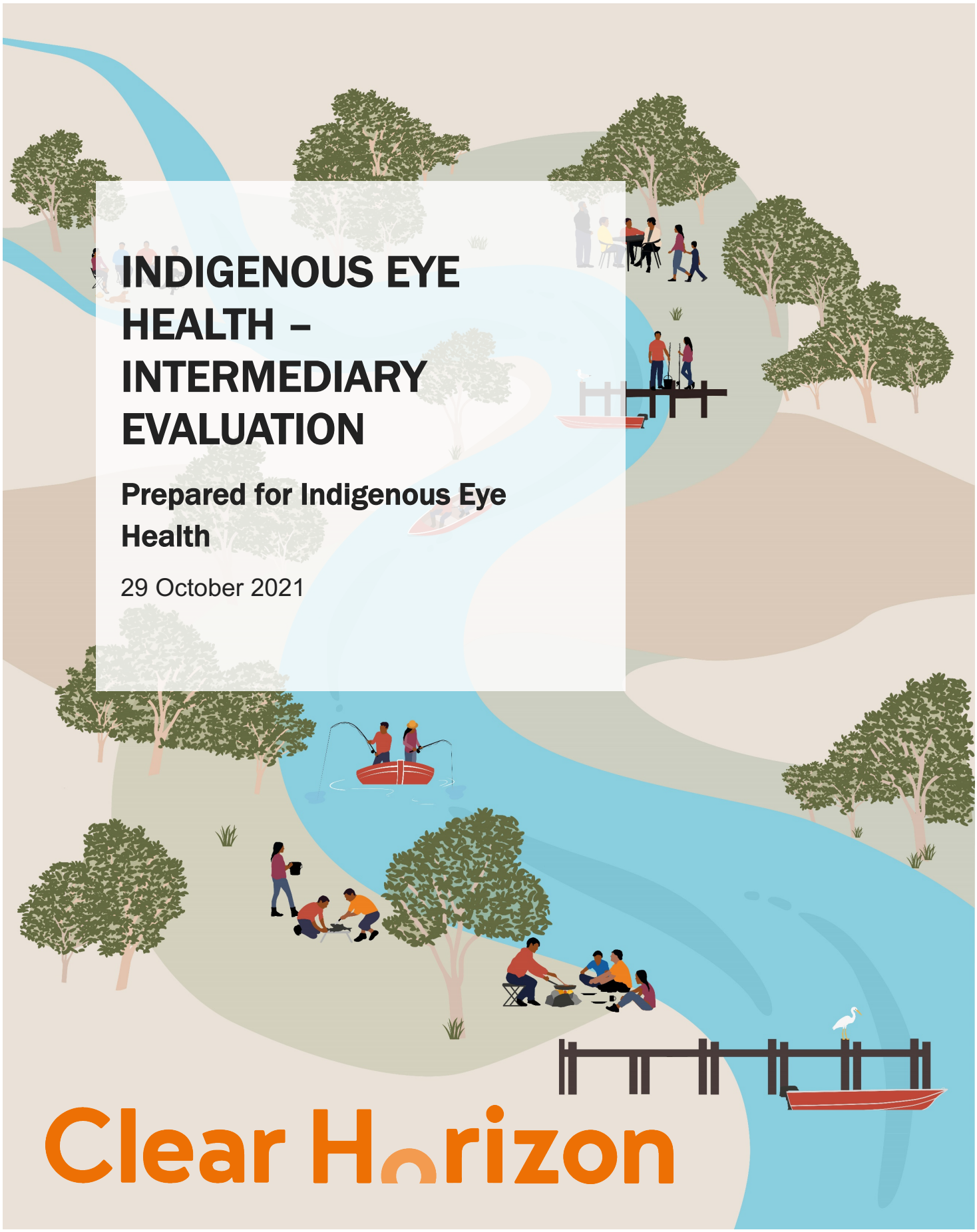

INDIGENOUS EYE HEALTH – INTERMEDIARY EVALUATION

Prepared for Indigenous Eye Health

29 October 2021

Clear Horizon

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Contents

Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ATSIRG	Aboriginal and Torres Strait Islander Reference Group
IEH	Indigenous Eye Health (Unit)
IEHU	Indigenous Eye Health Unit
KEQ	Key Evaluation Question
MBS	Medicare Benefits Schedule
MOIDCP	Medical Outreach Indigenous Chronic Diseases Program
RHOF	Rural Health Outreach Fund
VOS	Visiting Optometrists Scheme

1 Executive Summary

1.1 Background

This document presents the evaluation of the Indigenous Eye Health Unit (IEHU), which operates at The University of Melbourne. This evaluation was commissioned by IEHU and the Paul Ramsay Foundation.

Indigenous populations across Australia have higher rates of vision loss and blindness than other Australians. In response to this, the IEHU was established in the Melbourne School of Population and Global Health at The University of Melbourne under the leadership of Professor Hugh Taylor. The overall aim of the unit is to eliminate the inequities in vision loss and eye care by improving the eye health of Indigenous Australians. It intends to use evidence to influence policies that will lead to more effective eye health services for Indigenous communities. The key policy document guiding the unit's work is the *Roadmap to Close the Gap for Vision* (the Roadmap, published in 2012). The Roadmap identified a range of broader issues for Indigenous health and health service delivery in Australia.

In practical terms, the IEH team provides a whole-of-sector approach to addressing the gap for vision for Indigenous Australians. The unit characterises its work as providing advocacy and technical advice and support for the eye health service sector, which serves Indigenous communities.

1.2 About this evaluation

Clear Horizon conducted this evaluation. This evaluation has two purposes. The first purpose is to assess the impact and effectiveness of IEH, assess the extent to which outcomes generated by IEH were sustainable, and assess its contribution to building Indigenous leadership. Clear Horizon was also requested to identify how IEH behaved and operated as an intermediary and the effective elements of this way of working. An intermediary is an organised group of people who provide an enabling environment of whole-of-community or whole-of-sector responses to what would be considered a complex problem or issue. (The Bridgespan Group, 2009) The shape and direction of the evaluation are guided by three key conceptual frameworks: the theory of change, the key evaluation questions, and the field catalyst model.

Evaluation methods

The intermediary evaluation began in February 2020, and an evaluation planning workshop was conducted on 14 February, 2020. At this workshop, four Key Evaluation Questions were developed by Clear Horizon with IEH and PRF. In considering the role of IEH as an intermediary and the effectiveness of such an organisation working in Indigenous health, Indigenous leadership was a critical element to be included in the evaluation.

Between December 2020 and June 2021, the evaluation team interviewed 28 stakeholders across the eye health sector, government, NGOs, ACCHOs and funders. A short document review was conducted. The evaluation team also reviewed 13 interviews and survey data conducted by ARTD during their evaluation.

Collaboration with ARTD – evaluation of the regional implementation of the Roadmap.

An evaluation of the regional implementation of the Roadmap occurred simultaneously to this intermediary evaluation, led by external evaluators ARTD Consultants. ARTD and Clear Horizon

collaborated during the evaluation and shared evaluation data (interviews and surveys) to facilitate knowledge and collaboration.

This evaluation focuses on the activities and outcomes of the IEHU as an intermediary. Because regional implementation is an important function of IEH and needs to be included when considering IEH as an intermediary, this evaluation also investigates and discusses regional implementation.

1.3 Findings

The findings are disaggregated against the four Key Evaluation Questions (KEQs): impact, effectiveness, building Indigenous leadership, and sustainability.

Impact findings

Based on the analysis of the evaluation data collected and acknowledging the limitations of making evaluative statements about impact (described in further detail in section 4.1.1.), the evaluation team makes the following assessment regarding the contribution that IEH has made towards improving the eye health of Indigenous peoples:

- IEH has created a range of technical products that contribute to an improved evidence-base around Indigenous eye health and have contributed to the establishment of a sector that has a shared vision and plan for improving Indigenous eye health
- IEH has supported regional health networks to assess eye health status for Indigenous peoples in the region, understand the gaps in their health pathways, and identify solutions to identified gaps. Where regional implementation has been successful, this has led to improved collaboration among health networks and improved pathways to eye care for Indigenous peoples.
- IEH has supported the formal and informal sharing of information and evidence across national, state, and regional levels and has effectively facilitated stakeholder groups spanning sector, discipline, and place. Because of this, IEH has contributed to creating networks and collaborations that focus on improving access to Indigenous eye health services. This improved collaboration has occurred vertically (from national to regional) and horizontally (within and between regions).
- IEH has directly contributed to the facilitation of policy changes and increased funding at the Federal level. This has directly contributed to improvements in the way eye health services are delivered to Indigenous peoples and has increased the number of eye health services provided to Indigenous peoples.

Effectiveness findings

Effectiveness explores how a program creates change.

Based on the analysis of the evaluation data collected and acknowledging the limitations of making evaluative statements about effectiveness (described in further detail in section 4.1.1.), the evaluation team makes the following assessment regarding how IEH contributed to the changes and outcomes identified in the Impact section.

The following factors were identified as contributing to the effectiveness of IEH:

- IEH is led by a distinguished academic/practitioner in the eye health field who holds great influence within academic settings, Federal Government settings, and the eye care field.

- From the inception of IEH, the unit has drawn on, facilitated, or generated credible evidence about eye health status for Indigenous Australians, and its activities and recommendations are guided by credible evidence.
- In part because of the status of its leader and in part because of the credibility of the evidence, IEH has been effective in securing resources that have provided the unit with the flexibility to commit to the implementation of long-term goals.
- IEH has focused on developing research to describe an issue and has also researched how to resolve identified issues. Further to this, IEH has remained committed to implementing the identified solutions to issues over time.
- IEH has built a team with skills in knowledge translation, community development, marketing and communications, Indigenous knowledge (and cultural knowledge), and eye health care pathways. IEH has facilitated in building effective collaborations, engaging in effective research transfer, and having the capacity to be practical implementers. This has greatly assisted IEH to achieve its goals.
- IEH staff are committed to advocating for change, understand that change sometimes involves discomfort, and willing to engage with and address discomfort. (This discomfort is caused by a range of factors which are described in the following paragraph.)

