Independent Assessment Team Report
Prepared for AusAID

Situation analysis of the functioning and potential for the Australia Bali Memorial Eye Centre (ABMEC).

11 December 2008

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Key Abbreviations

ABMEC	Australia Bali Memorial Eye Centre
AusAID	Australian Development Assistance Agency
AVI	Australian Volunteer International
BPG	Bali Provincial Government
DepKes	Departemen Kesehatan (National Department of Health)
DinKes	Dinas Kesehatan (Provincial Department of Health)
GOA	Government of Australia
GOI	Government of Indonesia
NGO	Non Government Organisation
PERDAMI	Perhimpunan Dokter Spesialis Mata Indonesia (Indonesian Ophthalmologist Association)
RS	Rumah Sakit (Hospital)
RSI	Rumah Sakit Indera (Indera Hospital)
RSS	Rumah Sakit Sanglah (Sanglah Hospital)
YKI	Yayasan Kemanusiaan Indonesia

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SITUATION ANALYSIS OF THE FUNCTIONING AND POTENTIAL FOR THE AUSTRALIA BALI MEMORIAL EYE CENTRE (ABMEC)

1.0 RELEVANT BACKGROUND TO THE INDEPENDENT ASSESSMENT OF ABMEC

In October 2008, the Jakarta Office of AusAID commissioned an independent assessment mission to compare the originally envisaged Australia Bali Memorial Eye Centre (ABMEC) model with current operations, and make recommendations for AusAID's future engagement in order to assist the Government of Indonesia (GOI) to utilise ABMEC to the fullest extent possible.

The independent team comprised the following individuals:

- John Menzies — Team Leader
- Prof. Frank Billson — Clinical (Ophthalmology) Specialist
- Dianne Campbell — Hospital Standards Specialist
- Stephanus Indradjaya — Indonesian Health Sector Consultant

The assessment involved the team members inspecting facilities and records and meeting key stakeholders at ABMEC and relevant hospital and health facilities in Bali, and relevant stakeholders and health facilities in Jakarta. The inspections and interviews occurred from 14 to 20 November, 2008.

The team was to specifically carry out eight tasks viz.,

1. Gain a full understanding of Government of Indonesia (GOI) ownership, resourcing and strategic planning for ABMEC and determine whether these plans will ensure that ABMEC is able to reach its full potential in terms of both numbers and quality of clinical operations performed and as a training facility and centre of excellence.
2. Ascertain the number of free operations performed for poor people at the Centre (including mobile clinics) versus number of paid operations, and determine whether GOI intends to increase/decrease free services for the poor through ABMEC. Consider the implications on ABMEC's service plan.
3. Examine to the extent possible ABMEC's clinical standards, quality control and audit systems, operating theatre environments, surgical and diagnostic procedures.
4. Gain a clear understanding of the Indonesian Legal and Regulatory frameworks that relate to ABMEC, including relevant Provincial interpretations and applications that impact on YKI's engagement with ABMEC. Gain insights into Vision 2020 implementation in Bali, and the new Balinese Government's strategic health sector strategies relating to eye services.
5. Provide recommendations for particular options for AusAID to pursue in order to ensure the Centre is used appropriately and effectively, i.e. should the Australian Government continue to provide financial assistance to ABMEC? If so by which modality and at what level? What implications might additional Australian support have on long term sustainability?
6. Determine whether there is any possibility for YKI to re-engage with the Balinese Health Authorities and provide free services to the poor using ABMEC facilities.
7. Evaluate Australian Volunteer International (AVI) inputs to date and comment on the potential for future AVI engagement with ABMEC.
8. Provide recommendations for a new Subsidiary Agreement (SA) between the Government of Indonesia and AusAID for ABMEC.

The findings of the independent team were to be presented in a brief but concise consolidated report by 8 December, 2008. Due to delays in obtaining technical information and statistics the report was submitted on 11 December 2008. In addition to the consolidated report, the technical expert members of the panel were to produce short Assessment Notes. All relevant technical data and related information was to be attached as annexes. This document thus contains four key elements:

- The Assessment Team's Consolidated Report, and notes on relevant historical issues and their significance (Annex 2),
- the Clinical (ophthalmology) technical report (Annex 3),
- the Hospital Standards technical report (Annex 4), and
- the Indonesian Health Sector technical report (Annex 5).

2.0 STUDY METHODOLOGY AND REPORT FORMAT

Prior to the assessment visit, the Jakarta office of AusAID, with assistance from the Australian Volunteer International (AVI) hospital administrator at ABMEC, arranged a number of site inspections, individual and group interviews and external visits in Bali and Jakarta. In addition to these, the assessment team organised other site visits and interviews to ensure that it got as full an appreciation of ABMEC and related activities as possible. The final schedule of visits and interviews is attached as Annex 1.

In most cases the assessment team was able to gather the necessary data at the initial visit or interview. Where this was not possible, the team organised a return visit or sought supplementary information to ensure that interpretation of the initial data were confirmed. The team believed that it visited or interviewed sufficient of the relevant individuals and services to gain a fair and balanced version of events as required under the terms of reference.

On the penultimate day of the review, the team met to discuss all of the findings to date. At this meeting, each team member summarised their key observations. Whilst there were a few minor variances in some observations which are outlined in the separate technical member reports, there was unanimous agreement between the team members with the key conclusions and recommendations made in this report.

In a brief report such as this, it is not possible to give a detailed briefing on all of the relevant background events, observations and thought processes that led to the summated conclusions and recommendations made in this report. There are, however, some very significant relevant historical facts that need to be explained to help understand why the more important problems at ABMEC exist and why certain courses of action have been suggested. The more important historical facts are outlined in Annex 2. Most importantly, the historical facts explain why certain polarised views exist about the quality of services provided at ABMEC and its potential to be a training facility that can meet Indonesian and international standards.

In investigating the 8 specific tasks, there was considerable overlap between several tasks. Consequently, the findings for some of the tasks are grouped together.

3.0 SPECIFIC OBSERVATIONS RELATING TO TASKS 1, 2 AND 4.

Task 1. Gain a full understanding of Government of Indonesia (GOI) ownership, resourcing and strategic planning for ABMEC and determine whether these plans will ensure that ABMEC is able to reach its full potential in terms of both numbers and quality of clinical operations performed and as a training facility and centre of excellence.

Task 2. Ascertain the number of free operations performed for poor people at the Centre (including mobile clinics) versus number of paid operations, and determine whether GOI intends to increase/decrease free services for the poor through ABMEC. Consider the implications on ABMEC's service plan.

Task 4. Gain a clear understanding of the Indonesian Legal and Regulatory frameworks that relate to ABMEC, including relevant Provincial interpretations and applications that impact on YKI's engagement with ABMEC. Gain insights into Vision 2020 implementation in Bali, and the new Balinese Government's strategic health sector strategies relating to eye services.

3.1 Relevant Historical background.

Some brief historical facts must be considered before commenting upon current circumstances. Prior to the announcement of the Australian Government's $10.5m Bali Memorial Package in 2003 and the associated initiatives to help with eye disease management in Bali, the National and Provincial Governments / Departments of Health had not been contemplating a facility such as ABMEC. The concept of ABMEC and its initial proposed operational goals were very much driven by the lobbying of Mr John Fawcett the head of the John Fawcett Foundation and the related Indonesian entity Yayasan Kemanusiaan Indonesia (YKI) both of which are hereafter referred to as YKI.

As a NGO that had been doing good charitable eye surgery in Bali since 1991, YKI became an integral and influential stakeholder in the subsequent planning, design and construction of ABMEC, the mobile eye clinics and providing advice on staff training initiatives. As explained in more detail in Annex 2, ABMEC was seen by YKI as a facility that could be a base for screening of eye diseases and capable of doing large volumes of simple eye surgery – virtually a 'cataract factory'. In addition, the facility was to have extensive state of the art facilities for training both young and experienced eye surgeons to international standards, not just Indonesian standards.

Although not specifically enunciated over the last three to four years, the success of ABMEC would depend upon five important building blocks. The first was for ABMEC to become part of the Indonesian Health System (this was specifically enunciated) and the ability of the Indonesian Health system to i) meet most of the recurrent operating costs of the facilities, ii) coordinate the provision of all elements of eye disease management, and iii) provide and coordinate the training of medical students, new eye surgeons and existing eye surgeons. (The latter points were not as well enunciated).

The second was the need for the initial and some ongoing support from AusAID. The third was the continuing involvement of YKI with its expertise in accessing biomedical engineering, donated consumables and provision of clinical and other technical expertise. The fourth was the support of the eye surgeons of Bali. The fifth was a continuation of national and provincial health service payment support for the poor who could not afford to pay for eye surgery.

Apart from AusAID's continuing support and desire to see ABMEC function to its realistic potential, all four other important building blocks have either been eroded or altered in some significant way.

3.2 Breakdown in relationship with YKI.

With the breakdown in relationships between YKI and most Bali Provincial Government health agencies, YKI has withdrawn many key services that were needed for ABMEC to function effectively. Most importantly it has withdrawn biomedical and general engineering support for the complex equipment at ABMEC and support for visiting international eye surgeons who assist with education programs.

The implications are firstly, many items of ABMEC equipment are deteriorating and/or not being maintained effectively. This has resulted in delays for service delivery and some items not being used. Biomedical engineering services will need to be provided and funded by other sources if all the plant and equipment is to be used to maximum potential. To date, it has been difficult for ABMEC to implement a good alternate service although AusAID is intending to assist with some volunteer support.

Many promised donated consumables are also no longer available, and ABMEC now has to acquire consumables within its own limited budget. ABMEC will also need to arrange new training initiatives to ensure training programs using the donated equipment occur effectively. RSI / ABMEC senior staff have indicated that they would be most appreciative if AusAID could assist with some funding to help these activities occur.

3.3 Recurrent funding for ABMEC operation.

As the health authorities were not expecting the donation of such a complex facility in 2003, it is now clear as explained in Annex 2, the planning for the new facility was very much influenced by YKI, including its director and a supporting local eye surgeon (Dr Dharyata) who at the time was the Director of the original RSI. The facility was specifically designed to deal with a number of specific eye diseases (predominantly day only cases) and for surgical skills training of ophthalmologists. Relatively limited consideration was given to the long term role the Centre would play in whole of Bali eye service delivery and eye clinician training. Limited consideration was also given to the recurrent funding needed for the facility. As it is a uniquely designed facility, ABMEC has limited flexibility to treat other diseases either in an emergency or overnight capacity, especially as its pathology, radiology and overnight inpatient capacity is very limited. The implication is that ABMEC has limited flexibility to perform other functions and thus earn alternate sources of income.

With a limited recurrent budget, limited flexibility to arrange other sources of funding, the withdrawal of YKI resources and a need to meet the expectations of donors such as AusAID, ABMEC is not currently in a position

to substantially improve its range of services. DinKes and the management of RSI / ABMEC are trying to make alternate planning and resourcing arrangements within approved Indonesian regulations. Some preliminary discussions with the National Health Department (DepKes) would indicate that RSI will receive some additional funding for capital equipment in 2009. The Provincial Government is also likely to provide some additional recurrent operating funds in 2009 including some funds to allow more mobile clinic operations to be performed. The additional funds that will be provided, however, are unlikely to be sufficient to cover all of the gaps left by YKI's withdrawal and to meet the target levels that were expected when the facility was opened.

3.4 Support of Balinese PERDAMI members.

Only two of Bali's 21 eye surgeons have a good working relationship with YKI and the rest will not, or are reluctant to, assist the organisation. Accordingly, if the public system of Indonesia is to provide more eye services for the poor of Bali, there will be a need to obtain support from PERDAMI members to help with more eye surgery in the provincial hospitals and mobile clinics around Bali. Whilst the withdrawal of YKI has had a negative impact in some areas, it has had a positive impact in others ways. Several PERDAMI members have put their names forward to participate on a roster established by RSI / ABMEC to man the mobile clinics.

It is likely that if further local training is offered to PERDAMI members, and if improved mobile clinics facilities are available, additional eye surgeons are likely to help with more volunteer surgery, especially on Saturday mornings as is supported nationally by PERDAMI.

3.5 Payment and provision of health services for poor Indonesians.

This topic is covered in detail in the Indonesian Health Sector Consultant's report in Annex 5. The following is a summary of the key points.

The current National and Provincial governments are committed to providing free health care –including eye care, for the poor. In the past, public facilities including public hospitals, usually served as the 'safety net' for the poor. Poor patients would bring a 'poverty letter' from the village head of a sub-district so that charges could be waived. However, this system was open to potential fraudulent abuse and substantial leakages occurred. At the same time, many of the true poor sometimes were not even able to get to a health service for free care.

In 2005, the Ministry of Health launched the Health Scheme for the Poor (ASKESKIN) funded by the national budget. Under this scheme, the National Statistics Agency (Badan Pusat Statistik-BPS) produced estimates and identified the poor households in each district, verified by the district government. PT ASKES (a parastate enterprise), was responsible for the printing and distribution of the ID card for the poor and organising payment to the providers.

