- Participate as appropriate in the selection of technical advisors, sub contractors, twinning partners
- Contribute to the preparation of annual planning and budgets

RS Sanglah Representative

- Provide technical advice on appropriateness of training and equipment procurement
- Maintain cooperative and collaborative arrangements with ABMEC / RS Indera
- Participate as appropriate in the selection of training sub contractors
- Provide expert advice on the procurement of eye diagnostic and treatment equipment
- Represent the views and requirements of RS Sanglah

PERDAMI Representative Responsibilities

- Ensure ophthalmology treatment and training standards meet PERDAMI minimum standards
- Participate in the selection of training sub contractors
- Advise on capacity building of eye doctors
- Provide expert advice on the procurement of eye diagnostic and treatment equipment
- Represent the views of PERDAMI

Udayana University- Eye Department Representative

- Provide input into the approval of relevant training curricula
- Participate in the selection of training sub contractors
- Represent the views and needs of training ophthalmologists

Bali Eye Disability Representative (Possible member of the PCC, subject to PCC decision)

- Represent the community needs in respect of eye health promotion
- Act as an advocate for visually disabled people of Bali