IEH currently experiences the following tensions, which can simultaneously act as barriers and/or enablers to effectiveness:

- The Roadmap was based on extensive consultation during its development to inform the development of the recommendations. While Roadmap implementation strategies have evolved, IEH has not systematically engaged in ongoing consultation to ensure that the Roadmap priorities are updated to respond to emergent cultural, social, and political changes occurring within Indigenous communities. The turnover of staff within agencies also means that Roadmap background and approaches require regular explanation and re-explanation. IEH has remained focused on the achievement of the recommendations as established in the original Roadmap.
- IEH staff are identified as being effective collaborators and facilitators. At the same time, the unwavering commitment of IEH staff to the Roadmap approach and goals has frustrated some stakeholders with the communication style of some IEH staff.
- IEH enjoyed flexible funding to support the Roadmap implementation and continue to advocate for additional funds to support Roadmap implementation. Still, regional groups do not have access to equally flexible funds to support the regional implementation of the Roadmap.
- IEH experiences the ongoing tension of intending to act as behind the scenes advocates, while some advocacy activities rely on IEH being front and centre as advocates. IEH has a prominent and influential leader, and IEH is willing and able to lead work when there are perceived gaps in systems, even though IEH acknowledges it is not their preference to lead. IEH could benefit from further thinking about the implications of this tension and how it enables and hinders effectiveness.

Currently, the most significant challenge affecting the effectiveness of IEH involves how IEH will respond to the expressed desire of Indigenous stakeholders (and other non-Indigenous advocates) for future priorities and activities for Indigenous eye health be determined by Indigenous communities and led by Indigenous people and organisations.

Building Indigenous Leadership Findings

When considering IEH historically, IEH did not consistently meaningfully consider the evolving implications of being a non-Indigenous organisation working in an Indigenous space and how to respond to these issues. It did not always meaningfully consider the difference between consultation and

leadership. While there has been ongoing engagement and consultation with Indigenous organisations and people, this has not been at a deep enough level. It did not act on considerations that the Roadmap and its recommendations may have benefitted from ongoing consultation and redevelopment rather than being a static document informed by consultation at the point of development. In its early days, IEH as an organisation did not substantively consider how to meaningfully contribute to building Indigenous leadership so that Indigenous peoples could control how eye health is delivered in their communities.

IEH acknowledges these historical shortcomings, and the IEH staff today engage in robust discussions regarding the future of IEH and what it can do to promote Indigenous leadership and self-determination over Indigenous eye health. There is strong internal will and desire to improve this aspect of the unit. Despite this, external stakeholders report ongoing tensions between IEH and Indigenous organisations when their priorities do not align. To guide these matters, IEH would benefit from strengthening Indigenous governance of the unit.

There is a strong stakeholder will to promote Indigenous ownership over advocacy and policy endeavours to improve and manage Indigenous eye health activities. Most stakeholders were not able to provide much clear insight or guidance as to how this should be facilitated or what it would look like.

Some stakeholders expressed a desire to establish an Indigenous-led organisation that is community-controlled and focuses on eye health. Any Indigenous person or organisation wishing to embark on such a project would do well to consider the lessons learned from the implementation of IEH and reflect on the implications of these lessons when considering how such an Indigenous-led organisation might work in this space.

Sustainability findings

Stakeholder views on what could strengthen the sustainability of the Roadmap outcomes have changed since the Roadmap was first released in 2012.

Stakeholders expressed that the sustainability of the outcomes that IEH have contributed to are now directly linked to supporting the development of activities that promote Indigenous leadership and self-determination over eye health services for Indigenous peoples.

IEH has advocated for changes in policy and funding that led to changes in how eye health services were delivered to Indigenous communities. When considering sustainability, both IEH and Indigenous organisations who might want to lead the future coordination of eye health activities for Indigenous populations should consider what funding mechanisms would support Indigenous ownership over the delivery of eye health activities. What funding is needed to support and sustain Indigenous-led and owned collaboration to support better eye health outcomes in Indigenous communities?

Assessment of IEH as an intermediary

This evaluation was asked to assess the extent to which IEH acted as an intermediary and the potential contribution of this function to building an Indigenous eye health field. An intermediary is a type of group or organisation that seeks to contribute to change across an entire field.

This evaluation drew on the field catalyst model as a framework for assessing the extent that the IEH could be considered an intermediary. This evaluation assesses that IEH essentially shares the characteristics of a field catalyst and broadly undertakes the same types of activities. This evaluation finds that IEH has contributed to the field of Indigenous eye health across all five criteria identified in the Bridgespan framework for a robust field. (The Bridgespan Group, 2009) IEH has made significant contributions to creating a shared identity for a sector, in codifying practices, creating a well-developed

and credible knowledge base, and identifying sufficient funding and supportive policies. It has effectively provided leadership and grassroots support, but this contribution is mitigated by tensions between IEH and some Indigenous organisations when their priorities do not align.

The scope of the work of IEH, the different ways the IEH team works in different environments and diverse places, and the multiskilled composition of the IEH team have resulted in diverse stakeholder perspectives as to the characteristics and achievements of IEH. This evaluation could identify stakeholder perspectives for and against IEH fitting each of the criteria of a field catalyst or contributing to a robust field.

Conducting an assessment of IEH as an intermediary is complicated by the issue that IEH is a non-Indigenous organisation working across non-Indigenous and Indigenous spaces on Indigenous issues. The field catalyst model and the robust field models are not calibrated to consider criteria to assess the extent to which the intermediary function contributes, or could contribute to, good practice in working with Indigenous peoples on Indigenous issues. Other criteria need to be considered, such as the extent to which the intermediary facilitated Indigenous-led activities, Indigenous ownership, self-determination, and was culturally sensitive and appropriate.

Using the analogy of the river to describe the impact of IEH

When making sense of impact, we considered how to present findings about impact in a way that helps us understand IEH contribution to the observed impacts. To assist us in this consideration, we drew upon our river/waterfall analogy to describe how change happens.

In the river analogy, the waterfall represents how IEH influences stakeholders and creates change. The water in the river represents different stakeholders in the eye health pathway. The water has waves and currents: waves represent the knowledge of various stakeholders, and the currents represent various stakeholders' values. When the water passes through the waterfall (which represents the actions of IEH), it merges and blends the waves and currents. This signifies changes in knowledge and values among stakeholders. The waterfall's new waves and currents represent how stakeholders' knowledge and values are changed by their interaction with IEH. The waves and currents then continue downstream and are forever altered by the waterfall.

The river as a metaphor for change

We can think about observing the impact of IEH for this evaluation the same way we think about following the impact of the waterfall on the waves and currents over time:

- The waterfall has very clearly impacted changes in the waves and currents that happen at the waterfall
- As you go further down the river, the less likely you are to understand how the waterfall reshaped the waves and currents in the river. Go even further down the river, and you may not even know about the waterfall – even though you feel its effects.

What was happening upriver

Upriver represents various stakeholders working across eye health, public health, Government, philanthropy, policymakers, Indigenous communities, and Indigenous organisations. All of these stakeholders were represented in the water by waves and currents. Some of the waves and currents of these stakeholder groups were stronger and more dominant than others. The direction of the water in the

river tended to be dominated by certain types of waves and currents. Not all of the waves and currents had equal power over the direction of the water in the river.

IEH as the waterfall and how it creates change

IEH is represented in this metaphor as a waterfall. The waterfall is the mechanism for the waves and currents in the river to blend and merge. The extent to which the waterfall can merge currents and waves depends on the strength of the waterfall. The stronger the waterfall, the more significant the change in the waves and currents in the water. When the waterfall causes waves and currents to merge, it creates standing waves. These waves can be turbulent, and the stronger the waterfall, the greater the turbulence.

These are the findings we found about how the waterfall created change:

- the IEH waterfall successfully merged waves (which represent knowledge). By doing this, IEH distributed knowledge about improving eye health services across the body of water in the river.
- The IEH waterfall was not as successful at changing the direction of the currents in the water (which represent values), there was less sharing of values across the body of water
- the IEH waterfall was not strong enough to reduce how dominant some of the waves and currents in the river were. Waves and currents that were dominant upriver continued to be dominant after they went through the waterfall.
- despite not being strong enough to change the dominance of some waves and currents, it was successful in producing energy. The waterfall effectively kept the river flowing and generated new resources to keep the water going on its journey and create new life in the river. This ensured that the water in the river did not go stagnant.

Standing waves

Because of the energy created by the waterfall, it made standing waves, and these standing waves created some turbulence. (1) This meant that some of the waves and currents experienced a period of turbulence, but this is to be expected when bodies of water are merging and changing. It looked turbulent, and whist the turbulence has affected the flow of water, it has also allowed the water to continue its journey.

Who should continue to care for the river?

Rivers are at their healthiest when they are well cared for by the people who live on the river and have the most profound connection to the river. People who have grown up on and near rivers have a deep understanding of the ecosystem around the river. They understand how to care for the river and how the ecosystem works to support river life. Rivers should be entrusted to those peoples who have the most profound connection to and understanding of how the river operates. (2)

(1) For example, the unwavering commitment of some IEH staff for their mission results in stakeholders who express frustration with the communication style of some IEH staff. Additionally, stakeholders are ambivalent about IEH dual role of being front and centre advocates whilst at the same time aiming to be effective behind the scenes facilitators and advocates

(2) This speaks to the need to focus on building Indigenous leadership and self-determination. Eye health care for Indigenous communities can be entrusted to Indigenous peoples who are supported by non-Indigenous allies.

2 Introduction

This section provides background and contextual information about Indigenous Eye Health (IEH) – the focus of this evaluation. This evaluation was led by external evaluators, Clear Horizon and commissioned by the Indigenous Eye Health Unit (IEHU) and the Paul Ramsay Foundation, a philanthropic organisation supporting the IEHU since 2017.