In early 2008, the Ministry of Health changed the Askeskin scheme to Jaminan Kesehatan Masyarakat (JAMKESMAS)[1] to cover 19.1 million households or 76.4 million people throughout Indonesia. The Ministry of Health determines the quota of poor households in each district that can be funded by the scheme. Based on this quota, district heads should issue the list of poor households in their respective districts. Households that are not on the list are not eligible for free health care. However, if the district head considers that the quota is not enough, district government can bear the additional cost. PT Askes is still responsible for issuing new ID Cards but no longer acts as the payer to the provider. The Ministry of Health reimburses the hospitals directly after claims have been verified by a designated team at a district office.

In response to this new regulation, on 21 September 2007 the Government of Bali and the Head of the nine Bali District governments developed a consensus on the criteria required for a poor household to be considered poor, and the quota of the poor households in each district. The programme covers 147,044 poor households or 548,617 people (16%) in Bali province. The Heads of Districts (Bupati/Walikota) updated the list of poor households on 31 December 2007. This updated list is currently being used for poverty alleviation programmes, including free health care provision. In addition, on 11 April 2008, the Provincial Health Office (DinKes)

[1] Minister of Health Decree no. 125/Menkes/SK/2008 on Guidelines on Jamkesmas implementation.

announced that if the number of poor people exceeds the quota, free care can still be provided if the district authority issued a statement of poverty and there was availability of local budget to cover the cost of the patient[2].

YKI tried to 'get around' this new requirement but were told by ABMEC administrators that they could not bend the rules for YKI and that if they wanted to help a person who they believed to be poor but was not on the Government's list, they would either have to pay the Government approved public hospital fee on behalf of the patient or they could continue to provide the service themselves at a YKI mobile clinic. As the stipulated fee for a cataract operation was IDR 1,350,000, YKI elected to do the operations on people they considered to be poor, except those that were on the Government's list and could easily access the service at ABMEC.

With the introduction of JAMKESMAS and the GOI measures to limit corruption in government run facilities and agencies, all hospital administrators are applying the new regulations correctly, for fear of being regarded as presiding over corrupt practices which would have very serious consequences for them. The net result of these two national initiatives is that there are now fewer 'free' in-house operations being performed.

ABMEC has since April 2008 continued to provide free operations but only to people who meet the GOI criteria. All other patients must pay the prescribed fee. It is important to note, however, that ABMEC does not charge a fee for any category of patient that wishes to have their surgery in one of the mobile clinics. It is for this reason that ABMEC is keen to continue providing mobile services to rural areas as it will be able to meet the goal of providing a free service to as many deserving people as possible. Several local members of PERDAMI are providing their time on a voluntary basis to help meet the target of 1,000 operations for calendar year 2008. DinKes will provide ABMEC with additional recurrent funds in 2009 to achieve a higher target number. The relevant related point to note and mentioned in following sections, is that the current mobile clinics provided to ABMEC by AusAID are really no longer fit for purpose and require structural modification or replacement to allow operations to occur with minimal infection control risks. Without good mobile clinics, the one facet of flexibility that ABMEC has to offer more free eye surgery in impoverished rural areas, will thus be limited.

3.6 Balinese Commitment to Improving Eye Health Services and Delivery.

As a response to a pledge from the National Committee on Prevention and Control of Impaired Vision and Blindness, on 18 September 2008, the Governor of Bali established a provincial committee for the same purpose[3]. This Provincial committee has the tasks to develop, coordinate and implement prevention and control of impaired vision and blindness programmes at Provincial level. Since the programme needs intersectoral collaboration, the Vice Governor personally serves as an advisor. The Head of the Bali Province Health Office (DinKes) is the Chair and the Director of RS Indera is the co-chair. The committee includes 3 working groups (WG): (a) WG on Promotion chaired by the Provincial Health Office; (b) WG on Service Delivery chaired by the Director of RS Indera; and (c) WG on Partnerships chaired by the local chapter of PERDAMI. All Balinese activities related to Vision 2020 will be coordinated by this umbrella organization. In addition, hospitals and health care entities should work in collaboration with DinKes if the hospital / entity would like to conduct a community outreach programme[4]. As a consequence, YKI activities should also be under coordination of this Provincial and relevant District Committees. This would authorise YKI to work as a legal entity in Balinese districts and avoid duplication of activities and reduce avoidable inefficiency and misunderstanding. At present only Jembrana district has established a District Committee.

3.7 Balinese Commitment to Improving Eye Doctor Training.

Currently, there are 12 young eye surgeons in training in Bali. The numbers in training are believed by local authorities to be appropriate given the resources available for training and the number of ophthalmologists needed in the Bali community. The successful training of young eye surgeons requires access to good training facilities, access to good diagnostic equipment, opportunities to work with experienced teachers and the opportunity to see sufficient numbers of patients with different eye disorders. Until the opening of ABMEC, all training for new and existing eye surgeons in Bali was carried out at RS Sanglah. RS Sanglah is a general tertiary teaching hospital in which ophthalmology is but one medical specialty service providing acute and

[2] Circular letter No. 005/1424/Binkesmas Diskes to public hospitals and District Health Offices in Bali province
[3] Governor of Bali Decree no. 1121/03-K/HK/2008
[4] Minister of Health Decree no 1045/2006

elective services. RS Sanglah has tried to provide new eye surgeon trainees with the necessary tuition, patient exposure, surgical skill training, access to diagnostic equipment and the support that is needed for all round specialist eye surgeon training. Unfortunately, there have been deficiencies in eye surgeon training at RS Sanglah including, lack of diagnostic equipment, limited laboratory skills equipment, limited access to operating theatre time and limited space for clinics. The opening of ABMEC has provided Bali with an expanded base upon which good eye surgeon training can be built – not just for Bali, but for all of Eastern Indonesia.

It is apparent that prior to ABMEC's construction, little attention or planning was given to eye surgeon training as a whole. The skill training facility at ABMEC, whilst having broader application, was basically designed to train doctors in cataract surgery technique. There is substantial potential to use both the wet laboratory facilities and the audio-visual equipment to train doctors in many more facets of ophthalmology. It must be stated, however, that even though ABMEC has excellent patient care facilities and equipment, it can not offer complete eye surgeon training by itself. Successful eye surgeon training in Bali will depend upon multiple facilities combining their tuition resources, speciality clinical equipment and clinical material. With careful planning by all key stakeholders, sharing of resources and some judicious purchase of new diagnostic equipment, the combined major hospitals of Bali with support from other Eye Department of Medical Schools outside of Bali, could realistically together become the major eye training centre for Eastern Indonesia, with ABMEC specifically being the major surgical eye service and training facility. (Some of the preceding activities may need some assistance from AusAID). RS Sanglah would continue to be the main facility for complex eye disorders such as those associated with multiple trauma, systemic diseases, major head and neck cancer surgery and neurological disorders.

Over the last year, the key stakeholders of eye surgeon training have been giving consideration to how the combined Bali facilities can be better utilised. It has been acknowledged that for all specialist eye training, close collaboration will be critical between the Department of Ophthalmology, Faculty of Medicine at Udayana University, RSI / ABMEC and RS Sanglah. A MOU between these organizations was signed in September 2008, and a follow up meeting has been planned. It has initially been agreed that ABMEC will specialize in four eye sub-specialties - cataract, glaucoma, retinal surgery and refraction, while Sanglah Hospital will concentrate on the other eye subspecialty areas. In the interim, staff from RS Sanglah/ Faculty of Medicine will become visiting ophthalmologists to ABMEC. With support, this arrangement should help develop better under- and post-graduate training for doctors in ophthalmology disciplines. Coordination of service delivery and planning for integrated training programs should also be assisted by the return to RSI / ABMEC in 2009 of two doctors who have been completing Masters Degrees in Hospital Management. Support from the members of the Bali chapter of PERDAMI will also be critical. The Bali members of PERDAMI fully support the national Vision 2020 movement and this is reflected with their members' involvement on the Provincial Committee and with ABMEC mobile clinic activities.

Although the actions in the preceding paragraph have already been agreed locally, it was the assessment team's conclusion that ABMEC has even greater potential for eye disorder training and treatment. (Detailed comments are made in Annex 3). The key observations at this point are that given the space and central geographical location of ABMEC in Denpasar, and the greater cooperation with the services at RS Sanglah, ABMEC has the potential to do more eye disorder management and clinician training than that already agreed. It will of course depend upon local, sustainable funding becoming available. In particular, the assessment team believed that ABMEC is well placed to undertake complex isolated eye trauma, manage acute eye emergencies including glaucoma, retinal detachment and late vitreoretinal surgery. With its spare theatre capacity, it is in an ideal position for giving priority to sight threatening eye disease in Bali. It is also an appropriate setting for oculo plastic surgery particularly eyelid and lachrimal surgery.

3.8 ABMEC Utilisation Statistics

The following are the available key statistics relating to utilization of ABMEC services. The majority of RS Indera's acute and elective eye services are now provided on the ABMEC campus. Prior to October 2007, the services were provided on the main RS Indera campus in west Denpasar. More details are provided in tables in Annex 5.

1. Outpatient visits at ABMEC
    a. The total number of visits remained stable around 18,000 to 19,000 visits per annum during 2004 – 2007 and it is estimated that it will be the same range for 2008 with 16,069 attendances to the end of October. Most visits are for assessment of refraction problems.
    b. The proportion of free outpatient services has declined over the last 4 years from 47% of all services in 2004 to around 31% in 2008, consistent with the implementation of the JAMKESMAS rules.
    c. Data for 2008 shows that almost 90% of patients come from southern Bali - Denpasar (50%), Badung district (18%), Gianyar (12%), and Tabanan (8%).

2. Surgical procedures at ABMEC
    a. There has been a decrease in the number of surgical procedures conducted within ABMEC from about 1,600 in 2004, to about 1,100 since 2006. In house cataract procedures have decreased from 1,139 per annum (2004) to about 900 since 2006 and these numbers have remained stable over the last 3 years
    b. Cataract surgery accounts for the major proportion of procedures done at ABMEC. The proportion has increased from 69% in 2004 to 82% in 2008
    c. Total cataract procedures performed in-house and by outreach have been relatively stable around 1,100 – 1,400 from 2004-2008 with a slight decrease in 2006-2007. Outreach cataract procedures increased to almost double in 2008 compared to 2007
    d. 64% of cataract patients reach vision above 6/30 on day 1 after surgery, 75% after one week, and 80% after one month.

3. Free cataract surgery in 2008 (first 10 months)
    a. 651 patients out of 1090 received free cataract surgery (= 60%); 334 cases were done in outreach activities.
    b. In house non paying patients dropped substantially in April 2008, after YKI withdrawal. However, patients paying for surgery increased substantially from an average of 5 prior to YKI withdrawal to an average of 27 cases per month in the following months happening instantly in April, the first month after YKI withdrawal. It might be that some of those that had previously had their fees paid were not truly 'poor' but could still afford to pay (previous system leakage), and the quality of cataract surgery at ABMEC was considered acceptable. This is very encouraging and an important variable to be considered towards sustainability of the institution.

4. Government subsidy for the poor (January - November 2008)

    a. In treating all of its patients, the hospital has received from government sources total subsidies of IDR 1.4 billion (=65%) as compared to only IDR 0.74 billion (=35%) received from fee paying patients.
    b. Half of the government subsidy i.e. about IDR 0.7 billion is used to treat poor category patients requiring surgical procedures in house (mostly cataract procedures) and the rest is used on the outreach programmes including mobile clinic cataract operations.
    c. This substantial amount of subsidy funding reflects the commitment of government to providing services to the poor. The national government funding is via JAMKESMAS payments and Bali Government funding is via recurrent funding for the outreach program.

Separate data provided by YKI who operated one of the two AusAID donated buses from January 2006 to March 2008, indicate that the number of free cataract operations were greater in the YKI operated bus than the RSI/ABMEC operated bus (2,256 compared to 380)[5]. The main reason why the YKI bus was able to complete more operations was YKI's access to higher recurrent operational funding. This observation is important as it shows that with additional resources (not just money) there is considerable potential for more procedures to be done in mobile clinics.

[5] Correspondence provided by YKI to Assessment Team November 2008.

Following discussion with the head of DinKes and the management team at RSI / ABMEC, it is clear that neither the National nor Provincial Governments will change the laws specifically for ABMEC to allow free operations for non authorised poor category patients. Therefore, the number of free operations provided will depend upon the number of entitled poor people that attend for care, and those people who receive care in the mobile clinics. Community awareness strategies, particularly in rural areas could help encourage more people with eye diseases, including the poor, to attend for care. (RSI / ABMEC senior staff acknowledged that YKI did service promotion much better than they did). The Provincial Government is committed to increasing funding for mobile care in 2009, so it is possible that the percentage of poor category patients receiving free surgical care will increase in 2009.

4.0 SPECIFIC OBSERVATIONS RELATING TO TASK 3.

Task 3. Examine to the extent possible ABMEC's clinical standards, quality control and audit systems, operating theatre environments, surgical and diagnostic procedures.