The primary purpose of this evaluation was to investigate the impact, effectiveness of IEHU and assess the extent to which outcomes generated by IEHU were sustainable. It also intended to examine how the IEHU contributes to building Indigenous leadership in the eye health sector. Clear Horizon was also asked to assess the extent to which the IEHU functions as an intermediary and if so, what was the contribution of the intermediary to developing a robust Indigenous eye health care field.

This section first describes how IEHU functions. We then discuss the definition and purpose of intermediaries and their implications for this evaluation.

2.1 About the Indigenous Eye Health Unit

Description of Indigenous Eye Health

The Indigenous Eye Health Unit (IEHU) in the Melbourne School of Population and Global Health at The University of Melbourne was established in 2008 by Professor Hugh R Taylor AC, Melbourne Laureate Professor and the Harold Mitchell Chair of Indigenous Eye Health.

The stated overall aim of the unit is to '*close the gap for vision for Indigenous Australians'* and to improve the eye health of Indigenous Australians. Indigenous Australians have higher rates of vision loss and avoidable blindness than the mainstream population. Years of policy, research and funding under successive Governments previously had done little to improve the eye health of Indigenous Australians.

What IEH does

In practical terms, the IEH team provides whole-of-sector support for stakeholders who support eye health for Indigenous populations. This includes people working in political spheres, those responsible for running health services, health workers, practitioners managing eye health programs, people in policy and program development roles and those providing funding. IEH generates and disseminates evidence to influence policies and practice that lead to more effective eye health services for Indigenous communities. IEH characterises its work as providing advocacy and technical advice and providing support across the Indigenous eye health sector to implement evidence-based improvements. This role, and the elements and activities of IEH, have continued to change over time in response to need and opportunity. For example, IEH is responding to how to adjust strategically to better embrace the need to promote Indigenous leadership and foster self-determination across the eye health sector. IEH has also facilitated the development of a national conference which has contributed to the emergence of an Indigenous eye health sector.

Key activities of IEH

The implementation of the National Indigenous Eye Health Survey

In 2009, the IEHU unit published the National Indigenous Eye Health survey with the Centre of Eye Research Australia (CERA). This was the first time that a piece of research had extensively documented the eye health of the Indigenous population since 1980. The 2009 survey provided an informative picture

of the status of the eye health of Indigenous Australians. One of the key findings of this survey was that Indigenous children had better vision than other Australian children. Despite this, Indigenous Australians over 40 were six times more likely to experience blindness than other Australians. Indigenous Australians living in urban, rural or remote areas were all equally likely to experience issues with their eyesight. The survey also identified barriers to accessing eye services, including that services were underutilised by Indigenous Australians and that services needed to increase and be better coordinated and organised.

The Roadmap to Close the Gap for Vision

The *Roadmap to Close the Gap for Vision* 'the Roadmap' was released in 2012. Its purpose of the Roadmap was to develop a health systems policy framework in eye care for Indigenous Australians for presentation to the Australian Government. The Roadmap documented barriers to delivery and enablers to access of eye health services for Indigenous Australians. The Roadmap was intended to be used as a document to inform the development of policy, practice and funding mechanisms that could reshape the delivery of eye health services for Indigenous Australians.

The Roadmap was the result of extensive consultation across Australia and was sector endorsed through NACCHO, RANZCO, OS and Vision 2020 Australia. To develop the Roadmap, the IEHU conducted ten focus groups with 81 Indigenous community members, 289 staff in field interviews at 21 sites, and 38 meetings with 75 people representing 56 stakeholder organisations. Three stakeholder workshops were held over two years with a contribution from 86 people.

The consultations generated some key findings:

- Many primary health care staff had poor knowledge of eye conditions. There was a poor understanding among primary health care staff about referral pathways and linkages with eye health providers. Delivery of services in primary eye health care appeared to be inefficient.
- The majority of eye health guidelines were disease-specific, and treatment focused and did not focus on pathways of care.
- Aboriginal Health Workers were interested in eye health care but did not know where to get information. Additional training in understanding eye health and eye health pathways was considered beneficial.
- Mainstream providers did not understand the barriers for Indigenous peoples in accessing services. Indigenous peoples were reluctant to use services that were not perceived as being culturally safe.

The Roadmap outlined 42 interconnected recommendations to improve Indigenous eye health over nine domains of activity to achieve these goals. These nine domains were:

1. Primary Eye Care as Part of Comprehensive Primary Health Care: to improve identification and referral for eye care needs from primary care.
2. Indigenous access to Eye Health Services: to enhance access to Aboriginal and mainstream eye services.
3. Coordination: to improve coordination of eye care services and the successful navigation of referral pathways.
4. Eye Health Workforce: to increase availability and improve the distribution of the eye health workforce.
5. Elimination of trachoma: to eliminate blinding trachoma from Australia.
6. Monitoring and evaluation: to capture and report information about progress and improvement of services and outcomes in Indigenous eye health.
7. Governance: to ensure that there is oversight for the national delivery of Close the Gap for Vision

8. Health promotion and awareness: to improve understanding and knowledge of eye health in communities to support self-empowerment.
9. Health financing: to ensure adequate funding is allocated to Close the Gap for vision.

Regional implementation of the Roadmap

To facilitate the achievement of the Roadmap goals, the IEHU developed a mechanism to implement the recommendations - regional stakeholder groups. The IEHU recruited staff with a range of backgrounds and skills to connect with and work with regional stakeholders to implement the recommendations of the Roadmap. The IEHU also developed a Regional Implementation Toolkit to support implementation. This toolkit included resources to assist with the coordination and integration of eye health care into primary health care services. At a regional level, IEH staff engaged with local providers of eyecare including ACCHOs, optometrists, hospitals, ophthalmologists, primary health care providers and those who support these providers. The IEHU staff worked with local providers to facilitate regional planning and reporting, undertake needs analysis, and compare the eye needs of the region with population-based research. The IEHU staff also supported regions to establish regional monitoring systems that could encourage accountability and oversight over eye health care in the region.

Elimination of Trachoma

To contribute to the elimination of trachoma, the IEHU developed the Trachoma Story Kit in 2010. This was a resource for community health promotion and social marketing to support the elimination of trachoma. A key feature of the Story Kit was Milpa the Goanna, a mascot for 'Clean Faces, Strong Eyes' and the elimination of trachoma. The IEHU also recruited community health promotion workers to support communities utilising the Story Kit and implementing health promotion activities.

Check Today, See Tomorrow

In 2015, the IEHU launched the 'Check Today, See Tomorrow' set of resources intended to raise awareness of diabetes-related eye health and encourage Aboriginal and Torres Strait Islander people with diabetes to get annual eye checks. The IEHU offer a resource kit that contained brochures, a flip chart, and community posters. A range of multimedia and social media resources were also available.

The Close the Gap for Vision National Conference and other roundtables and workshops

The IEHU established the *Close the Gap for Vision* national conference in 2017 to provide an opportunity for stakeholders working across the eye health pathway to come together, share knowledge, collaborate, and work together to improve eye health care for Indigenous Australians. The annual national conference has been held in different locations and co-hosted with local Indigenous partners. Five conferences have been convened, with the 2020 event impacted by COVID-19 and the most recent conference held virtually in April 2021.

The IEHU unit also hosted seven roundtables and workshops around a range of eye health issues between 2013-2020, providing a forum for stakeholders to connect and discuss matters relating to Indigenous eye health. The success of the roundtable meetings and their contribution to the growth of the sector led to the instigation of the national conference.

Development of resources about eye health

The IEHU has produced publications that provide information and evidence about Indigenous eye health matters. These resources include:

- Annual Roadmap Updates, which have been published annually since 2012 and show progress against the Roadmap recommendations and regional implementation
- The production of 18 technical reports between the years 2009 – 2020. These provide technical information about eye care and the findings from workshops and roundtables held by IEHU, and snapshots of Indigenous eye health in jurisdictional areas.
- Thirteen policy position papers have been produced that focus on technical eye health issues and viewpoints and guidance on policy and practice.
- The IEHU has developed six self-directed online training courses in trachoma, trichiasis, diabetes, and diabetic retinopathy.
- Peer-reviewed publications (over 280) and conference presentations (over 140)

Collaboration with partners at the national level

The IEHU invests time and effort into nurturing and facilitating strong partnerships with national organisations. These collaborations aim to disseminate evidence, influence policy and funding, and advocate for improvements to Indigenous eye health among stakeholders who hold power and influence.

Some of the organisations that IEH interacts with include NACCHO, NACCHO jurisdictional affiliates, Optometry Australia, the Royal Australian and New Zealand College of Ophthalmologists (RANZCO), Vision 2020 Australia, Brien Holden Vision Institute/Brien Holden Foundation, Diabetes Australia, The Fred Hollows Foundation, Australian College of Optometry, Lions Outback Vision, the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), State and Federal Governments, and jurisdictional fundholders.

The IEHU and IEHU staff also sit on a number of boards, committees and project groups relevant to the work and currently including:

- Vision 2020 Australia
  - Prevention and Early Intervention Committee
  - Aboriginal and Torres Strait Islander Committee
  - Strong Eyes, Strong Communities Implementation Working Group
  - National Subsidised Spectacles Scheme for Indigenous Australians Project Group
- Optometry Australia
  - Aboriginal and Torres Strait Islander Eye Health Advisory Group
- Optometry Victoria South Australia
  - State Advisory Committee Victoria
- Optometry Council of Australia and New Zealand
  - Indigenous Strategy Taskforce
- Royal Australian and New Zealand College of Ophthalmologists
- Australian College of Optometry
- Close the Gap Committee
- Medical Research Futures Fund (MRFF), Indigenous Health Research Fund
- Australian Institute of Health and Welfare
  - Indigenous Eye Data Report Advisory Group
- National Diabetes Strategy Advisory Group
- Australian Committee on Safety and Quality in Health Care
- National Trachoma Reference Group
- State trachoma committees in three jurisdictions
- Environmental health, hygiene and education trachoma working groups across three jurisdictions
- State and regional eye care committees

- IEH directly participates in 40/63 regional stakeholder groups and 6/7 jurisdictional stakeholder groups

How IEHU is funded

The IEHU is a unit located at the University of Melbourne and occupies an unusual space in the University. It operates as a translational research group with different expectations to traditional research groups (for instance, the unit has limited specific expectations in teaching, grant writing or publication of academic work). The University provides important operational and structural support that allows the unit to function.

IEHU has received funding from several philanthropic organisations, which has provided IEHU which a great deal of flexibility and time to commit to its goal of Roadmap implementation and trachoma elimination. Organisations that have funded IEHU include Harold Mitchell Foundation, Potter Foundation, Cybec, CMB, Gandal Foundation, Queen Elizabeth Diamond Jubilee Funds, AB Miller, MML, Paul Ramsay Foundation and Minderoo Foundation. The Paul Ramsay Foundation provided operational funding to IEH from 2017-2021 and are the funder of this evaluation.

In addition to philanthropic funding, IEHU has received funding grants from the federal Department of Health to fund the implementation of the Roadmap from 2014-2023 and fund trachoma activities from 2015-2024.

How IEHU is staffed

Professor Hugh Taylor founded the IEHU in 2008, and he remains the leader and director of the unit.

Professor Hugh Taylor has been involved in Indigenous eye health since the 1970s and is an internationally renowned leader in ophthalmology and public health. He has been the Harold Mitchell Professor of IEH at the Melbourne School of Population and Global Health since 2008. Professor Taylor's research interests include blindness prevention strategies, infectious causes of blindness, and health policy development. He has extensive experience working with Indigenous leaders and organisations. Professor Taylor has served on numerous national and international Boards and Advisory Councils, including the International Council of Ophthalmology, Fred Hollows Foundation and Vision 2020 Australia, and as an advisor to the WHO.

The staffing structure and skills in the IEHU has changed over time. But IEHU has remained committed to facilitating multi-disciplined and multi-skilled teams. The team currently includes skills and experience in ophthalmology, optometry, workforce policy, government relations, photography, community engagement, consultation, service and education, health promotion, nutrition, naturopathy, politics, project management, health service management, health policy and communications. This breadth of skills and experience allows the team to collectively respond to the complex challenges in Indigenous eye health.

The current IEH staff group is outlined below:

- Deputy Director and Senior Research Fellow - joined 2009. Leads trachoma elimination team with significant experience working in health sector and government
- Translation Research Scholar - joined 2010. Works with government, ACCHOs, NGOs to develop engaging health promotion and multimedia strategies that are being used to support elimination of trachoma in Australia. Masters in Public Health

- Multimedia Administrator - joined 2010. Supports implementation of health promotion activities, has Diploma of Arts in applied photography and maintains IEH and social network sites
- Deputy Director and Associate Professor - joined 2010. Optometrist, Academic and Public Health Practitioner with extensive experience working collaboratively across eye care and health sectors and leads a number of national advisory committees
- Translation Research Scholar – Health Promotion - joined 2014. Leads diabetes eye care work and supports regional implementation. 15 years experience working in health program management and evaluation
- Senior Research Fellow - joined 2016. Supporting regional implementation of Roadmap with background in rural health workforce policy. Currently completing PhD
- Research Fellow - joined 2017. Supports regional implementation of the Roadmap with 15 years experience working in health and primary health care project management. PhD examining complexities of Indigenous identity politics.
- Academic Specialist in Indigenous Eye Health Policy - joined 2018. Supports regional implementation of the Roadmap with experience working in ACCHO sector. Obtained PhD – dissertation on the early history of the Aboriginal Community Controlled Health Services Movement in Australia
- Marketing and Communications Officer - joined 2018. Aboriginal man with health sector and government experience, engaging stakeholders with a particular focus on trachoma
- Trachoma Community Engagement Officer - joined 2019. Aboriginal woman, located in Northern Territory with experience in community health and health promotion
- Assistant to IEH Director - joined 2019. 15 years experience in the tertiary education sector as professional staff and administrator
- Trachoma Community Engagement Officer - joined 2020. Aboriginal man located in Alice Springs with extensive experience in community engagement and consultation
- Academic Specialist in Indigenous Eye Health Leadership - joined 2021. Aboriginal man based in Northern Territory with background as Aboriginal Health Worker and extensive experience in primary health care and passion for eye health services in Indigenous communities

The governance structure of IEH

The IEH Advisory Board provides overarching advice, direction on the program of activity, guidance on funding, and advice as to how data collected can be used to implement policy change.

The Board assists with advocacy within the appropriate networks and provides technical advice as required. The Advisory Board was established in 2008 and currently meets three-times each year.

Current members include:

- Mr Trevor Buzzacott - former National Trachoma and Eye Health Program member
- Ms Trish Crossin - former Senator for the Northern Territory

- Professor John Funder AC - Senior Fellow, Hudson Institute of Medical Research
- Ms Karen Hale-Robertson - Deputy CEO, CheckUP Australia
- Professor Hugh R Taylor AC - Melbourne Laureate Professor and Harold Mitchell Chair of Indigenous Eye Health, The University of Melbourne
- Mr James van Smeerdijk – former partner, PricewaterhouseCoopers
- Dr Marianne Wood - Public Health Medical Officer, Aboriginal Health Council of Western Australia
- Ms Shannon Drake - Executive Manager Health and Wellbeing, Rumbalara Aboriginal Cooperative

Current members include Aboriginal and Torres Strait Islander people expert and active in health service delivery and policy, former Federal politician, senior academics, a Public Health Medical Officer from a NACCHO state affiliate, deputy CEO of a jurisdictional fundholder and a partner of an international consulting firm.

3 About this evaluation

In this section, we describe the intended audience for this evaluation and the conceptual frameworks designed to shape the direction of the evaluation.

Finally, we provide a summary of the key evaluation activities that were undertaken for this evaluation.

3.1 Evaluation audience

The primary audiences of this evaluation are IEH, the Paul Ramsay Foundation, Indigenous organisations working in the health sector, philanthropic sector and other organisations functioning as intermediaries.

- The Paul Ramsay Foundation wishes to use IEH as a case study to understand better the role of intermediaries in system change approaches and share learnings with stakeholders involved in complex system change within Australia and internationally.
- Indigenous organisations working in the health sector may be interested in understanding how to promote self-determination of Indigenous peoples and organisations across the health sector.
- IEH is interested in understanding how to sustain system changes for improved eye care for Indigenous people to eliminate avoidable vision loss and blindness. IEH and the sector more broadly want to increase Indigenous leadership across the eye health sector and to facilitate greater ownership into the future. IEH is also interested in capturing the contributions and effectiveness of IEH so that others can learn from and improve efforts to support change in eye health and other health conditions.
- Other organisations functioning as intermediaries or wanting to understand how intermediaries function are another primary audience for this evaluation.

The secondary audiences comprise the myriad of stakeholders involved in contributing to improved eye health for Indigenous Australians and the Indigenous communities of Australia. These audience members will benefit from understanding how the actions of IEH, which can be understood in the context of an intermediary, contribute to changes in health systems, what types of changes in health systems are needed, and then how these changes contribute to improved eye health for Indigenous Australians.

3.2 Conceptual frameworks

There are three conceptual frameworks guiding this evaluation:

- The first conceptual framework is a theory of change. A theory of change provides us with a map of what kinds of changes we want to look for as a result of IEH activities in the evaluation.
- The second conceptual framework is the key evaluation questions (KEQs). The KEQs inform the evaluation tools that are developed and provide a framework for the presentation of findings.
- The third conceptual frameworks is the field catalyst model (and the five criteria of a robust field) a type of intermediary seeking field change.

Theory of change

The theory of change was developed with the IEH team in early 2020. The theory of change is the key conceptual framework driving data collection tools for the evaluation.

Below we present a high-level summary of the theory of change in table form, then a more detailed narrative description of the theory of change.

Identify stakeholders, gather information, set strategic direction	Collaborate and disseminate	Outcomes
Gathering information • Identify stakeholders who work across the eye health pathway to deliver services for Indigenous peoples • Gather evidence about factors impacting Indigenous eye health **Setting strategic direction** • Assess the political environment • Set a strategic direction with stakeholders **Working with Indigenous stakeholders** • Identify Indigenous stakeholders who can take ownership of activities that improve eye health service delivery	**Participate in networks** • Informally liaise with a diverse range of stakeholders working across the eye health pathway • Participate in formal activities that set policy agendas and set strategic direction **Facilitate networks** • Provide informal and formal opportunities for stakeholders to meet **Disseminate information** • Disseminate information to stakeholders • Provide guidance and support around policy and strategic directions **Promote interests of Indigenous stakeholders** • Ensure Indigenous cultural knowledge about eye health is integrated into work **Advocate for resources and policy change** • Advocate for improved resourcing for provision of eye health services for Indigenous peoples	**Improved knowledge** • Stakeholders who liaise with IEH have access to information that can improve the provision of eye health for Indigenous communities **Improved access to networks** • Stakeholders who interact with IEH have improved access to networks that they can leverage to improve eye health pathways and systems **Improved access to resources** • Stakeholders have improved access to resources to deliver eye health care to Indigenous communities **Improved self-determination for Indigenous communities** • Indigenous peoples have greater ownership over how eye health care is provided to communities **Improved eye care systems and services for Indigenous communities** • Indigenous peoples have better outcomes in eye care

Narrative description of the theory of change

Identify stakeholders, gather information, and set a strategic direction

Identify stakeholders

In both formal and informal ways, IEH routinely scans the eye health landscape to understand what types of stakeholders are involved in the eye health care pathway, either as a person/organisation delivering a health service, a beneficiary of eye health services, or stakeholders and duty bearers who can influence and improve access to eye health services. IEH is an active repository for aggregating the combined knowledge, wisdom, and experience of all the involved stakeholders and acts as an intermediary for this information, gathering the data and developing products that document practice knowledge.