The reports by the technical experts on Ophthalmology and Hospital Standards give an excellent overview of the services currently being provided, the clinical standards, quality assurance and audit reviews at ABMEC including its mobile clinics. (See Annexes 3 & 4). In particular, the surgical skills of all the young surgeons who were observed whilst operating, was of a very acceptable and safe level. The assessment team members have made objective observations noting that ABMEC services are trying to perform at good Indonesian Standards and wherever possible, at International Standards. The team has not tried to make unrealistic international comparisons which would require unrealistic, substantial increased resources at ABMEC that would not be sustainable or in keeping with Indonesian Government requirements. The team has based its recommendations on information gained from discussions with senior PERDAMI members and senior nursing staff in both Bali and Jakarta and following observations of specialist eye services at other Indonesian hospitals including RS Sanglah in Bali and RS Cipito Mangunkusumo in Jakarta.

In summary, it is believed that most procedures at ABMEC are being performed to acceptable Indonesian standards, although additional improvements can still be made in many areas such as improved infection control and operating theatre procedures. The clinical audit procedures are still relatively basic but there are plans to improve the activities. It was acknowledged that some external assistance in this area would be welcomed.

With some targeted additional resources, especially for in-house education and capacity building, there is potential for the facility to do both an increased number and variety of relevant eye procedures. The ultimate mix of eye operations that are performed will depend upon integration and support of PERDAMI members and technical nursing expertise at RS Sanglah and the University of Udayana. The proposed suggestion that ABMEC should only initially focus on four eye sub specialty disciplines viz., cataract detection and correction, refraction detection and correction, retinal surgery and procedures and glaucoma detection and correction, is supported as being both realistic and affordable. In due course the facility has the potential to take on additional eye disciplines as clinical staff gain experience and recurrent funding increases. (See also comment in section 3.7).

There are, however, some significant concerns about infection control standards in the mobile clinics. The two existing mobile vans can no longer offer the safest infection control environment for mobile eye surgery and the vans should immediately adopt new infection control procedures to minimize risk. Further, the vans should either be substantially modified to minimize infection control risks or replaced as recommended in the technical reports. It was the assessment team's view that if capital was going to be spent on the vans to reduce infection control risk, it would most likely be more cost effective to replace rather than refurbish. Each technical expert has made some recommendations about clinical standard improvements that should be considered if AusAID wishes to continue supporting ABMEC as outline in the concluding section of this report.

5.0 SPECIFIC OBSERVATIONS RELATING TO TASK 6.

Task 6. Determine whether there is any possibility for YKI to re-engage with the Balinese Health Authorities and provide free services to the poor using ABMEC facilities.

At every interview and site inspection, the assessment team sought information about the involvement of YKI with eye disease management in Bali. Information was also sought about the evolution of the relationship between each interviewee's organisation and YKI. The assessment team also spent a couple of hours at the South Bali Clinic of YKI, which is located at John Fawcett's residence in Sanur, to speak personally with John Fawcett and his senior staff. The assessment team believed that it had the opportunity to get a fair balance of opinions.

Almost without exception, the views expressed by Indonesian Health Department representatives, hospital executives, university and professional association representatives and individual clinicians were similar. YKI was regarded as a NGO trying to help the poor, visually impaired in Bali. It was acknowledged that its work was generally of a high standard and that YKI had been instrumental in getting extra resources for Bali. However, everyone believed that the working and trusting relationship between their organisation and YKI had broken down and was probably irreparable. The key reasons given for this were:

- The constant and inappropriate comments made by senior YKI officers about the standards of care in Indonesian health facilities and the care offered by Indonesian eye surgeons. (Some of the comments are considered potentially libellous).
- An inability of YKI to work cooperatively with Indonesian agencies and systems- driven by a desire to 'control' rather than 'cooperate'.
- Inappropriate ways of manipulating the Indonesian health system and organisations to get its way without considering the impact on the Indonesian Health System as a whole.
- Alleged inappropriate methods of managing some elements of patient care e.g. using expired donated intra ocular lenses.

The interviewed Indonesian representatives indicated that they had constantly tried to seek cooperation but YKI's attitude was one of wanting to dictate what should be done, rather than negotiating and seeking compromise. The summated feeling of most groups was perhaps best expressed by one interviewee who described YKI as a 'rogue NGO that did not want to cooperate with the Indonesian Health System'.

After talking personally to John Fawcett and his senior officers, it was clear that John Fawcett holds very strong views about how eye surgery and eye services should be run in Indonesia, and he is not willing to compromise the standards of YKI services. He believes that services should be provided to international standards and he should not have to lower them because the Indonesian health system can not match his high standards which are supported by international donations.

The assessment team also observed that the breakdown in relationship was causing some problems for the Indonesian Health System including unnecessary duplication of services in some parts of Bali and confusion for certain communities about service availability.

As every Indonesian entity and individual that was interviewed indicated that they believed the relationship had irreparably broken down, it was the assessment team's unanimous conclusion that this was indeed the case and it was unlikely that the relationship could be repaired in the foreseeable future. In particular the relationship with the Bali division of PERDAMI is severely damaged and it is unlikely that the majority of Balinese eye surgeons will cooperate with any YKI service.

Unless YKI changes its approach to one of working cooperatively with the Indonesian Health System, it is recommended that any further assistance by AusAID to Bali for eye disease services should be arranged on a Government to Government basis and not directly, or indirectly, involve the YKI NGO. To do otherwise, would most likely cause further difficulties for relevant Indonesian stakeholders.

6.0 SPECIFIC OBSERVATIONS RELATING TO TASK 7.

Task 7. Evaluate Australian Volunteer International (AVI) inputs to date and comment on the potential for future AVI engagement with ABMEC.

It is always hard to evaluate the work of volunteers, including those that volunteer in a semi structured program as occurs with AVI. The volunteers are always keen and enthusiastic but it is not common for a volunteer to always have exactly the attributes a client requires and there are often some compromises to be made by both parties. Further, a client can not be as demanding as compared to a contracted consultant, who has to perform to strict KPI's.

AusAID supports three volunteers provided by AVI in Bali. Technically only one is appointed exclusively to ABMEC. That is the position of Hospital Administrator. The other two positions are nursing positions that were appointed in March 2008 to RSS. The first is a critical care nurse educator that is 100% based at RS Sanglah. That AVI nurse has provided some education for nursing staff in the ABMEC Operating Theatre in CPR, anaesthetics and recovery room care. The second AVI nurse at RS Sanglah is a nurse educator who is contracted for 60% of his time at Sanglah and 40% at ABMEC to assist with infection control issues.

After questioning the senior administrative staff at both DinKes and RSI / ABMEC it was ascertained that the AVI nurses are perceived to be doing a good job and their work is appreciated. (This view was also ascertained from senior staff at RS Sanglah). The AVI nurse providing infection control assistance was considered to have good theoretical and practical knowledge but was not a 'doer' in that he did not always mentor or demonstrate methods to the local staff. It would be better if he adopted a more practical, 'hands on' approach working directly with staff and demonstrating what is required. The other AVI nurse was well regarded. (More comments about the nurse AVI's are contained in the Annex 4).

The AVI Administrator's role was initially established to help the Indonesian staff at RSI to plan and commission ABMEC. With the difficulties surrounding the operation of the centre, the position has been extended on two occasions and will now conclude in November 2009. The AVI appointee occupying the position has had limited experience in managing clinical development issues of a major teaching hospital and in dealing with complex multi cultural issues. The perception of the AVI administrator was different to that of the nurses. He was perceived as someone who generally knew what to do for general administrative functions such as security, logistics management and financial and statistical reporting. He was not perceived as being as well versed in clinical administrative matters and he often relied upon the advice of the two AVI nurses for clinical administrative issues. His interpersonal style was also seen as directive and at times, not sensitive.

The requirements of the AVI hospital administrator have changed over time. Initially there was a need for administrative advice about the planning, construction and commissioning of ABMEC. This was most important as the senior administrative team at RSI were relatively inexperienced in such matters. However, as the new appointed management team at RSI/ABMEC have gained experience, they now need assistance with different administrative skills than those offered by the current volunteer. Assistance is needed in certain areas of clinical administration and clinical governance to help develop services in a cost effective way with multiple local stakeholders including PERDAMI, University of Udayana and foreign NGO's.

Although the preceding comments about the AVI volunteers may be perceived as having negative elements, the assessment team noted that all three AVI volunteers had been given little structured feedback about their performance. This was not considered ideal given the medico-political complexities associated with ABMEC's operation. The assessment team believed that given the difficult events that have occurred, and the need to ensure that ABMEC fulfils as many of its initial intended purposes, there will still be a need for further AVI volunteers or consultant inputs to help RSI / ABMEC achieve its goals.

The assessment team has noted in the individual technical reports those areas where further technical assistance may be needed either by AVI volunteers or contractors. There are two general areas worthy of special mention. As AusAID and YKI had initially set such high expectations for ABMEC, there will be a need for some further AVI volunteer or contractor support in two specific areas. The first is some capacity building assistance with biomedical and equipment maintenance skills, particularly as the initially promised YKI

assistance has been withdrawn. The second is in relation to planning clinical service development in a restricted recurrent budget situation. To ensure that the specific needs of the local ABMEC staff are met and that correct KPI's are prepared for either existing or any new AVI volunteer or consultant appointments, the assessment team recommends that:

1) AusAID should work with AVI to give the current volunteers structured feedback about their performance so they can improve and be more responsive to the clients needs,
2) Before any further extensions of existing positions or new volunteers are engaged, planning / endorsement should occur with the key stakeholders,
3) If additional support is to be considered for a highly technical area where specific skills and/or experience is needed as recommended in this consolidated report or any of the three technical expert reports, it may be better to consider a specialised consultant rather than a generalist volunteer, and
4) The supported activities should have a focus of encouraging integration and cooperation between all elements of eye service delivery and training of clinical staff.

7.0 SPECIFIC OBSERVATIONS RELATING TO TASKS 5 & 8.

Task 5. Provide recommendations for particular options for AusAID to pursue in order to ensure the Centre is used appropriately and effectively, i.e. should the Australian Government continue to provide financial assistance to ABMEC? If so by which modality and at what level? What implications might additional Australian support have on long term sustainability?

Task 8. Provide recommendations for a new Subsidiary Agreement (SA) between the Government of Indonesia and AusAID for ABMEC.

Unlike the other elements of Australia's Bali Bomb Assistance Package to Indonesia, the ABMEC project has not yet achieved its full potential for many reasons. As explained in Section 3.1 above, from the beginning, the program required the ongoing cooperation of the four key stakeholders viz., YKI, AusAID, PERDAMI and the GOI (as represented by its health service entities), if it was to succeed and meet the original goals. The role / involvement of the NGO YKI has been complex from the start and the breakdown in its relationship with GOI entities and PERDAMI means that if the ABMEC concept is to achieve its main goals, then a new strategy will need to be established bilaterally between AusAID and GOI excluding YKI. Obviously some compromises will be needed. Accordingly, it is recommended that AusAID consider a completely new strategy for supporting ABMEC that does not involve YKI, unless that organisation gives a cast iron guarantee that it will cooperate appropriately with the Indonesian Health System as required by the national DepKes and the provincial DinKes.

Before the new Subsidiary Agreement is developed, AusAID will need to decide upon two important issues:

i. How much longer does AusAID wish to support ABMEC activities? and
ii. What specific outcomes and/or standards and/ KPI's does AusAID expects ABMEC to achieve over the remaining duration of the project?

With the withdrawal of YKI involvement, alternate support will be needed for some ABMEC services. From a sustainability point of view, it would be good if all of the additional support could be provided by GOI entities. Whilst some additional local support has already been provided, it is unlikely the major goals will be achieved without some additional AusAID support. A number of the original goals can still be achieved but it will take extra time and depend upon the cooperation of many stakeholders. In formulating its recommendations for the contents of a new subsidiary agreement, the assessment team noted the following:

- The success of ABMEC will depend upon effective planning by DinKes and RSI /ABMEC executives as they are ultimately responsible for the running of ABMEC and the delivery of most of the major blindness prevention and treatment activities in Bali required by the GOI 2006 National Strategic Plan.
- DinKes and RSI / ABMEC will have to provide the services within the approved Indonesian laws and budgets for capital and recurrent expenditure- this will include those services that can be offered to poor category patients
- The integration and best use of all Government supported eye service will depend upon cooperation between the major providers of eye disease services viz. DinKes, RSS, RSI / ABMEC and PERDAMI and its members throughout Bali.

- If all training facilities are to be effectively used to maximum potential it will depend upon cooperation between all the major educational bodies viz., RSS, University of Udayana and PERDAMI
- If ABMEC wishes to continue its goal of achieving best Indonesian standards of care, and where possible international standards of care, it will require further assistance with education and training from both Indonesian and international experts, preferably supported by additional donor assistance.
- Any further support provided by AusAID should be based on Government to Government arrangements only. (NGO's should only be involved if they guarantee they will abide by Indonesian Government requirements).
- The viability of ABMEC will ultimately depend upon good business planning for resources and management of the facilities by RSI /ABMEC management. Some further targeted and time limited Australian aid would be helpful to assist RSI/ABMEC management staff prepare better business and service plans as well as capacity building.

Although the creation of ABMEC was not planned in phases, it may be appropriate to say that its development should be considered in two phases to help AusAID plan an exit strategy.