Gather information

IEH conducts a range of research activities that inform the development of policy and practice advice and strategic direction. The IEH develops materials and products that can be used to promote eye health and influence health policy. This information can be formal and technical information about eye health and the health system and knowledge about best practices in working with Aboriginal and Torres Strait Islander communities. IEH also seeks to understand cultural and political dynamics in Aboriginal and Torres Strait Islander communities, health service systems, and Governments (at local, state, and federal levels) to identify Indigenous stakeholders who can lead and take ownership of IEH activities.

Working with Indigenous stakeholders

IEH seeks to work with Indigenous stakeholders to blend Indigenous cultural knowledge with mainstream knowledge about eye health and the eye health sector and provide opportunities for communities and Indigenous stakeholders to take ownership of eye health. IEH also does this to understand and share knowledge that Indigenous organisations have about improving health systems and health services for their communities. This knowledge may be technical or clinical but is underpinned by cultural knowledge.

Collaborate and disseminate

Collaborate

Relationship building with diverse actors contributing to the Indigenous eye health sector is an essential strategy for advocacy and promotion of evidence and information. The staff at IEH use various methods to engage actors based on the type of stakeholder.

IEH facilitates formal and informal opportunities for stakeholders to meet, conducts adaptive and targeted dissemination of information based on needs of stakeholders, develops products that disseminate information that will contribute to improved eye health, and conducts focused connection of stakeholders across local, state, and national networks.

IEH participates in and facilitates a range of events and roundtables. IEH is the convenor of the *Close the Gap for vision* conference, operating since 2017. IEH staff also participate in regional stakeholder meetings, supporting Roadmap implementation at the regional level. These are formal events that also provide opportunities for informal networking, communication and advocacy.

An example of how the staff adapt their approaches based on the type of actors is highlighted in the table below:

Working with fundholders	Connections often happen at formal events, such as meetings and roundtables. IEH staff are looking for influence points where IEH can leverage fundholder relationships to promote advocacy objectives when connecting with fundholders.
Individual clinicians (such as optometrists and ophthalmologists)	IEH uses multiple approaches in its work with clinicians, it takes an individual approach to work with individual clinicians, and it also utilises clinician networks to bring clinicians together. The focus here is on promoting knowledge that will lead to increasing accessibility of services for Indigenous peoples. A benefit of IEH engaging in this space is that the staff have credibility as technical experts in eye health.
ACCHO affiliates	IEH wants to focus on reciprocal, two-way learning, building trust and rapport with the affiliates. Often identifying a single point of contact (for instance, if the affiliate has an eye health program) is leveraged to build a relationship with an organisation. Building this relationship is to connect ACCHO affiliates with the broader eye health network and support ACCHO affiliates to take leadership in leading changes to the way eye health services are delivered.

Disseminate

IEH leverages its networks to disseminate information and knowledge. Below are examples of the types of products that IEH has developed:

- The Roadmap to Close the Gap for Vision (and its subsequent updates)
- The Eye Care Services Calculator
- Research articles and policy submissions
- Health promotion resources for both diabetes and trachoma
- Technical papers and position papers
- Newsletters and e-bulletins
- 'Share Your Story' platform for sharing local stories of success across Australia
- Educational tools and resources for health professionals
- Conference presentations and skills sessions for a range of stakeholders across the health sector
- Tools to support Roadmap implementation

Outcomes

IEH is broadly seeking the following types of outcomes

Changes in knowledge

- Stakeholders who directly interact with IEH have access to information that improves the provision of eye health care for Indigenous communities. The type of information needed varies by stakeholder. IEH facilitates the codification and dissemination of knowledge that can support the broader Indigenous eye health sector at a national level. At the regional level, IEH helps

stakeholders to assess their environment and develop an understanding of how the current eye health pathway needs to be improved and integrated to promote access and how to better integrate and coordinate eye health services into the primary health care pathway; how low cultural awareness and cultural capacity of services acts as a barrier to utilisation of eye health services; and what kinds of innovations can be implemented to promote access to eye health services for Indigenous communities.

Changes in access to networks

- Integrating eye health services into primary, secondary, and tertiary networks (including primary health care networks) in regional settings is seen as a pathway to promoting access to services. The IEHU intends to create and foster an enabling environment for collaboration at regional, state, and national levels. Collaboration happens horizontally through the creation of regional stakeholder groups. Stakeholders who directly interact with IEH have access to networks that they can leverage to improve eye health pathways and systems.

- Stakeholders across all levels and types (mainstream and Indigenous, local, state, and federal) are increasingly connected. Here, collaboration happens vertically by connecting local groups to state and national groups (which can involve multidisciplinary groups) and horizontally, connecting groups across regions. This promotes advocacy objectives to change policies and practices at the federal level, which creates an enabling environment at the regional level.

Changes in access to resources

- IEH leverages its networks, knowledge, experience, and influence to advocate for policy changes at the national level.

- IEH advocates with fundholders and governments to advocate for improved funding to deliver eye health services for Indigenous peoples. IEH does not just focus on securing more funding but also considers advocacy for equitable distribution of funding.

Promoting Indigenous leadership and self-determination

- Indigenous stakeholders who could lead eye health initiatives into the future are identified and connected to other actors in the eye health sector. This is about sharing knowledge to inform and guide what others do, which should inform culturally safe practice and ensure that service delivery is informed and guided by Indigenous people.

Key Evaluation Questions

These Key Evaluation Questions (KEQs) were developed with the IEH team in early 2020. KEQs help guide the nature of the inquiry. Practically, KEQs have two purposes; firstly, they inform the way that evaluation tools are developed. Secondly, they inform how the findings in the final report are presented. To provide a framework for the KEQs, we use criteria – these offer the principles we use to evaluate the IEHU.

Four KEQs are guiding this evaluation. The full set of KEQs, including sub-KEQs, are included at Appendix Two.

1. **Impact**. Which individuals, agencies and groups have experienced change as a result of their interaction with IEH, and what kinds of changes have they experienced?
2. **Effectiveness**. What does IEH do that contributes to change? What are the qualities and attributes that have contributed to IEH effectiveness? Is there anything different that IEH could have done to be more effective in its work?
3. **Building Indigenous Leadership.** How has IEH promoted Indigenous leadership? What is the way forward for IEH and building Indigenous leadership into the future?
4. **Sustainability.** If IEH were to cease work, what would be the enduring impact of its work?

Field catalysts

When considering the nature and form of intermediaries for this evaluation, we primarily drew on the work of Taz Hussein, Matt Plummer and Bill Breen and their article 'How field catalysts galvanize social change'. This article was published in the Stanford Social Innovation Review in 2018. The article discusses different types of intermediaries. The term intermediary appears to be relatively recent but is linked to research on systems change, achieving population-level change, and collective impact approaches. The authors in the Stanford article attribute the genesis of the term intermediary to The Bridgespan Group[1], who in 2009 were asked by the James Irvine Foundation to investigate what it takes to create systems-changes effects in a given field.

The Stanford article identifies three existing types of intermediaries:

1. Capability specialists – provide the field with a kind of supporting expertise
2. Evidence-Action Lab – take on a range of functions to help stakeholders scale up evidence-based solutions
3. Place-based backbone – coordinates local and regional stakeholders to address local issues in a defined region

The authors of the Stanford article identified a new type of intermediary: the Field Catalyst (the Stanford article uses the term 'Field Catalysts' but this evaluation will instead substitute the word 'intermediary') In this article, they coined and described the role of the Field Catalyst. This type of intermediary seeks to help multiple actors achieve a shared goal.

To contribute to a robust field, field catalysts do the following:

1. Help the field meet its evolving needs by filling key capability gaps across a range of disciplines. Identify and fill the voices in the fields' skill sets. Span traditional organisational boundaries. Conduct research, build public awareness, assess the fields strengths and weaknesses, advance policy, contribute to technical support to direct-service providers, collect, analyse and share data.
2. Appeal to multiple funders. Secure multiple funding sources. Earn credibility and win enough trust to influence the fields other actors. Steer funding streams without controlling them.
3. Consult with many but make decisions within a small group. Seek input from many but limit decision making to a comparative few. By taking a consultative rather than consensus-driven approach, they can respond quickly to new developments.

According to the authors, Field Catalysts share the following four characteristics:

1. They focus on achieving population-level change, not simply scaling up an organisation or intervention
2. They concentrate on getting things done, not on building consensus
3. They are built to win, not to last. They set to achieve change in a field and contribute to population-level goals, but they do not seek to become a field feature.

[1] The authors are current staff members of The Bridgespan group

4. They influence the actions of others rather than acting themselves directly. They often prefer their work to go undetected.

We chose to use the Field Catalyst as the conceptual framework for assessing the effectiveness of IEH as out of the four intermediaries presented above; the field catalyst model appeared to be the closest fit to the theory of change that IEH and Clear Horizon developed in February 2020.

The role of an intermediary in contributing to a robust field

A Field Catalyst contributes to the development of a robust field. The Bridgespan Group defines a field as a community or organisations and individuals working towards a common goal and using a set of standard approaches to achieving that goal. To achieve population-level change, fields need to be intentional about strengthening the field in which they operate.

The Bridgespan Group (2009), who conducted some of the early research into intermediaries, identified the following constructs that make up a robust field. The evaluation uses this as its framework to assesses the contribution of IEH to a robust field.

1. A shared identity that's anchored in the field. Individuals and organisations identify as a field and have a shared vision of what the field is trying to accomplish. A shared identity can also assist in connecting organisations with diverse and distinct practices and goals.

2. Standards of codified practices. These refer to established processes to ensure quality of implementation.

3. A well-developed knowledge-base built on credible research and which is widely disseminated among the field. This informs the efficacy of practices in the field.

4. Leadership and grassroots support that advances the field. A robust field has influential leaders and exemplary organisations working to advance the field. The field has a broad base of support.

5. Sufficient funding and supportive policies. The field has adequate funding to support its goals and a supportive policy environment. The field is actively involved in improving the policy and funding environment.

3.3 Evaluation methods

The key evaluation methods we used were semi-structured interviews and focus groups, a document review, and a review of focus group interviews. We also conducted a secondary analysis of survey data and interview data provided by the parallel evaluation of the regional implementation of the Roadmap conducted by ARTD.