It could be stated that the first phase is now complete i.e. the planning, construction, commissioning and first full year of operation of the facility. A second phase could be a period of consolidation and capacity building to stabilise the initial services and implement refinements to ensure the facility can operate sustainably. The first phase could be said to have concluded on 30 September 2008 and the second phase started on 1 October 2008 with a completion date set at a date that is strategically suitable to AusAID e.g. at 6, 12 or 24 months from 1 October 2008.

If a second phase is to be endorsed, the assessment team recommends that the following activities should be considered for inclusion in the new Subsidiary Agreement, thus ensuring that ABMEC meets as many of its original goals as possible. The following suggestions relate primarily to the recommendations contained in the three technical expert reports:-

After discussion with the key stakeholders

- provide additional AVI and/or consultant and/or educational support in key clinical areas as recommended in the technical experts reports- especially to help with infection control activities in mobile and fixed clinics, biomedical maintenance of equipment and clinical governance issues
- replace the existing mobile clinics with slightly larger vehicles that have two compartments thus allowing safer infection control during operations
- support arrangements to help ABMEC liaise with external organisations that will help it to develop in a sustainable way (such organisations could be in Indonesia or elsewhere)
- encourage the cooperation between the recently formed training group of RSI/ABMEC, RSS, PERDAMI and University Udayana to ensure that the training facilities are used to maximum affordable potential
- to assist the previous recommendations, consider providing support for a short term AVI volunteer or consultant to help RSI / ABMEC management plan and implement strategies to improve both service delivery numbers and quality
- provide clear indication of specific outcomes, timeframes and responsibilities of each participating party
- for any new volunteer or consultant appointment provide structured and timely feedback about performance and suggestions for improvement

8.0 EXECUTIVE SUMMARY

Since the Australia Bali Memorial Eye Centre (ABMEC) opened in September 2007, there have been a number of comments and accusations, (most unfounded or ill informed), that the facility has not met, or will not meet, the original goals and standards that were expected of it. In November 2008, to assist in understanding the issues and concerns, an independent assessment team reviewed the situation, including current activity and standards, as well as considering ABMEC's future potential.

Unlike the other components of Australia's Bali Memorial Package announced in 2003, ABMEC has been plagued by a number of difficulties since its inception. When it was initially planned, there were high hopes that the facility would be an exemplar, international standard specialist training eye hospital. As well as the main ABMEC buildings in Denpasar, the package included two mobile clinics to allow eye surgery to occur in remote parts of Bali. In particular, it was hoped that the fixed and mobile facilities would be able to provide free services to as many poor, visually impaired people as possible.

The assessment team noted that many of the current problems confronting ABMEC can be traced back to its inception. The facility was not planned in a normal Indonesian way. It was very much driven by the ideals of John Fawcett and YKI who lobbied the Australian Government to build the facility. The principal intents of the project were reasonable i.e. i) to build a facility that allowed international standard, mass management of patients with cataract and related eye disease and ii) provide modern training facilities for training and experienced eye surgeons. Unfortunately, some issues were inadequately considered such as the ultimate recurrent costs of running the facility, and how the training facilities would fit in with the entire education program for ophthalmologists. The project was also dependent upon the ongoing support of YKI in a number of areas.

For many reasons, the local professional relationships with YKI broke down and they are now considered irreparable. In April 2008, YKI withdrew its support, which left ABMEC with several problems such as difficulties in maintaining biomedical equipment. These issues and others such as a limited recurrent budget, are now being addressed by the local management team at ABMEC and the Provincial Department of Health. As well as the problems associated with initial planning and construction, some significant unexpected issues arose. The most significant was the introduction in April 2008 of a new national medical scheme for the poor (JAMKESMAS), that specifies which people in the population can be truly classed as 'poor' and thus entitled to free health care. The consequence has meant that more people in the 'near poor' category now have to pay for services like all others in the community. This has had an impact on the number of 'free' in-house operations performed, and has caused unfair criticism to be directed towards ABMEC.

Despite the difficulties, it was the assessment team's view that the facility was generally offering good standards of care (including microsurgical techniques) to the patients that present at both the fixed and mobile clinics. However, there is still room for improvement, especially with mobile clinic services and clinical auditing. There are also opportunities for improving service and training integration with the major Bali hospital – RS Sanglah. Preliminary planning and activities in these areas has commenced and should be encouraged. In many ways, the withdrawal of YKI actually offers ABMEC an unencumbered opportunity to do things in a different and better way in the interests of improving services to the people of East Indonesia. In this regard, the assessment team believe that ABMEC's future is exciting and deserves careful consideration.

To move forward, it is suggested that AusAID should initially make a decision as to whether it wishes to continue supporting ABMEC or whether it considers the project is now technically complete as the service has been open for one year, and that it withdraws from further support. Alternatively, AusAID may wish to commence a time limited second phase of support during which it can assist the facility to further develop and achieve a fuller, but more realistic potential. A number of recommendations have been made irrespective of which option is chosen.

If the decision is made to enter a second phase, there are some important recommendations that have highest priority. These include 1) ensuring that any new assistance is arranged strictly on a Government to Government basis, 2) that careful planning occurs relating to the implementation of the recommendations, 3) consideration is given to refurbishing, or preferably upgrading, the mobile clinic facilities and the operating microscopes in the main operating theatres, and 4) that better structured feedback is given to the AVI volunteers to help them provide better support.

Annex 1.

ABMEC Independent Assessment
Visit and Interview Schedule - November 2008

Date	Activity	Team members	Location
Thursday 13			
	Preliminary AusAID dinner briefing	JM DC FB	Sanur
Friday 14			
	Formal AusAID Team briefing	JM DC FB	Sanur
	Site inspection ABMEC	JM DC FB	ABMEC Denpasar
	Meeting with ABMEC Site Director of ABMEC and senior ophthalmologists	JM DC FB	ABMEC Denpasar
Saturday 15			
	Visit to ABMEC community screening activity	JM DC FB	Bebandem Puskesmas NE Bali
Sunday 16			
	Meeting with AVI nurses based at RS Sanglah and part time at ABMEC Informal visit and meeting with Director of Nursing Informal discussions and briefing for SI who joined team	DC JM DC FB SI	RS Sanglah, Denpasar Sanur
Monday 17			
	Clinical service observation and data inspection & gathering	JM DC FB SI	ABMEC Denpasar
	Meeting with Dr Oka Head of provincial Health and Dr Srijoni Director of RS Indera and ABMEC	JM DC FB SI	DinKes Denpasar
	Meeting with John Lincoln (AusAID consultant engaged to supervise ABMEC construction)	JM	Sanur
Tuesday 18			
	Interview with AVI Administrator ABMEC	JM	ABMEC Denpasar
	Interview with senior medical and nursing staff	DC FB SI	ABMEC Denpasar
	Meeting with Dr Srijoni and senior management staff of RS Indera	JM SI	RS Indera Denpasar
	Visit to ABMEC mobile clinic operating in rural area	DC FB	Tabanan
	Visit to RS Sanglah to meet CEO and Senior executive	JM DC FB SI	RS Sanglah Denpasar
	Visit to YKI Sanur Clinic to inspect facilities and meet John Fawcett and senior staff	JM DC FB SI	Sanur
Wednesday 19			
	Clinical service observation and data inspection & gathering	DC SI	ABMEC Denpasar
	Visit to meet Bali Head of PERDAMI and representative of Udayana University (Dr Budiastra) and ophthalmologists and	JM FB	RS Sanglah Denpasar

	registrars		
	Feedback session with Senior Management Staff RS Indera & ABMEC – including Dr Srijoni and Dr Yunity	JM DC FB SI	ABMEC Denpasar
Thursday 20			
	Visit to meet National Chair of PERDAMI Dr Tjahjono Gondowiardjo	JM DC SI	RS Cipito Mangunkusumo Jakarta
	Visit DepKes Director of Specialised Hospital Directorate (Dr Kemas Akib) and Dep. Director (Dr Josephine)	JM DC SI	DepKes Jakarta
	Formal Debriefing with AusAID	JM DC SI	Australian Embassy Jakarta

Team Members
JM- Dr John Menzies
DC- Dianne Campbell
FB- Prof Frank Billson
SI- Dr Stephanus Indrajayana

Annex 2.

RELEVANT HISTORICAL ISSUES AND THEIR SIGNIFICANCE.

Relevant Point 1. Eye Disease and its management in Bali.

It is well known that Indonesia, including the Province of Bali in particular, have high rates of preventable blindness – especially cataract. Throughout Indonesia eye care for the poor is provided by a mix of providers including i) the National and Provincial Governments through their networks of hospitals and Community Eye Care Institutions, ii) Local Government through their limited district hospital and community health facilities especially puskesmas, as well as the Bupati who can fund individuals or other agencies to receive/provide a service, and finally iii) NGO's such as voluntary and charitable bodies. (YKI is one such organisation). In addition, some care is provided in private hospitals that deliver eye care. Members of the Indonesian Ophthalmology Association (PERDAMI) also volunteer their time in a voluntary capacity.

To date, the public and private sectors have not been able to provide adequate levels of health services to prevent and treat all of the cases of blindness that occur. In particular, the very poor in rural and remote areas have greatest difficulty in obtaining affordable treatment and consequently their disease often remains untreated. Indonesia is attempting to address the issue through its *2006 National Strategic Plan for Visual Impairment and Blindness Control to Achieve Vision 2020*. The National and Provincial Governments are trying to progressively implement the plan but with limited resources it is not proceeding as rapidly as everyone would like.

In Bali, historically, major eye surgery services and the training of specialist eye surgeons have been provided by the main tertiary teaching hospital in Denpasar- Rumah Sakit Sanglah (RSS) in conjunction with staff from University of Udayana. (RSS is owned and primarily funded by the national government). Surgical services are also provided in other hospitals in Denpasar and major cities in Bali that are run by the Provincial and District Governments. There is currently a total of 21 ophthalmologists in Bali. Eight hold positions at RSS, there is at least one, and usually 2 or 3, at the major provincial hospitals and a couple who are exclusively in private practice. (Most eye surgeons work for a Government hospital in the morning and work in their private rooms in the afternoon).

Most of the eye disease prevention activities have been provided by Provincial Government services. The old leprosy hospital of Denpasar, RS Indera (RSI) was the original home for the main provincial community screening programs for eye and ear disorders. It was subsequently endorsed in 2008 by the GOI and Bali Provincial Government to be a tertiary specialist for Eye, ENT and Dermatology.

Significance:

Indonesia has a major problem with preventable blindness that it is trying to deal with by adopting a nationwide strategy. The strategy depends upon hospitals, health services, training institutions and NGO's working cooperatively together to provide the necessary services in line with the strategic plan. International NGO's such as Christian Blind Mission (CBM) and Helen Keller International (HKI) work very closely with the national and subnational authorities. Bali has developed its own Provincial Plan and ABMEC will need to play a significant part, especially in service delivery.

Relevant Point 2. The previous role of Rumah Sakit Indera (RSI)

Rumah Sakit Indera (RSI) was historically an old Bali Provincial hospital that looked after patients with leprosy. Over time, for various reasons, it deteriorated both in significance and physical structure. As well as providing in and out patient service for patients with leprosy, the facility served as a centre for community based eye and hearing disorder screening programs. The latter services were provided in conjunction with local puskesmas.

In 2002, YKI was given access to a part of RSI that was in poor condition to use as an operating theatre base for treating poor category patients with eye disorders. With donated resources, YKI started to develop the hospital facilities for its purposes and was prepared to do further development with its donated funds. In 2003, the Provincial Government in consultation with the National Ministry of Health (DepKes) decided to establish RSI as a specialist hospital for Eye, Ear Nose and Throat and Dermatology. (Leprosy patients were still to be treated at the hospital by physicians. 'Dermatology' was chosen as the parent discipline as it both related to leprosy and did not carry the stigma related to leprosy). In addition, the hospital was to become a centre of excellence for eye disorders for Eastern Indonesia.

The staff at the hospital in the period 2000-2004 whilst having good public health, health promotion and primary hospital expertise, had limited experience in providing and running tertiary level eye disorder services. This is significant as the key staff members were not able to significantly contribute to the technical design and planning of ABMEC when it was announced in 2003.

When the GOA made the offer of building ABMEC, it was logical that the Bali Provincial Government (BPG) would want ABMEC to be associated with RSI. As no land was immediately available on the original campus, the BPG donated a parcel of land in central Denpasar adjacent to the DinKes building on which ABMEC could be built. From the time of the original discussions about the creation of ABMEC, it was always the clear understanding of the GOI and BPG that the new facility would become part of the Indonesian Health system run by the BPG.

At the time of planning, construction, commissioning and the first few months of operation, Dr Dharyata was the Director of the hospital and the most significant person representing RSI at meetings with AusAID, YKI, DinKes and other parties. (YKI had little interaction with any other staff at RSI). Dr Dharyata was an eye surgeon given post graduate training by YKI and a person trusted as a competent surgeon by YKI. Dr Dharyata remained as the Director of RSI and subsequently RSI / ABMEC until March 2008, when he was replaced by the current management team of CEO –Dr Srijoni and Clinical Director Dr Yunity. It is possible that Dr Dharyata may have been seen as 'too close' to YKI or at least a supporter of YKI and some of its inappropriate activities. The new CEO, Dr Srijoni joined ABMEC from her previous position that was in the Provincial Health Department.