Collaboration with ARTD – evaluation of the regional implementation of the Roadmap.

An evaluation of the regional implementation of the Roadmap occurred simultaneously with this intermediary evaluation. We (Clear Horizon) collaborated with the second group of external evaluators (ARTD) during the evaluation implementation and shared evaluation data (interviews and surveys) to facilitate knowledge and collaboration.

Because regional implementation is an essential function of IEH and needs to be considered when contemplating the evaluation of IEH, this evaluation also investigates and discusses regional implementation.

Evaluation planning workshop

An evaluation planning workshop was held with IEH on Tuesday, 18 February 2020. At this workshop, Clear Horizon and the IEH team met to discuss the history of IEH, began developing a theory of change, and codeveloped the Key Evaluation Questions.

Semi-structured interviews

Interviews took place between December 2020 and June 2021. We conducted interviews with 28 stakeholders from 13 different organisations; these include:

- Three jurisdictional fundholders
- Eight stakeholders working in the eye health sector (including NGOs and peak bodies)
- Two stakeholders working for the Federal Government
- Three stakeholders working for ACCHOs
- One funder

These stakeholders were located in Tasmania, Western Australia, South Australia, New South Wales, Queensland, and Northern Territory.

An additional 12 IEH staff were also interviewed.

The interview schedule is included with this report in Appendix Three.

In addition to these interviews, we analysed interview transcripts of 13 group and individual interviews that ARTD conducted to evaluate the regional implementation of the Roadmap. Stakeholders in these interviews included professionals working in the eye health sector, ACCHOs, and other stakeholders involved in the regional implementation of the Roadmap.

Document review

We reviewed the following documentation:

- The Roadmap to Close the Gap for Vision

- The 2020 update on the implementation of the Roadmap
- IEH roundtable and conference reports from 2014, 2015, 2016, and 2020
- Tools to support regional implementation of the Roadmap

Survey data

We analysed data that ARTD provided as part of their evaluation of regional implementation of the Roadmap. The survey was administered to stakeholders working in regional implementation across Australia.

- The survey received 98 responses
- 25% of survey respondents identified as Aboriginal and/or Torres Strait Islander
- The state in which people most commonly worked was Victoria (33%), followed by NT (18%) and QLD, SA (13%) and NSW (12%).
- The most commonly selected organisations respondents worked for were: Aboriginal Community Controlled Health Organisation / Aboriginal Medical or Health Service (20%), NGOs/NFPs/Charities (15)%, Hospitals (14%)
- The most commonly selected roles were: Program/ policy/ other management/ administrative role (34%) and Optometrist 16%
- Most respondents (63%) had been part of one (34%) or more (29%) regional groups/ networks.

Sense-making workshops

Several sense-making workshops were conducted over the life of the evaluation to create a dialogue with IEH staff and validate and make sense of evaluation findings. The following evaluation workshops were conducted:

- A review of the findings from interviews with IEH staff was held on 25 September 2020 with IEH staff and a representative from ARTD
- The evaluators held a preliminary workshop to present evaluation findings on 30 April 2021 with two IEH staff
- The evaluators presented findings to the IEH team on 18 May 2021
- The evaluators presented findings to the ATSIRG and other stakeholders on 25 May 2021

Analysis of evaluation data

All evaluation data was disaggregated against the three conceptual frameworks guiding this evaluation

- the key evaluation questions which were developed in collaboration with the IEH team
- the characteristics of field catalysts (intermediaries)
- the extent to which the activities of IEH align the key activities of field catalysts (intermediaries) and the contribution of IEH to five criteria that define a robust field

This data was aggregated into evidence tables which can be found in Appendix One.

4 Evaluation findings

This evaluation had two purposes. The first purpose was to respond to the Key Evaluation Questions, investigate the impact, effectiveness, and sustainability of IEH, and assess its contribution to building Indigenous leadership. Clear Horizon was also asked to determine the extent to which IEH functions as an intermediary, what this looks like, and how IEH contributed to a robust field for Indigenous eye health. This has shaped the way we present the evaluation findings. An overview of how findings are presented is outlined below:

- Section 1 describes findings against the KEQs.
- Section 2 provides an assessment of IEH as an intermediary using the description of the field catalyst as the framework for analysis, and then assesses the contribution of IEH to a robust field, using The Bridgespan Group's five criteria of a robust field as the framework for analysis.
- Section 3 uses the metaphor of the river to describe the journey of IEH

4.1 Findings 1: key evaluation questions

This section covers the findings against the four KEQs:

1. **Impact** – this section investigates what changed
2. **Effectiveness** – this section investigates how IEH as an intermediary effected change
3. **Building Indigenous Leadership** – this section describes how IEH engaged with Indigenous stakeholders
4. **Sustainability** – this section discusses what is needed to ensure that the efforts of IEH endure

4.1.1 KEQ 1 Impact – what's changed

This section responds to KEQ 1: *Impact. Which individuals, agencies and groups have experienced change as a result of their interaction with IEH, and what kinds of changes have they experienced?*

Making sense of impact

Evaluating the impact of organisations such as IEH that seek to influence multiple stakeholders to engender population-level changes poses challenges for evaluation.

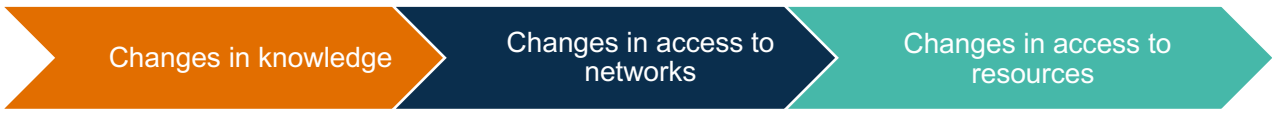
The challenges include:

- Findings that describe intangible changes or changes that might be hard to observe tend to be evidenced by stakeholder opinions. For instance, stakeholders may tell the evaluators that 'IEH has contributed to a less fractured sector'. So, if the finding here is that IEH has contributed to a less fractured sector, our evidence supporting this finding is that several stakeholders expressed this opinion. But we may not have access to other forms of data to support this conclusion.
- How to measure change when the organisation intends not to be observed. Stakeholders reported that IEH often works 'behind the scenes'. (This aligns with the intentions of some intermediates which also seek to work behind the scenes). This has important implications for developing evaluation findings around impact, where stakeholders either may not realise that the impact is attributable to the work of IEH, or they may overestimate the contribution that IEH has made to a change.
- Working out how to assess contribution to population-level changes. There have been multiple changes to Indigenous eye health in the past decade, and these changes have likely come about due to numerous stakeholders working across multiple contexts. In this evaluation, we use the effectiveness findings to assess the contribution that IEH has made to population-level changes, with an awareness of the limitations of our data in conducting such assessments.

Findings about impact

This section is presented in two parts. In the first part, we describe the impact on stakeholders who had direct interaction with IEH. In the second part, we assess the contribution of IEH to population-level impact.

Changes for people who interacted with IEH



This section looks at changes for groups of stakeholders who have had direct interaction with IEH. We consider the following kinds of changes: changes in knowledge, changes in access to networks, and changes in access to resources.

In this section, we provide an overview of the key themes emerging from the analysis of the evaluation data; we then offer a conclusion section that provides an evaluative assessment of the impact of IEH.

Changes in knowledge

When analysing evaluation data to identify changes in knowledge, the following themes emerged:

- The IEHU has contributed to improved access to eye health knowledge and research for stakeholders working across the eye health pathway
- IEHU is bridging geographical gaps in knowledge for stakeholders within and across national, state and regional levels
- IEH is facilitating knowledge exchange in regions

IEH has improved access to eye health knowledge and research for stakeholders working across the eye health pathway

IEH has developed publications and facilitated events to distribute information. The Roadmap publication and the annual Roadmap updates have provided the sector with a clear evidence-based assessment of the eye health status of Indigenous peoples and provides a path to improvement. In the regional implementation survey, 80% of respondents reported that the Roadmap was a key support for them in their role, and 76% of respondents reported that the annual Roadmap updates were a key support for them in their role.

> *The Roadmap. I think that has been a fantastic document and a really reliable resource for the likes of myself when I'm not sure of stuff. I can actually refer back to it and make sure that we're actually on track to meet the closing the gap provisions.*
>
> Government stakeholder

Stakeholders reported that the publications and products developed by IEH contributed to improved knowledge and understanding of the eye health status of Indigenous peoples and contributed to improved knowledge across a multi-disciplinary field regarding how to improve coordination and collaboration between services to improve access to eye health care.

The IEHU established the *Close the Gap for Vision conference* 'the conference' in 2017 to provide an opportunity to stakeholders working across the eye health pathway to share knowledge, collaborate, and work together to improve eye health care for Indigenous Australians. Each year, the conference is held in a new location and co-implemented with a local Indigenous partner. Four conferences have been held, with the most recent conference being held virtually in April 2021.

Stakeholders reported that the annual conference provides an opportunity for stakeholders working across the Indigenous eye health sector to share knowledge. The facilitation of the conference has also contributed to a knowledge base around Indigenous eye health, which brings people together to share information about Indigenous eye health. This knowledge covered technical eye health issues and the provision of Indigenous public health services. Interviewees reported that the conference is a good way to hear different perspectives from a range of multi-sectoral actors working across the eye health system. 72% of survey respondents who completed the survey evaluating regional implementation agreed that attending the conference or a roundtable was a key support in their role in regional implementation.

> *I think that one of the more recent innovations around sharing knowledge is their conference, which brings people together to read share the information about great little ideas and initiatives that are happening on the ground all the way through to the latest data that AIHW have released.*
>
> Stakeholder working in eye health

In addition to the conference, IEH has hosted a range of technical roundtables over the years on health promotion, fundholders, retinal photography, regional implementation, software, and diabetes eye care health promotion. The outputs of these roundtables are documented and published on the IEH website. A rapid review of stakeholder feedback included in these roundtable reports indicates that stakeholders valued the opportunity to learn from other stakeholders in the sector in these roundtables.