Significance:

RS Indera is a hospital that has evolved with staff that had a predominantly public health background and limited primary/secondary hospital planning, administrative and clinical expertise. This is significant as the key staff members were not able to significantly contribute to the technical design and planning of ABMEC when it was announced in 2003.

The previous Director Dr Dharyata was an eye surgeon supported and trusted by YKI and very influential in the initial planning, construction and commissioning phases of ABMEC. He was replaced in early 2008 by DinKes with a new management team that have been performing their duties in line with BPG and DinKes policies and procedures. The new management team are keen and enthusiastic but not as experienced as the executive teams in other major tertiary public hospitals. There may be a need for some additional short term support, particularly in relation to clinical governance issues.

Relevant Point 3. Details of YKI activities in Bali.

In 1991, John Fawcett established the John Fawcett Foundation (now also functioning as Yayasan Kemanusiaan Indonesia (YKI) and referred to hereafter as YKI), to provide surgical and other services to help poor Indonesians. In particular, the Foundation has attempted to provide cataract surgery with service provided by local doctors and health staff, assisted by training provided by foreign trained doctors and health care workers. Whilst the Foundation was happy to provide its services from small community based and mobile clinics, it wanted to provide its core surgical services from a formal fixed base in Bali.

YKI has been influenced over the last 15 years by many international eye doctors – especially from Australia, to provide eye services including cataract surgery, to international standards rather than traditional Indonesian standards. In trying to provide eye services to international standards, YKI regularly brought in foreign nationals to train local Indonesian doctors and health workers to raise their standards. This has included the acquisition of considerable high-tech and advanced equipment and medical consumables that are not readily available or affordable in many parts of the Indonesian public or private health sectors.

Over the years, YKI has developed a belief that the majority of Balinese eye surgeons are not performing at satisfactory levels and this has been stated publicly and privately on many occasions. To ensure that patients assessed and treated by YKI receive care at a level that is acceptable to YKI, it has tried to develop and implement its own treatment programs and facilities with local and international staff/volunteers that are committed to YKI ideals and standards. Whilst many of the activities have been implemented correctly, a number have either not been, or perceived not to have been, done in accordance with local laws, regulations and customs. Whilst YKI intentions to do good for the poor, visually impaired of Bali is acknowledged and not challenged by the Indonesians, YKI methodology is not regarded as highly.

In Indonesia, YKI is seen by many as arrogant and deliberately breaking or 'bending' Indonesian laws and regulations for their own benefit. Most importantly, YKI is often described by Indonesian doctors and organisations as an NGO that only wants to do things their way without compromise. It is seen as an organisation that inappropriately influences politicians both in Australia and Indonesia, assisted by lobbying done on its behalf by international visitors including eye surgeons, who benefit from YKI hospitality.

Consequently, YKI is regarded differently by different parties - hence the polarisation of opinions. Thus YKI is seen as a caring charity by Indonesians who are poor and receive free eye care. Some local govt officials also view YKI services favourably as they help in local areas both for clinical and political reasons. Conversely, PERDAMI and its membership, DinKes and Bali's senior Public Hospital administrators view YKI as an organisation that uses inappropriate political and other means to promote its cause whilst at the same time making inappropriate, unprofessional, and in some case libellous, statements about particular Indonesian doctors and the Indonesian health system.

Many view YKI as an organisation that over accentuates its own positive attributes whilst downplaying its negative attributes. It does the reverse about the Indonesian health system by over-accentuating the weak points and downplaying the strong points. Perhaps most importantly, YKI is seen as 'rogue NGO' that only wants to do things its own way without regard to the Indonesian health system as a whole which is trying to grapple with all health issues for 220 million people and not just those associated with eye disorders.

In Australia, YKI would generally be perceived as a charity doing good work for the visually impaired and handicapped. The fact that it attracts large individual and corporate donations testifies to this. YKI would also be regarded as a charity that performs its surgical services to high standards. The main concerns about YKI activities would be 1) its sustainability in the long term, particularly with continuing poor relationships with local eye surgeons and hospitals, and 2) its 'safety net' reliance on flying patients to Australia for ongoing care should a surgeon have a major complication such as a 'dropped lens'.

In 2003, following the Bali bombings, John Fawcett and his Foundation personally lobbied the Australian Government who wanted to provide some significant donations to the people of Bali as a memorial. They suggested the creation of a specialist eye hospital that could do both screening and treatment of patients with eye diseases. It was also suggested that the hospital should have international standard facilities for training Indonesian doctors at both under and post graduate levels in eye surgery. Further the hospital could be a base for mobile clinics. YKI had a belief that the facility should develop as a metaphorical 'cataract factory'.

The Australian Government subsequently approved the project that was to be ultimately a facility given to the Provincial Government of Bali to manage as part of the Indonesian health system. The planning was to be a tripartite effort between the Bali Provincial Government, YKI and AusAID on behalf of the Australian Government.

During the planning, construction and commissioning of the facility, John Fawcett himself and YKI staff were intimately involved at all levels and there was perhaps an expectation that YKI would continue to be intimately involved with the management of the facility.

Significance:

YKI is genuinely attempting to help the visually impaired in Bali, especially the poor, by providing high quality screening and treatment services. It relies upon both local and international support to carry out its charitable work. Unfortunately, some elements of the way the service is run and promoted causes frank antagonism for Indonesian ophthalmologists and Health Authorities and it has bred significant distrust.

Relevant Point 4. Method of Design & Construction of ABMEC and the impact on recurrent costs.

After the Australian Government announced the project, a decision was made by AusAID to use a 'design and construct' methodology to build the facility. Whilst this would allow for a time efficient construction period, it meant that the planning had to be done quickly and relied upon good ongoing input from knowledgeable health professionals and planners. With the local staff at RSI having no, or limited, experience in designing an international standard teaching eye hospital/clinic, much of the input for design came from YKI, and the Australian based architectural firm. The main input from RSI came from Dr Dharyata who was primarily focused on the eye surgery and training facilities.

During the planning phase, the local staff of RSI was appreciative of the major donation of bricks and mortar and state of the art equipment that was being given to them and allowed the design team to do most of the design work. There was limited consideration given to the ultimate recurrent cost of operation and the clinical linkages that would have to occur when the hospital was fully operational. Consequently, some elements of the hospital were built in a way that did not allow maximum efficiency from a recurrent cost perspective.

Significance:

The design planning did not give sufficient consideration to the ultimate running cost of the facility.

Relevant Fact 5. Deterioration in Relationships between certain stakeholders during Construction of ABMEC.

During construction, the provincial Department of Health (DinKes) became more appreciative of the significance of the facility in terms of its interrelationship with other public and private Indonesian health services, the impact on recurrent costs, the need for new and easily serviceable equipment and the substantial influence of YKI on the whole process. As a consequence there was more scrutiny of issues.

Significance:

During this period the relationship between YKI and DinKes and local clinicians started to deteriorate and DinKes started to correctly assert its authority as the body that would have ultimately responsibility for ABMEC

Relevant Point 6. Issues related to PERDAMI

From 2002, there have been between 20 and 24 ophthalmologists practicing in Bali. The vast majority are engaged full time by the Bali public hospitals. The largest hospital RSS has 8. Major district hospitals have 2 to 3 and some small facilities have single ophthalmologists. The clinical standard of the ophthalmologists varies substantially depending upon their under and post graduate training. All of the ophthalmologists work cooperatively within the confines of the Indonesian health system. Most try to earn their income from salaried

work in the mornings in their paid government hospital positions and from paying patients in their private practice in the afternoons.

PERDAMI believes that there is a critical balance between the number of ophthalmologists that can viably practice and be trained in Bali. The national body and the Bali chapter of PERDAMI support the national Government's strategy for addressing blindness and encourage their members to assist with voluntary and related programs to provide surgery for people who can not afford to pay for eye surgery. Throughout Indonesia, many ophthalmologists volunteer their time to PERDAMI sponsored cataract operations. Funding comes from donors to meet the costs associated with the surgery – this totals IDR 500,000 and includes the consumables, medicines and a fee of IDR 50,000 (about AUD 7) for the surgeon.

Unfortunately, for many years there has been a poor relationship between YKI and PERDAMI members in Bali. This is mainly due to a real / perceived belief that YKI is trying to dictate to them what should be happening, and concern that certain YKI members have made inappropriate and derogatory remarks about a number of their members. By April 2008, only two ophthalmologists were working for YKI in Bali -one in the YKI mobile clinic in Denpasar and the other in the YKI fixed/mobile clinic in the north of Bali. Although these two ophthalmologists are still members of PERDAMI they are regarded as 'black sheep'.

With the reduced support from local PERDAMI members, YKI is attempting to bring ophthalmologists from other parts of Indonesia to do the YKI voluntary work. This is likely to cause a further rift with local PERDAMI members. Technically what YKI is doing is not in accordance with national registration requirements for doctors. As an engaging entity, YKI must get permission from the local chapter of PERDAMI before it can bring in doctors either from Indonesia, or internationally, to practice medicine or to train doctors. To date, PERDAMI has not lodged a formal complaint about YKI, however, if it did, the Indonesian authorities could remove incorrectly registered doctors - including requesting that immigration instruct such international doctors to leave the country. If the local chapter of PERDAMI were to take this course of action, it would cause further deterioration in the relationship.

The local Department of Health (DinKes) and the local Bali hospitals support their ophthalmologists as they are providing the majority of eye care in Bali. They also understand and support DinKes with the running of RSI / ABMEC and there is a desire to strengthen the links between the major eye hospitals so there is better opportunity for treating patients with eye disorders and training of ophthalmologists.

Over the years, there have been many attempts to repair the relationship with YKI as it is believed that the traditional eye services of Bali and those provided by YKI are both needed in the Province and they should be working cooperatively together. DinKes and PERDAMI indicated that they are willing to repair the relationship and cooperate effectively if YKI agree to work within the Indonesian health system laws and regulations and stop trying to direct what should be happening and stop making inappropriate remarks about the competence of Indonesian ophthalmologists. Unfortunately, YKI have refused to reconcile their differences.

Significance:

There is a long history of distrust between PERDAMI and YKI that has led to a breakdown in relationships that most believe is irreparable.

Relevant Point 7. Issues associated with equipment acquired for ABMEC and its maintenance.

During the early phases of planning it was expected that AusAID would donate most of the equipment for ABMEC with some equipment and consumables such as spectacle lens being donated by YKI. AusAID was expecting that all the equipment it donated would be new. It is believed that YKI wanted to donate a mix of both new and used equipment and consumables. During the construction phase, for various reasons, the provincial authorities issued an edict that the Province would only accept new equipment in ABMEC. This was a concern for AusAID as it was always expecting to provide new equipment. It was an issue, however, for YKI and it

caused some friction and was another reason why the relationship with YKI and Provincial DinKes officers deteriorated further.

AusAID continued with its equipment purchases for ABMEC including the two mobile clinics believing that they would be new and would comply with the Provincial decree. As it transpired, all AusAID equipment except one main item was new (discussed below). All new equipment was generally under at least a one year warranty. This meant that most equipment was maintained by the supplier's biomedical or general maintenance staff for the first year. At the time of planning, there was an expectation that after the first year of operation, highly technical equipment would have had some assisted maintenance from YKI biomedical technicians/engineers or ABMEC engineering staff (with capacity building training). Unfortunately, the former has not happened and with the breakdown in the relationship with YKI, some equipment is not being maintained to ideal levels and there is a possibility that some equipment may not reach its maximum clinical or training application.

As a certain amount of equipment was not purchased though the usual local Indonesian distributors, there is also a possibility that long term maintenance of equipment after the warranty periods expire may not occur to desired levels. It is understood that AVI is looking to provide some biomedical volunteer support to hospitals in Bali. This support would be welcomed at RSI/ABMEC especially if there is an element of capacity building of local engineering staff.

As mentioned above, one important piece of equipment was not new. It was an operating microscope that is used in one of the two main theatres. It was a demonstration model. This occurred because during the phase of construction when equipment was being purchased, the equipment budget was limited and it was believed that a good demonstration model with a full warranty was good value and a reasonable purchase. Unfortunately, this microscope has had a number of maintenance problems and does not give a clear field of view for the operator. The fact that an important piece of equipment such as an operating microscope i) was not new, and acquired against the direction of the Provincial authorities, and ii) has not been well maintained, has caused lingering unhappiness for some ABMEC staff.

The mobile clinics were acquired in 2004 after the initial design was completed with input from YKI and local clinicians. The van design was reasonable at the time and the vans have been used for work in rural areas. One van was initially used by YKI volunteer staff until April 2008 when it was returned to ABMEC. It is generally in better condition than the second van as it was maintained by YKI staff and engineers. The second vehicle is in a poor state with some equipment and some physical plant deteriorating due to rust, ageing or lack of maintenance.

Both vehicles are now causing problems for safe operating and it is hard to maintain reasonable infection control standards. Technically the vans are no longer suitable and ideally should be replaced with vans that are slightly larger and have two isolatable compartments to allow effective infection control. If Australia wishes to assist ABMEC in any further way before the Bali Memorial Program ceases, it could consider donating one or two new mobile vans to replace the existing vans. The existing vans could still be of use for less technical clinical activities or non-urgent patient transportation.

Significance:

The purchase arrangements of the equipment at ABMEC was made on the belief that the equipment would be well maintained after purchase - initially by manufactures for the first year under warranty and then by RSI engineers with assistance from YKI volunteer technical support. With the breakdown in relationships, and the purchase arrangements made by AusAID, some equipment items are now not being maintained to acceptable standards and there is a real risk that the equipment will not see out its full life expectancy nor assist with the purpose for which it was intended. One item was not new when purchased and for diplomacy reasons it may be appropriate to replace it. At least it should be immediately serviced to bring it to acceptable optical standards.

The mobile clinics were designed with probably the best available design advice at the time, but they are now not performing to acceptable standards and should either be substantially refurbished or replaced by better designed vehicles.

Relevant Point 8. Relationships between key training stakeholders: DinKes, DepKes, University of Udayana, RS Sanglah and PERDAMI.

The Indonesian health system and the University system for training undergraduate and postgraduate doctors is not as well developed or resourced as in developed countries. Nevertheless, it is doing the best it can and standards and resourcing at all levels continues to improve each year. The Indonesian systems are evolving and are going through the same developmental phases that occurred in countries such as Australia. Specifically, the training of young Indonesian doctors as eye surgeons is also improving and the Universities with Medical Schools and the major hospitals with eye departments are improving remarkably with the available resources. Most importantly, they are training young eye surgeons in safe techniques that are affordable.

In Denpasar, most of the major eye trauma, eye emergencies and complex eye surgery occurs at RS Sanglah. The hospital also manages simple elective surgery such as cataract surgery. Whilst that hospital has limited equipment, its clinical and academic staff of 8 specialists attempt to provide contemporary training and care in line with acceptable Indonesian standards and where possible, International standards. There are 12 eye registrars in training as specialists. The training facilities at RS Sanglah are limited and there is a desire by all parties to use the exceptionally fine facilities that have been provided by the Australian Government at ABMEC.

The University of Udayana, DinKes Bali, RS Sanglah and RS Indera have had formal preliminary discussions and signed in September 2008 a MOU to develop integrated services and cooperation between the organisations for training and management of patients. In discussions with representative of all parties, they indicated that they would be willing to cooperate with YKI, if it would be flexible and cooperate with them and not try to direct them as to what they should be doing. It is unfortunate that YKI is no longer willing to participate as it was going to help with doctor training by providing / sponsoring its international specialist visitors to assist. It will now be the responsibility of the signatories to the MOU to arrange the necessary tuition. It was indicated during the assessment team's visit that it would be advantageous if AusAID could help in some way with this activity.

Significance:

ABMEC's training laboratory and audiovisual equipment is perhaps the best in Indonesia and has incredible potential to be used for training of new and existing eye surgeons. It has not been used effectively to date. The facilities require effective maintenance if they are going to be of practical use to trainees in the future and there will be a need to ensure that trainers who will instruct using the new equipment, are themselves appropriately trained in how to use the equipment.

Annex 3.

AUSTRALIA BALI MEMORIAL EYE CENTRE (ABMEC)

INDEPENDENT ASSESSMENT MISSION

OPHTHALMOLOGIST TEAM MEMBER INITIAL OBSERVATION REPORT

TEAM VISIT 14-20 NOVEMBER 2008

DENPASAR / JAKARTA

Prepared by:
Prof. Frank Billson
Clinical (Ophthalmology) Specialist

INITIAL OBSERVATIONS REPORT

The following are the initial key observation points following the inspection of facilities at ABMEC and associated facilities during the Assessment Team's Visit to Bali 14-19 November 2008. More detailed comments and discussion will occur in the final report.

1. CLINICAL FACILITIES AT ABMEC

1.1 Main ABMEC Operating Theatres

The Operating Microscopes available do not provide an optimal "red reflex" to perform cataract surgery with Intra Ocular Lens Implantation. Funding for a Zeiss Microscope is needed but with the caveat that an advisory group be formed to discuss the specifications and plan how the unit should be utilized with the surgical staff.

1.2 Mobile Vans modified as mobile theatres

The mobile vans are now suboptimal environments for safe eye surgery. Preferably they should be replaced with slightly larger vans. As a minimum, new infection control procedures should be introduced whilst using the current vans. Ideally, the theatre area needs to be separated from the general purpose area. However the surgery and surgical expertise I witnessed was such as to limit the risk of infection, in spite of the limitation of the mobile theatre environment.

1.3 Clinical support by Nursing Staff

The doctors have reasonably good support from the trained nurses. There are good opportunities for team building and the development of middle management. The potential for leadership in nurses we interviewed was clear. How this will evolve will be influenced by cultural factors. (See also notes by Clinical Standards Consultant).

2. SURGICAL SKILLS OF OPHTHALMOLOGISTS

2.1 The Eye Surgeons I observed in ABMEC have an excellent level of basic eye surgery microsurgical skills.

2.2 I witnessed small incision microsurgery performed for cataract removal with intraocular lens implantation, competently performed by the young eye surgeons in ABMEC.

2.3 I am confident the level of surgical expertise evident was at a level that would allow teaching and skill transfer and acquisition of new skills for more complex operations befitting a tertiary training centre.

2.4 Not all operative cases are documented and kept as a personal record of performance by each doctor. The keeping of personal logbooks can be helpful not only for personal audit activities but also as evidence that can be used educationally, and in bringing about change.

2.5 Basic Clinical skills of doctors in history taking and diagnosis are at a level to build upon.

3. OBSERVATIONS ON EDUCATIONAL NEEDS AND REQUIREMENTS

3.1 There is a need for training of staff in many areas. Training of technicians to maintain equipment and training experience for middle management could usefully occur at larger facilities in Indonesia or in neighbouring countries. Much Ophthalmic training could initially occur in country.

4. OBSERVATIONS ON POTENTIAL DEVELOPMENT OF TERTIARY LEVEL EYE SERVICES AND TRAINING IN BALI

4.1 GENERAL ISSUES

4.1.1 The development of high level tertiary eye services in Bali will depend upon cooperation of all parties involved with ophthalmologist training and eye service delivery. In particular, there is a need for good cooperation between RSI / ABMEC and RS Sanglah.

4.1.2 If there were cross appointments to both hospitals there is every reason to believe that if the combined staff could plan together, they could collectively develop a plan for the optimal utilisation of facilities and opportunities at both hospitals.

4.1.3 To ensure optimal development of eye services, it would be advantageous if the skill levels of both doctors and nurses are improved at the same time to ensure best outcomes for patient care. In particular, it would be advantageous to enhance ophthalmic nursing skills to allow nurses to capably use diagnostic equipment, thus assisting the ophthalmic team.

4.2 RS SANGLAH ISSUES

4.2.1 Expertise of staff is greater in the Department of Ophthalmology at RS Sanglah. Ophthalmology training is established there and there are currently 12 registrars in training.

4.2.2 The National Government has designated the Hospital as a National Facility in Indonesia

4.2.3 Physical space for Ophthalmology clinics, however, is limited as are a number of items of diagnostic equipment needed for a major hospital. The training of young eye surgeons would be enhanced if the diagnostic equipment at RS Sanglah was improved. This would help in the diagnostic work up of patients that are to be operated upon either at RS Sanglah or ABMEC.

4.2.4 As a training Institution, it has the advantage of Ophthalmic trainees seeing patients with eye disease related to systemic disease and multiple site trauma.

4.2.5 As the hospital is a major general hospital, operating theatre time and resources are limited and eye surgical emergencies must compete with other forms of trauma for theatre time.

4.3 RS INDERA /ABMEC ISSUES.

4.3.1 Although only four eye disciplines (cataract, glaucoma, refraction and retinal surgery) are currently being offered at ABMEC, the facility has the potential to be an acute surgical Eye Hospital / Institution where eye disease and threatened blindness can be given priority and other subspecialty disciplines can evolve over time. This would allow trainees to see a concentration of cases sufficient to gain the necessary skills in the subspecialties. Already there are the rudiments of two subspecialty clinics viz., glaucoma and retina.

(Cataract surgery and refraction diagnosis and correction are regarded as general ophthalmic disciplines).

4.3.2 The space at ABMEC has the potential to be better utilized to encompass the needs of the current and other eye subspecialties.

5. ISSUES RELATED TO COMMUNITY UNDERSTANDING AND THE ACTIVITIES OF YKI

5.1 The costs of performing surgery in the community are clearly not understood in the broader community. This results in uninformed individuals and groups making unfair criticism of government institutions, including ABMEC.

5.2 YKI's perception of the history and potential role of ABMEC is clearly at variance with the view of those who see a different evolution of ophthalmic services involving training and rationalisation of staff and services. Additional opportunities for training are possible now that ABMEC exists.

Frank Billson

Annex 4

AUSTRALIA BALI MEMORIAL EYE CENTRE (ABMEC)

INDEPENDENT ASSESSMENT MISSION

TEAM MEMBER (NURSING) REPORT

TEAM VISIT 14-20 NOVEMBER 2008

DENPASAR/JAKARTA

Prepared by:
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Hospital Standards Specialist
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Introduction

This report focuses on a clinical review of the Australia Bali Memorial Eye Centre (ABMEC) from a nursing perspective, in accordance with the terms of reference, and an evaluation of the Australian Volunteer International (AVI) inputs particularly as they relate to nursing positions.

As part of the independent review team the contractor participated in meetings with key stakeholders and contributed to the overall review of current operations aimed at determining the most appropriate way forward.

In reviewing the clinical standards and procedures the contractor visited mobile outreach clinics at Bebandem and Tabanan to observe a screening clinic and also operations on the mobile bus clinic located at the community health centre (Puskesmas).

Meetings were also held with the 2 AVI nurses, the Director of Nursing (DON) from RS Indera/ABMEC and senior nursing staff from ABMEC. The contractor also visited the RS Sanglah Hospital and was provided with an opportunity to inspect the facilities and meet with the DON.

Australian Volunteer International (AVI)

In addition to the AVI Administrator there are 2 AVI nurses who commenced 12 month placements in March 2008.

One, a critical care nurse educator is based at RS Sanglah Hospital on a full time basis. She has provided some education for nursing staff in the Operating Theatre (ABMEC) in CPR, training and education for nurses in anaesthetics and recovery room care. From discussion with staff, observation and feedback from the AVI nurse, there is a demonstrated need for further training in these areas to adequately equip staff with the skills required to provide safe care. This is particularly so for paediatric patients and those requiring general anaesthesia. (A one day education program has been developed.)

In May 2008 a request was made for a mannequin to be purchased to facilitate basic life support training- to date there has been no response to this matter.

The second AVI nurse is a nurse educator with infection control experience whose contract provides for a 40% time allocation to ABMEC and 60% at RS Sanglah. (See comments under Infection Control, Clinical Standards and Mobile Outreach Services.)
It is apparent that the contribution of AVI nurses is highly valued and appreciated by management and staff.
Feedback suggests that a more practical, “hands on” approach working directly with staff and demonstrating what is required would be beneficial.

A large number of reports with suggestions for improvement have been generated by the AVI infection control nurse during the past 6 months. Whilst some matters have been dealt with, there does not appear to be a structured process of action and follow up.

The AVI nurses suggested that initial briefing could be improved together with formal evaluation and feedback on their performance. This should be undertaken to assist in determining detailed ongoing requirements.

Ongoing support and involvement of AVI nurses will be valuable in the short term to ensure appropriate skills and competencies are developed and are sustainable.
Optimally nursing staff would benefit from the acquisition of some advance skills in the ophthalmology sub-specialties as they evolve at ABMEC. It may be preferable to develop these skills by supporting additional nursing staff to attend short programs at appropriate centres in Jakarta (Jakarta Eye Hospital) or in Australia (Sydney Eye Hospital).

Recommendations

1) A mannequin for basic life support training be purchased.

2) The basic life support education program be conducted for all nursing staff.

3) Education requirements for anaesthetic/recovery room staff be determined and an appropriate program developed.

4) Action plans/statements be utilized so that actions, responsibilities, time frames and outcomes can be documented

5) Formal evaluation of the AVI nurses be undertaken by AusAID so this can inform briefing requirements and expectation for future positions.

6) Evaluation of the AVI nurses contribution occur on a 6 monthly basis against agreed objectives and feedback be provided to them. This should be undertaken by AusAID in consultation with medical and nursing directors of the appropriate hospitals.

7) An AVI nurse educator (with education and infection control experience) be appointed on a full time basis at ABMEC with the specific brief to ensure that sustainable programs are established in infection control, basic life support, relevant clinical competencies and quality and that these programs are regularly evaluated.

8) Reporting lines for AVI nurses be clarified.

Clinical Procedures.

ABMEC opened in October 2007 and is a first class facility providing a limited range of eye services to the people of Bali. However, it is clearly operating below its capacity.
From its beginnings as a community eye service at Indera it has come a long way in the last 12 months and staff have adapted well to the change in spite of an initial apprehension regarding the move.

ABMEC consists of 2 operating theatres (1 room has 2 tables) and each theatre is fitted with a microscope (1 on loan from Leica and 1 (WILD) which the surgeons claim is unsatisfactory as the fundus of the 'scope is not clear. The latter microscope was purchased as a demonstration model and should be serviced as a priority.
There is also a small microscope in the main OR which may be better utilized in the OPD procedure room.