IEH is bridging geographical gaps in knowledge for stakeholders within and across national, state and regional levels

IEH operates across the national, state, and regional levels. Stakeholders at national and regional levels reported that IEH is an effective disseminator of information across geographic areas and diverse stakeholders. They reported that IEH leverages knowledge across multiple places and contexts and can tailor knowledge to audiences to build connections and promote eye health activities

Stakeholders working in government and in the eye health sector at the national level reported that they could access information about what was happening in Indigenous eye health in regions due to IEH's presence in the regional implementation. Likewise, some stakeholders working at the regional level reported that IEH provided knowledge about what was happening at the national to provide support for regional implementation.

> *One of the things that IEH does that's really valuable for someone like me as a national policymaker is that it maintains data and metrics and expertise around the system that's incredibly valuable. If that wasn't there it would be much harder for us to understand how to focus, where to focus. And what it does is it does allow that to be connected to on the ground intel in a systematic way.*
>
> Stakeholder working in eye health

So there aren't other organisations that I would say with the exception of NACCHO and the Aboriginal health peaks, but there aren't other eye specific organisations, other than IEH who have that much on the ground knowledge specifically into communities. The rest of us operate at a more, if not state, then national level.

Stakeholder working in eye health

We engage with them as part of our states Aboriginal and Torres Strait Islander Eye Health group. They bring a broader perspective to that conversation than just what we, as service providers within the state have. So, they are able to sometimes facilitate a bit broader thinking, which is very, very handy.

Stakeholder working in eye health

Data and other information gathered from collaborators at national, state, and regional levels are then synthesised by and generated by IEH into documented formal knowledge. Examples include technical reports and peer-reviewed articles published by IEH and contribution to publicly available formal knowledge. One example of the latter being the regional Roadmap data included in the *Indigenous eye health measures 2020* report – published by the Australian Institute of Health and Welfare (AIHW).

Changes in knowledge: IEH is facilitating knowledge exchange in regions

To support regional implementation of the Roadmap, the IEH unit developed a toolkit that supports the establishment of local groups to collect and assess data that provides a picture of what is happening along the eye health pathway and how to facilitate improved integration and collaboration along the eye health pathway. The implementation team intends to facilitate, rather than lead or implement. Some stakeholders involved in regional implementation reported that the IEH regional teams have been effective in working with regional networks to support networks to better understand the eye health sector in the region.

IEH staff and some other stakeholders reported that the effectiveness of activities intended to improve knowledge varies from region to region. Where regions are performing well, the IEH staff report that they stay connected to well-performing regions to provide opportunities to build a picture of what is working and contributes to disseminating knowledge about good practice in delivering eye health services across stakeholder groups. Where regions are not performing well, IEH staff report spending more time and offering more support and this similarly helps to identify barriers to service improvement.

In the regional implementation survey, 83% of respondents indicated that looking at eye health care data was a key support in their role, and 80% of respondents indicated that mapping the pathways for eye conditions at a regional level was a key support in their role. 88% of respondents agreed that the regional groups provide opportunities for stakeholders working across the eye health pathway to learn from each other, but 63% agreed with the statement that regional groups were learning from other regional groups.

With the stakeholder forums IEH came down and they gave a presentation. They were able to tailor a presentation that just had nationally aggregated data to specific regional data as well which made it really relevant. Then following that they did some workshopping to work out the pathways for cataract surgery, diabetic retinopathy and access to specialist eye care. The fact that it was facilitated to a regional level and that

workshopping was input by local expertise was really good. Then that information was collated and shared back with all the stakeholder groups as well.

Government stakeholder

Changes in access to networks

When reviewing data to assess changes in access to networks, the following themes emerged:

- The roundtables and conferences have been an important catalyst for the creation of networks that have contributed to the development of a sector for Indigenous eye health care
- Its peers recognise IEH as an important facilitator of networks across the Indigenous eye health pathway
- IEH have been effective facilitators of networks at the regional level in some regions (

Roundtables and conferences have been an important catalyst for creation of networks that have contributed to the development of a sector for Indigenous eye health care

Stakeholders reported that the IEH roundtables and yearly conferences have been effective in creating multidisciplinary networks across the eye health sector and increasing collaboration across eye health care networks across the country.

By hosting those conferences and inviting key stakeholders in our state, being invited to participate and attend those conferences, that has paved the way for some really important networking with other stakeholders - so similar ACCHOs in other jurisdictions, as well as the College for Optometry and that's formed their own connections. So completely outside of us as fundholder, the IEH is facilitating these conferences and providing the information to our stakeholders has meant that some really good work has come about through that networking.

Jurisdictional fundholder

After the year that we've had, it's the only conference that I've heard people talking about really missing the opportunity to get together face to face with people; the information exchange of catching up with colleagues, particularly colleagues that are spread so far out across the country and working so hard in their day-to-day; bringing everyone together and the conversation with COVID and not being able to do it in March was all about not having, not having the dinner, not having the chance to catch up, not having the chance to see where everyone had grown and where the world had changed over 12 months and the idea of having to leave that for another 12 months before we got to check in again, on where some of those innovations have gone, who's got the next bright idea and what are they doing with it. That people missed it in a way that I haven't sort of seen talked about with other conferences that we would regularly go to.

Stakeholder working in eye health

IEH is recognised as being an important facilitator of networks across the Indigenous eye health pathway

Stakeholders reported that IEH is an active and effective facilitator of different stakeholders working across the Indigenous eye health pathway and providing opportunities for these actors to collaborate across a health pathway. Some stakeholders reported that the Roadmap has contributed to a unity of purpose and reduced a siloed eye health sector, and has advanced a shared advocacy agenda for Indigenous eye health.

At a national level, IEH staff sit on numerous boards, committees, and working groups on eye health and use the formal networks as opportunities to advocate for improvements for Indigenous eye health. At a state level, IEH has established (or participates in) state-level Indigenous eye health committees. At a regional level, IEH establishes (or facilitates the establishment of) regional groups to oversee the implementation of the Roadmap. IEH often works informally with a range of organisations at the national, state, and regional level, so whilst IEH is not always leading the facilitation of networks, they are often a vital background facilitator and connector across the Indigenous eye health pathway.

> *Without IEH having started that conversation, we would all be operating in our silos. Optometry would be talking about primary eye health care. The ophthalmologists would be talking about surgery. The Aboriginal medical services would be talking about bringing people in for the first screening. And instead, because of the work that IEH have done, we're all having those conversations regularly, multiple times throughout the year and altogether.*
>
> Stakeholder working in eye health

> *I think to me, the most important contribution that IEH has made is that they've created that notion that there needs to be broad stakeholder input into a well-coordinated and comprehensive plan to improve Aboriginal and Torres Strait Islander eye health. And they have put that on the map as an important advocacy issue.*
>
> Stakeholder working in eye health

> *More recently, my experience has been that collaboration at a national level has happened under the banner of Vision 2020 Australia and IEH is quite an important player in that, but they're not the people drawing it together. They are however, very instrumental in massaging and shaping things in the background as well as in the foreground.*
>
> Stakeholder working in eye health

IEH have been effective facilitators of networks at the regional level

The regional implementation of the Roadmap has been a key strategy to implement the recommendations of the Roadmap. Since 2013, 63 regional networks have been established in Australia, created to implement the Roadmap, covering 99% of the Indigenous population. Stakeholders working in the eye health sector reported that IEH has been effective advocates at the regional level. Regional stakeholders reported that IEH has been invaluable in providing background support in creating regional groups. They

act as informal connectors and provide tools and resources to facilitate regional collaboration. Stakeholders also remarked that where possible, the regional implementation team seek to facilitate the creation of regional groups rather than lead implementation.

> *They've been a great mediator in bringing people together and also being very impartial and being able to facilitate the need on a broader scale and bringing it into context of the regions that we're talking to, without any sort of bias. The other thing is that they've actually been very good at getting those participants to bring the information to the table, rather than being told. So, the resolution at the end is, well, this is our information, we can see now that it's lacking and we need to do something. Then we were able to collaborate on a solution. So, their facilitation, at a grass roots level, has been very, very effective*.
>
> Stakeholder working in eye health

IEH staff and some stakeholders also reported that collaboration and network at the regional level vary from region to region, with some regions are more connected than others. IEH staff reported that they are more involved in leading regional implementation in some regions and provide secretariat support. They expressed that this is not their preferred role but will undertake these functions to address gaps at the regional level.

In the regional implementation survey, 82% of respondents indicated that participation in local or regional stakeholder meetings was a key support in their role. 71% of survey respondents agreed with the following statement: '*as a result of the regional group/network activity, Aboriginal and Torres Strait Islander people are more easily able to access eye care'.*

> *I think the tools that they developed as part of the Roadmap, so those regional implementation tools, I think those were really effective because they provide really useful resources where people can actually take them away and use them the way that they need to.*
>
> Jurisdictional fundholder

Changes in access to resources

One of the key goals of the Roadmap was to contribute to changes in policy and therefore contribute to improvements in health delivery and increased funding for eye health services for Indigenous peoples. IEH utilises its status, networks, knowledge, and influence to advocate for policy changes. IEH understands that policy change involves long-term advocacy, mobilisation of stakeholders, and generation and dissemination of evidence.

IEH has been recognised as an effective advocate and effective in leading changes in policy and resourcing for delivering services to support Indigenous eye health. Their efforts have had far-reaching consequences for improving resourcing for delivering eye care services for Indigenous populations across the nation.

> *I have heard indirectly and directly through contacts, through the Commonwealth and other peak bodies, that the reason jurisdictions have this funding to support activities is directly as a result of the advocacy of Indigenous Eye Health Unit, and part of that Roadmap work.*
>
> Jurisdictional fundholder

Examples of policy changes that IEH has contributed to include:

- The National Eye Health Survey's establishment and funding to measure the status of eye health for Indigenous peoples. The first survey took place in 2009, and the following survey is expected to take place in 2021.
- Advocating for the expansion of funding for the Visiting Optometrist Scheme (VOS) that has increased access to Optometrists for Indigenous peoples.
- Advocating for expansion of funding for the Rural Health Outreach Fund (RHOF) which has led to the fund focusing on eye health as part of its suite of services.
- Facilitation of sector funding bids through Vision 2020 Australia, including funding for the National Subsidised Spectacles Scheme.
- Advocacy for Medicare Benefits Schedule (MBS) categorisation for bulk billing of testing for diabetic retinopathy.