There are 4-10 operations per day but there is potential to increase this activity within the current staffing and instrumentation levels. This needs to be planned taking into account the following-:

- There are 12 cataract instrument sets available.
- OR staff and 2 instrument sets are required for mobile units. This can be for up to 3 days /week at present.
- CSD turn around time for sterilization.

Most patients have surgery under local anaesthesia although a limited number of procedures under general anaesthesia have been undertaken. Appropriate anaesthetic and resuscitation equipment is available. A current limitation is staff knowledge of anaesthetic and recovery room care.

Work flow and the patient journey through the OT from pre-op to discharge appear to be well coordinated and appropriate.

There is a 6 bed ward and a single room –all well equipped but rarely used.

The outpatient clinics (approx. 80 patients per day appeared to function effectively, the only apparent limitation being the waiting area within the clinic. An increase in clinic patients would necessitate a

review of work flow and reallocation of rooms for consultation/testing, noting that there are rooms unused at this time.
The AVI administrator suggested changes to the function of some rooms which would require minor modifications eg, increasing the waiting area for clinic patients/family utilizing the pathology area. (Reviewing the work flow and redesigning processes may be a less costly option).

The only pathology provided on site is strip urine testing for glucose .This function has moved from the designated pathology room to the area originally identified as the lens surfacing laboratory.
A number of rooms have become available following the withdrawal of YKI. This does provide opportunities to increase OP activity. Reallocation of rooms/functions needs to be considered in conjunction the service plan and clinical services.

Infection Control

The AVI nurses have made a significant contribution to the implementation and maintenance of infection control standards at ABMEC. The OT nurse manager stated this to be one of their major achievements. We were advised that an IC policy and procedure manual was available.
The AVI nurse recently reviewed sterilizing and other practices in the CSD and was satisfied that standards were being maintained.
During a brief visit to the OT and CSD the contractor observed staff at work. All areas were clean and uncluttered and every effort was made to maintain the integrity of sterile areas.
Feedback from the AVI nurse suggests that maintaining good infection control standards requires ongoing vigilance and from discussion with staff this is supported.

The DON, Indera/ABMEC indicated that an IC program is being developed. The input of the AVI nurse would be beneficial. There is a need for a number of staff to be trained (eg 3 OPD, 3 OT) in basic infection control, eg, standard precautions, development of a quality improvement program and management of risk including monitoring of the physical environment and staff health. It is suggested that a short course (say 1 week) be developed and nursing staff be released to participate. These staff would then be able to monitor/conduct IC/environmental audits and provide monthly reports on nosocomial infections. A formal link with the Sanglah Hospital IC group should be established.
It is apparent that until ABMEC staff are appropriately skilled and able to take responsibility for maintaining acceptable IC standards, there will be lapses in practice.
Ongoing audits and monitoring by the AVI nurse must be supported with education that is sustainable.

Where access to hand washing is not available, antimicrobial or alcohol hand rub/gel is advised.

Recommendations

1) The AVI nurse develop an IC course (education sessions) to adequately equip staff and to promote and sustain safe, effective IC practices.

2) Clinical indicators (CIs), appropriate to the environment and clinical services, be identified and audits be developed to monitor these CIs and results be forwarded to the Nosocomial IC Committee and the Medical Services Advisory Committee.

3) Infection control updates be mandatory on an annual basis.

4) Appropriate sharps containers be obtained.

Clinical Records

A number of medical records were reviewed (translated) and all appeared to be well documented and comprehensive. There was a unique identifier, allergies recorded, diagnosis, details of treatment plan etc with all contributors to the record appropriately identified. Consent procedures are rigorous. Nurses also complete a nursing diagnosis form and use the SOAP method for recording progress notes.

There does not appear to be a structured review of clinical records for completeness of documentation or continuity of clinical care. Guidelines could be obtained to facilitate this with the review/audits being conducted by medical/nursing staff.

Recommendations.

ABMEC support the development of documentation and clinical content audits and outcomes be forwarded to the Medical Services Advisory Committee for action and follow up.

Post Operative Treatment.

Post operatively all patients, both hospital and outreach, are observed for 1 hour. Patients appeared to always be accompanied by a family member(s) and post operative care is explained to patients and family by the nurse and the patient is provided with an intra-ocular lens card. No pre or post operative written information is available.
Review post surgery occurs at 1 day, 1 week, and 1 month at either the OPD or the local Puskesmas. If any problems occur for outreach patients the community GP indicated that contact was made with ABMEC.

There is no clinical audit of outreach services conducted
Comprehensive operation logs are maintained for all surgery performed. A process to capture data following review of patients in the outreach clinics should be established to facilitate clinical review.

Recommendations

1) Pre and post operative information brochures be provided to ensure patient understanding of their condition and ongoing care.

2) Clinical review of all outreach surgery occurs.

Education and training.

From discussion with staff and observation of processes in place, it is apparent that staff in management roles eg, nursing supervisor, nurse managers in OT and OPD would benefit from management training.
It is unrealistic to expect these staff to manage resources effectively without the appropriate knowledge base compounded by cultural expectations surrounding seniority. In addition there is no performance management system, no clinical competencies and mandatory education is minimal.

Nursing staff were most appreciative of the IASTP3 education program conducted earlier this year and projects arising from this activity have been beneficial.

Many of the nurses expressed a keen interest in gaining more knowledge and education in ophthalmology and its sub specialties. All staff were enthusiastic and eager to learn.

The development of nurse specialists in sub specialty areas is supported which would free ophthalmologists for more complex work whilst enhancing nursing skills.
The development of these roles would require close collaboration between medical and nursing staff. The practice of rotating nurses through various clinics has been changed recently which will allow them to develop specialist skills.

An orientation program is in place and ongoing mentoring for new staff occurs.

ABMEC is to support a further 2 nurses to Cicenendo Hospital in 2009 for a 2 month program.

It would be advantageous for ABMEC to establish links with the Nursing School for clinical placements.

Recommendations

1) AusAID considers support for middle management staff training which could be on site or distance learning.

2) The AVI nurses, through a train the trainer approach, establish sustainable mandatory training programs in CPR, infection control and fire training.

3)AusAID consider facilitating the establishment of a sister hospital relationship to support ABMEC with education, skill training, competency development etc.

4) ABMEC establishes a link with a nursing school.

Mobile Outreach Clinics

The clinics provide a screening service which is followed shortly after by surgery performed on the mobile operating outreach vehicle (bus).
Staff from ABMEC provide both these services with support from the Puskesmas.
A large number of patients are screened (most attending with many relatives), many are old and frail and need assistance.
There is an established process for testing/screening patients and it appears to work efficiently in cramped, inadequate facilities. Hand washing facilities are poor but given the circumstances staff work effectively whilst trying to minimize actual touching of patients. It would be beneficial to review the work flow so that the nurse or another health care worker could do the urine testing and not be involved in other activities.
Alcohol gel should be used between patients.
A visit by the AVI nurse to suggest improvements in IC practices should be a priority.

Up to 14 cataract operations can be performed in the bus on a single day. Currently up to 3 villages are visited each week.
There are 2 buses available and both are in need of refurbishment or replacement.
During a site visit contractors observed 2 cataract operations being performed on the bus.
Staff appeared dedicated and attempted to maintain a sterile/clean environment under difficult, cramped conditions.
The facilities are sub optimal-the door opens directly into the sterile area, the cleaning practices are inadequate, hand washing limited, rust is evident and the air conditioner drips into a bucket sitting on the sterilizer, etc.
As a matter of urgency the buses require a major clean and this was conveyed to the DON, RS Indera/ABMEC.
The AVI nurse should organize a field trip to advise on appropriate IC practices and work with them to achieve a short term solution to these issues.

Teams, with an identified team leader, should be designated for each bus and be charged with the responsibility of ensuring that cleaning and maintenance is carried out at the conclusion of each session.

The buses were initially fitted out and workflow established with YKI assistance. YKI now have modern larger buses and conform with IC practices.

Recommendations

1) AusAID replaces the mobile operating vehicles as a matter of priority and ensures that cleaning/ maintenance schedules are in place.

2) ABMEC identifies designated teams and team leaders with clearly delineated responsibilities for each vehicle.

3) The AVI nurse undertake a review of IC practices at the outreach services and work with staff to implement change.

4) Antimicrobial/alcohol gel be available for staff providing outreach services.

Organizational Structure and Communication

There appears to be a number of avenues for management decision making eg, weekly and monthly meetings and a quarterly nursing forum has been recently established for discussion of professional issues including quality. However progress and action has been hampered and could be attributed to the gap in management knowledge and experience, lack of appropriate systems and the destabilizing influence of YKI.

Whilst it was stated that there is ISO certification of some areas at RS Indera (certification documentation not sighted) there appears to be minimal activity in relation to quality systems. Audits are restricted to CSD activities.
Patient satisfaction surveys have occurred in the past 2 years and some improvements have occurred including the establishment of a complaint flow chart and an information desk. However a structured system was not apparent to facilitate action and follow up.
Also lacking was a system for managing risk and incidents.
The provision of management training should incorporate principles of risk management and quality improvement to assist staff to measure performance and outcomes.

Summary

The recommendations and suggestions contained in this report are provided as a way forward and a means of improving the quality of clinical services.

Those recommendations specifically referring to ABMEC are included for consideration by RS Indera/ABMEC management and for implementation if appropriate and achievable. Some of the issues/matters were discussed at meetings with management and clinical staff during the course of the review.

A number of recommendations are for the attention of AusAID and these will need to be considered in the context of the duration of their ongoing involvement with this project.
If implementation of these recommendations is acceptable and continues beyond AusAID's involvement, alternative strategies to address any outstanding issues may need to be considered.

AUSTRALIA BALI MEMORIAL EYE CENTRE (ABMEC)

INDEPENDENT ASSESSMENT MISSION

INDONESIAN HEALTH SECTOR CONSULTANT REPORT

TEAM VISIT 14-20 NOVEMBER 2008

DENPASAR/JAKARTA

Prepared by:
Stephanus Indradjaya
Indonesian Health Sector Consultant

TECHNICAL REPORT ABMEC
INDEPENDENT REVIEW TEAM

Introduction

The Australia Bali Memorial Eye Centre (ABMEC) was established as part of the grant from the Australian Government following the Bali bombing in 2002. It aimed to facilitate the Bali Provincial Health Office to achieve the Indonesia Sehat 2010 and Vision 2020[6]. Since its conception, it was clearly stated that ABMEC will be a component of RS Indera and will be located on the Maruti campus, next to the Bali Provincial Health Department Office. One of the main objectives was to provide free cataract surgery for poor patients and become a training institution for eye care in the Eastern Indonesia.

An independent review team was established by AusAID to review activities and especially relationship between ABMEC and Yayasan Kemanusiaan Indonesia (YKI) and advise AusAID about the next phase of AusAID assistance to ABMEC. The independent review team met with the Head of Provincial Health Office, the Director of RS Indera and staff, AVI's, Director of Sanglah hospital and YKI.

Overview of health system and legal and regulatory framework

Indonesia is a unity republic has a population of about 220 million people living in 33 provinces and 440 districts scattered in an archipelago of 15,000 islands. Before 2001, administration was highly centralized where all decisions were taken at the central level. There are 3 levels of government, i.e. national/central, provincial and district government. This situation changed substantially when decentralization was introduced in 2001[7] when the national government decentralized authority to district government in most sectors except in foreign affairs, defence and security, monetary and fiscal, and religious affairs.

Realizing that there is a huge variation in the fiscal capacity among provinces and districts, district governments receive General Block Grants, Specific Block Grants and Revenue sharing on natural resources from the central government. In addition, local government can also raise their revenue from taxes and services provided to their population, such as medical services through public facilities. Therefore, all revenue that comes from service provision in public facilities should be submitted to the respective district/province treasurer[8]. In return, the facilities will receive budget to implement programmes. The current government is committed to eradicating corruption, thus it is very difficult to deviate from the fiscal administration rules and regulations.

Provincial and District Health Offices in every province and district are the main agencies responsible for developing, coordinating and implementing health programmes. These offices are not directly under the Ministry of Health but are part of the province and district government. However, the Ministry of Health can still run vertical programmes funded by central government, including the medical scheme for the poor.

The Indonesian health system is a predominantly public system, although the private sector is growing especially in big cities. Primary care is delivered by Puskesmas (Community Health Centres) that provide basic services, including immunization. Most districts, except the new ones, have one district hospital. The Province hospital usually is the top referral public hospital located in the capital city. It provides all specialty services. At national level, there are top referral hospitals that provide a full range of subspecialty services. Sanglah is

[6] Bali Provincial Health Department – Strategic Eye Services Plan, 2004
[7] Law no. 22/1999 and Law No. 32/2004, Government regulation no. 28/2007
[8] Bali Province regulation no. 3/2004

one of the national hospitals. In addition, there are specialty hospitals such as RS Indera, Mental Hospitals. RS Indera is owned by the Bali Province government.

Service for the poor

The current government is committed to provide free health care for the poor. In the past, public facilities including public hospitals, usually served as the safety net for the poor. The poor patient would bring a 'poverty letter' from the village head and sub-district so that user charges could be waived. However, this system was fraudulent and substantial leakages occurred. At the same time the true poor sometimes did not have access to health care.

In 2005, the Ministry of Health launched the Health Scheme for the Poor (ASKESKIN) funded by the national budget. Under this scheme, the National Statistics Agency (Badan Pusat Statistik-BPS) produced estimates and identified the poor households in each district, verified by the district government. PT ASKES – a parastatal enterprise – was responsible for the printing and distribution of the ID card for the poor and payment to the providers. In the transition period, public facilities should still honour the 'poverty letter'.

In 2008, the Ministry of Health changed the Askeskin scheme to Jaminan Kesehatan Masyarakat (Jamkesmas)[9] to cover 19.1 million households or 76.4 million people. The Ministry of Health determines the quota of poor households in each district that can be funded by the scheme. Based on this quota, district heads should issue the list of poor households in their respective districts. Households that are not on the list are not eligible for free health care. However, if the district head considers that the quota is not enough, district government should bear the additional cost. PT Askes is still responsible for issuing new ID card but no longer acts as the payer to the provider. The Ministry of Health will pay the hospitals directly after claims have been verified by a designated team at district office.

In response to this new regulation, on 21 September 2007 the Government of Bali and the Head of the 9 District governments had developed a consensus of the criteria of poor households and the quota of the poor households in each district. The programme covers 147,044 poor households or 548,617 people (16%) in Bali province. The Heads of districts (Bupati/Walikota) updated the list of poor households on 31 December 2007. This list is currently used for poverty alleviation programmes, including free health care provision. In addition, on 11 April 2008, the Provincial Health Office announced that if the number of poor people exceeds the quota, free care can still be provided if the district authority issued a statement of poverty and availability of local budget to cover the cost of the patient[10].

This new scheme changes substantially the way free care is provided. No more free care can be provided for those who do not meet the criteria above. In addition, the anti corruption campaign also provides a 'threat' to administrators who would like to waive patient charges without abiding the rules.

Overview of RS Indera / ABMEC

Rumah Sakit Indera, has two campuses including the ABMEC campus. Rumah Sakit Indera is a specialty hospital that provides eye, ear, nose and throat and dermatology services owned by the Bali Provincial Government. There are 30 hospitals (13 public and 17 private) in Bali. In public facilities, eye services are provided also in Sanglah Hospital, the top referral hospital in Bali, owned by central government and serving as the teaching hospital of the Faculty of Medicine, University of Udayana.

[9] Minister of Health Decree no. 125/Menkes/SK/2008 on Guidelines on Jamkesmas implementation.
[10] Circular letter No. 005/1424/Binkesmas Diskes to public hospitals and District Health Offices in Bali province

Yayasan Kemanusiaan Indonesia (YKI) has a long relationship dating back to 1998 with RS Indera (eye division) when it was still a Balai Kesehatan Mata Masyarakat (BKMM-Community Eye Centre Institution). YKI provided additional logistics for cataract surgeries. YKI also played a big role in developing the proposal to build an Eye Centre (later called as ABMEC) as part of the Australian grant related to the Bali bombing tragedy. ABMEC is designed to be a state of the art eye centre, particularly for cataract surgery to control blindness especially for the poor in Bali. It was also expected that the institution would serve as a training facility in ophthalmology for eastern Indonesia.

However, the relationship deteriorated over time due to many factors. As ABMEC is considered to be a grant from the Government of Australian to the Government of Indonesia/Bali, confusion occurred on the role of YKI/JFF in management of the institution. Unfortunately, very limited effort had been conducted in clarifying this issue.

The conflict culminated when Dr Srijoni was appointed as the new Director of RS Indera in early March 2008. She enacted the new national guidelines of Jamkesmas and the respective local government mechanisms for free services. Therefore, YKI felt that they could not send their cataract patients anymore to ABMEC to get free surgery and withdrew from ABMEC in April 2008. The Government of Bali had already explained that it is their authority to determine who meets the eligibility criteria for the poor and not YKI's. On 3 April 2008, RS Indera accepted YKI withdrawal from ABMEC activities.

In anticipation of transportation barriers in accessing ABMEC services from surrounding districts and to meet the needs of the 'near poor' that might not be identified in the Bupati's list, the existing two mobile clinics conduct outreach programmes: open clinics, cataract screening and cataract surgery 2-3 times a week. All services are provided for free and fully funded by the Bali provincial budget.

Utilization of ABMEC facilities

A review of 2004-2008 activities has been conducted even though ABMEC was officially opened in September 2007. Reviewing data over the four year period gives a better understanding of its utilization. Thus the data relates both to the old RS Indera including the time when YKI performed surgery in the original building (Jan 2004 to September 2007) and from October 2007 onwards when the new buildings, equipment, management and human resources of ABMEC became a part of RS Indera.

The following are the key findings of utilization of services. (Also refer to Tables 1 & 2.)

1. Outpatient visits in ABMEC
    a. Total number of visits remains stable around 18,000 to 19,000 visits since 2004 – 2007 and estimated to be the same in 2008.
    b. The proportion of free outpatient services has declined over 4 years from 47% in 2004 to 31% in 2008 consistent with the implementation of the Jamkesmas rules.
    c. Data from 2008 shows that almost 90% of patients come from Denpasar (50%), Badung district (18%), Gianyar (12%), and Tabanan (8%).

2. Surgical procedures in ABMEC
    a. There has been a decrease in the number of surgical procedures conducted in house from about 1,600 in 2004, to about 1,100 since 2006. In house cataract procedures have decreased from 1,139 (2004) to about 900 since 2006 and have remained stable in the last 3 years
    b. Cataract surgery remains the major proportion of procedures done in ABMEC, the proportion has increased from 69% in 2004 to 82% 2008

c. Total cataract procedures in-house and outreach is relatively stable around 1,100 – 1,400 in 2004-2008 with a slight decrease in 2006-2007. Outreach cataract procedures increased almost double in 2008 compared to 2007
d. 64% of cataract patients reach vision above 6/30 on day 1 after surgery, 75% after one week and 80% after one month.

3. Free cataract surgery in 2008 (10 months)
   a. 651 patients out of 1090 received free cataract surgery (= 60%); 334 of the 651 cases were done in outreach clinics
   b. In house non paying patients dropped substantially in April after YKI withdrawal, however, paid surgery increased substantially from an average of 5 prior to YKI withdrawal to an average of 27 cases per month in the following months happening instantly in April, the first month after YKI withdrawal. It might be that some of those that had previously had their fees paid were not truly 'poor' but could still afford to pay (system leakage), and the quality of cataract surgery was acceptable. This is very encouraging and an important variable to be considered towards sustainability of the institution.

4. Government subsidy for the poor (January - November 2008)
   a. In treating all of its patients, the hospital has received from government sources total subsidies of IDR 1.4 billion (=65%) as compared to only IDR 0.74 billion (=35%) received from fee paying patients.
   b. Half of the government subsidy i.e. about IDR 0.7 billion is used to treat poor category patients requiring surgical procedures in house (mostly cataract procedures) and the rest is used on the outreach programmes including mobile clinic cataract operations.
   c. This substantial amount of subsidy funding reflects the commitment of government to providing services to the poor. The national government funding is via JAMKESMAS payments and Bali Government funding is via recurrent funding for the outreach program.

As a response to a pledge from the National Committee on Prevention and Control of Visual Impairment and Blindness, on 18 September 2008, the Governor of Bali established a provincial committee for the same purpose[11]. This committee has the tasks to develop, coordinate and implement prevention and control of impaired vision and blindness programmes at provincial level. Since the programme needs intersectoral collaboration, the Vice Governor serves as the advisor, the Head of Bali Province Health Office is the Chair and Director of RS Indera is the co-chair. It consists of 3 working groups (WGs): (a) WG on Promotion chaired by the Provincial Health Office; (b) WG on Service Delivery chaired by RS Indera; and (c) WG on Partnerships chaired by the local chapter of PERDAMI (Indonesian Society of Ophthalmologists). Therefore, all activities related to Vision 2020 should be coordinated by this umbrella organization. In addition, hospitals should work in collaboration with Dinas Kesehatan if the hospital would like to conduct a community outreach programme[12]. As a consequence, YKI activities should also be under coordination of this Provincial and District Committee. This would authorise YKI to work as a legal entity in the respective district and avoid duplication of activities that leads to avoidable inefficiency and misunderstanding. At present Jembrana district has also established a District Committee.

Given the physical infrastructure of ABMEC, there are ample potential opportunities for this institution to be a training centre for ophthalmology, especially for Eastern Indonesia. At present, RS Indera has been proclaimed to be a tertiary hospital, however, this hospital needs more resources, especially equipment and human resources. In this case, close

[11] Governor of Bali Decree no. 1121/03-K/HK/2008
[12] Minister of Health Decree no 1045/2006

collaboration with Department of Ophthalmology, Faculty of Medicine at Udayana University and Sanglah Hospital will be critical. An MOU between these organizations was signed a few weeks ago and a follow up meeting was planned. It has been agreed that in the long run ABMEC will specialize in four eye sub-specialties - cataract, glaucoma, retina and refraction, while Sanglah Hospital will concentrate on the other eye subspecialty areas. In the mean time, Staff from Sanglah Hospital/ Faculty of Medicine will become visiting ophthalmologist in ABMEC. On the management side, 2 medical staff will be returning soon after completing their master's degree programme strengthening its management.

The role of the Bali chapter of PERDAMI is also critical. There are only 21 ophthalmologists in Bali province and all are members of this organization. PERDAMI fully supports the Vision 2020 movement as reflected in their involvement in the Provincial Committee and ABMEC mobile clinic activities with very minimum pay.

Conclusions and Recommendations

1. The relationship between the Government of Bali and YKI is already in a non repairable situation. Therefore, direct involvement of YKI in ABMEC is not feasible anymore. In addition, the two institutions have different objectives. YKI focuses on 'mass cataract surgeries' while RS Indera/ABMEC is moving towards being a tertiary hospital, whilst serving the poor according to government regulations.

2. YKI can still operate in Bali but it should be under the coordination of the Provincial Committee for Prevention and Control of Low Vision and Blindness to avoid duplication, sense of 'rivalry or competition' with government programmes and build efficiency. The Government of Bali vividly stated that they are willing to work with any organization as long as there is mutual respect and external organizations work within the existing system.

3. RS Indera/ABMEC needs further support to strengthen both managerial and technical capacity to achieve its full potential. RS Indera, has been designated to be a tertiary hospital. Thus, there is a high potential for it to grow and fulfil the dream for it to become a Centre of Excellence and Training Centre in Eastern Indonesia. However, currently this facility is still under utilized due to many factors. Therefore, a clear strategic plan and road map, including investment in human resources and equipment should be developed followed by implementation plan and funding sources. AusAID could provide strong technical assistance in both managerial and technical areas and ensuring that the Government of Australia investment achieves its original intention. A team consists of national and international experts would be useful to optimize the assistance against local context.

4. Improvement of mobile clinics and finding alternative ways of service provision for the poor. In service provision for the poor, ABMEC must follow the national and local regulations. The RS Indera administrator has launched a more vigorous outreach programme to overcome the transportation and cost barriers faced by the poor. The mobile clinic should be redesigned or preferably replaced by newer better designed vehicles that will ensure better compliance with infection control. It would be advantageous if AusAID could provide ABMEC with the new mobile clinics. In addition, there is also discussion about the possibility of bringing the 'near poor' cataract patients to ABMEC and have them operated in house. From a medical perspective, this is definitely a superb idea and in line with the proposal of the ABMEC ophthalmologists. However, the strict rules of Jamkesmas may become the major obstacle in implementing this idea and need some political decision.

5. It would also be advantageous if the Provincial Committee on Prevention and Control of Low Vision and Blindness could be strengthened to become a more effective coordinator of the Vision 2020 programme in Bali and there was also strengthening of the network with the national committee and national and international teaching institutions.

Table 1.
ABMEC activities, 2004-2008

Activities	*2004*	*2005*	*2006*	*2007*	*2008 (Jan-Oct)*
In - house					
Outpatient clinic	18,688	19,444	18,065	18,514	15,996
- paying patient	9,972	12,392	11,138	9,607	11,096
- free	8,716	7,052	6,927	8,907	4,900
Surgical procedures	1,661	1,372	1,119	1,182	924
- cataract	1,139	1,110	880	981	756
- non cataract	522	262	239	201	168
Outreach (free)					
School screening	3,072	3,647	3,084	3,853	3,010
Clinics	2,543	2,991	4,477	3,787	4123
Cataract surgery	310	250	321	179	334

Table 2
In-house cataract operations by payment category, 2008

Month	Paying patient	poor	civil servant*	Total	poor as % total
Jan	6	53	19	78	68%
Feb	8	75	26	109	69%
Mar	2	65	13	80	81%
Apr	26	26	28	80	33%
May	33	22	24	79	28%
Jun	22	16	34	72	22%
Jul	22	11	24	57	19%
Aug	32	9	12	53	17%
Sep	30	23	32	85	27%
Oct	29	17	17	63	27%
TOTAL	210	317	229	756	42%

* Note: Civil servants fees are paid through the civil servant scheme