Many of these policy changes have directly led to an increase in resourcing for the delivery of eye health services for Indigenous peoples.

The table below highlights a snapshot of further changes to funding for Indigenous eye health from 2015. We cannot provide commentary on the extent to which each funding below can be solely attributed to IEH advocacy. Still, we note the consensus among interview respondents that IEH advocacy has been a key reason for improved financing of Indigenous eye health at the federal government level over the past ten years.

Year	Funding item
2015	Commonwealth funding: • $4.6 million for eye health coordination over four years • Funding approved for annual data reporting as part of national oversight over three years • $1.6 million for Trachoma health promotion over two years
2016	Commonwealth funding: • $3.5 million for eye and ear surgery support initiatives over two years • $5.1 million for audit of eye health equipment, provision of equipment to screen for diabetic retinopathy and associated training • $0.3 million for other eye health equipment to NGOs • $33.8 million for Medicare item for retinal screening over four years • $2.52 million for IEH to continue activities to improve Indigenous eye health outcomes over three years
2017	Trachoma health promotion funding: • New cataract surgery initiatives • VOS funding 2017-2020 • Medical Outreach Indigenous Chronic Diseases Program (MOICDP) and Rural Health Outreach Fund (RHOF) 2017-2020 • Retinal camera and equipment rollout
2018	Commonwealth funding • $4 million to boost ophthalmology services through the MOICDP • $2.5 million for additional sites for camera and training rollout • $0.5 million for cataract surgery through Eye and Ear surgical support • $2 million to improve access to subsidised spectacles • $0.9 million for Indigenous Diabetes Eye Screening

2020	Commonwealth funding • $1.5 million to Vision 2020 Australia for the National Subsidised Spectacles Scheme • Eye care outreach funding for VOS, RHOF, and MOICDP secured for 2023-2024

The contribution of IEH to population-level changes

In this section, we provide a brief review of some known changes in the eye health of Indigenous peoples over the last decade. The findings below are taken from the *Indigenous eye health measures 2020* report published by the AIHW. More detailed data about the eye health of the Indigenous population can be found in the 2016 National Eye Health Survey. However, comparison data about changes in survey results over time will not be published until the new National Eye Health Survey is published in 2021-2022. Because we cannot access updated data from the National Eye Health Survey, we are limited in the extent to which we can make conclusions about population-level changes over time. Instead, we present high-level findings from the 2020 AIHW report that show improvements in the delivery of eye health services for Indigenous Australians:

- Between 2010-11 and 2018-19, the proportion of Indigenous Australians who had an eye health check as part of a health assessment increased from 11% to 30%.
- Among Indigenous Australians who had a diabetes test, the proportion of those screened for diabetic retinopathy rose from 31% in 2008-09 to 37% in 2018-19.
- The number of services provided under the Visiting Optometrists Scheme, which offers specialist eye health services to Indigenous Australians in rural and remote areas, more than tripled from 8,300 occasions of service in 2010-11 to 25,850 in 2018-19.

Stakeholder views regarding the contribution of IEH to these changes

Population-level changes are often the result of multiple organisations, stakeholders, and actors working towards a common goal. It is not straightforward to attribute change at a population level to one initiative or organisation. Despite this, there is a strong and consistent view among stakeholders that IEH has contributed to population-level changes for the following reasons:

- The influence of IEH at the national level has resulted influencing Federal Government to implement policy and funding that has led to improved and better-resourced delivery of eye health services for Indigenous peoples
- The Roadmap provided an evidence-based assessment of the state of eye health for Indigenous peoples and was a catalyst for coordinated action across the eye health pathway.
- The creation of networks through the national conference and the regional groups has created groups of people working collaboratively on addressing eye health in Indigenous populations.

Conclusions about the impact of IEH

Based on the analysis of the evaluation data collected and acknowledging the limitations of making evaluative statements about the impact (as outlined at the beginning of this section), the evaluation team makes the following assessment regarding the impact that IEH has had on the eye health of Indigenous peoples:

- IEH has created a range of technical products that contribute to an improved evidence-base around Indigenous eye health and have contributed to the establishment of a sector that has a shared vision and plan for improving Indigenous eye health
- IEH has supported regional health networks to assess the status of eye health for Indigenous peoples in the region, understand the gaps in their health pathways, and identify solutions to identified gaps. Where regional implementation has been successful, this has led to improved collaboration among health networks.
- IEH has supported the formal and informal sharing of information and evidence across the national, state, and regional levels and has been an effective facilitator of stakeholder groups spanning sector, discipline, and place. This has contributed to the creation of networks and collaborations that focus on improving access to Indigenous eye health services. This improved collaboration has occurred vertically (from national to regional) and horizontally (within and between regions).
- IEH has directly contributed to the facilitation of policy changes and increased funding at the Federal level, which has directly contributed to improvements in the way eye health services are delivered to Indigenous peoples and increasing the number of eye health services provided to Indigenous peoples.

4.1.2 KEQ 2 Effectiveness – how does IEH create change?

This section responds to KE2: *What does IEH do that contributes to change? What are the qualities and attributes that have contributed to IEH effectiveness? Is there anything different that IEH could have done to be more effective in its work?*

These findings are generated from interviews with a range of stakeholders representing primary health care, the eye health sector, Government stakeholders, NGOs, and representatives from Aboriginal Community Controlled Health Organisations and funders. The findings here reflect their views on the effectiveness and contributions of IEH to improving the eye health of Indigenous peoples.

Enablers of effectiveness

The following conditions enabled the effectiveness of IEH:

- **Commitment to using credible evidence.** The development of IEH was informed by highly credible evidence, most notably the National Indigenous Eye Health Survey published in 2009. This led to the Roadmap development, which underwent significant consultation across the nation and provided an evidence-based clear and accessible vision for improving eye health for Indigenous Australians. IEH has continued to publish credible evidence over the life of its intervention.
- **A multidisciplinary team who are skilled facilitators.** The IEH team is comprised of academics, health promotion practitioners, people who have skills in community engagement, and people with marketing and communications experience. Collectively, the team has skills that allow collaborations along different levels of the eye health pathway. The team collaborates with partners at the national level, works extensively with regional networks, and collaborates with grassroots communities in the Northern Territory.
- **Research translation led by skilled staff and supported by structures within the organisation.** Stakeholders reported that IEH are effective facilitators of information, translation of research, and their detailed knowledge of the sector to promote advocacy and facilitate tangible and practical improvements in eye health care for Indigenous peoples. The research translation skills of the staff are supported structurally by the tools to support the regional implementation.
- **A prominent leader.** Professor Hugh Taylor is a distinguished academic who is well-known in eye health and among influential leaders in Government and broader Australia. He is considered among stakeholders to be influential and well connected among stakeholders who have power and influence at the national level. His advocacy with Federal Government has facilitated support for Roadmap implementation and has effected changes in policy and funding that has increased resourcing for eye health care for Indigenous peoples.
- **Access to flexible funding.** IEH occupies a unique space at its home within the University of Melbourne. It receives resources from the university but does not have the same obligations as other units (e.g.. teaching, production of academic work). This has allowed IEH to remain committed to its long-term goals and engage in communication of research using non-academic formats. IEH

has also benefited from access to flexible funding from a range of philanthropic organizations over the years, which has allowed it to remain agile and pursue the long-term visions in the Roadmap.

- **A committed and assertive team.** Stakeholders reported this factor as both an enabler and a barrier to effectiveness. Overall, stakeholders said that IEH has been unwavering in their commitment to implementing the Roadmap and unwavering in its advocacy for implementation of the Roadmap recommendations. Stakeholders also noted that this unwavering commitment comes at the cost of listening to emergent inputs and opinions from stakeholders across the eye health pathway or accommodating differing perspectives

Effectiveness of the Roadmap to Close the Vision for Health

The Roadmap was released in 2012. The purpose of the Roadmap was to develop a model of eye care for Indigenous Australians for presentation to the Australian Government. The IEHU conducted ten focus groups with 81 Indigenous community members, 289 staff in field interviews at 21 sites, and 38 meetings with 75 people representing 56 stakeholder organisations to create the Roadmap. 86 people provided input at three stakeholder workshops. The Roadmap was intended to document barriers to delivery and enablers to access eye health services for Indigenous Australians. The Roadmap was intended to be used as a document to inform the development of policy and funding mechanisms that could reshape the delivery of eye health services for Indigenous Australians.

Stakeholders reported that the Roadmap has been an important and influential guiding document that has provided a consistent and cohesive vision connecting the eye health pathway across the federal and regional levels. The Roadmap is comprehensive, considering all the barriers and enablers to improving eye health for Indigenous people. The Roadmap introduced the concept that improving eye health requires multiple stakeholders working across multiple sectors in a coordinated manner. This vision has facilitated unity and purpose across a range of stakeholders working across the eye health pathway.

> *I think the achievement is that notion that we need a comprehensive and well-coordinated plan that we're all sort of working on together. So I think there's a lot else they've achieved. But to me that's probably the most significant.*
>
> Stakeholder working in eye health

> *My understanding is that a lot of the funding programs we administer have been brought about by the lobbying that's occurred as a result of the Roadmap, the policy Roadmap. In that the Indigenous Eye Health Unit have had in getting that Roadmap accepted by Federal Government, has resulted in resources being distributed to the states and territories to implement.*
>
> Stakeholder working in eye health

IEH has remained committed and unwavering in its commitment to implementing the Roadmap over time. Stakeholders held differing perspectives on the effectiveness of this unwavering commitment. Some stakeholders reported that this unwavering commitment to the implementation of the Roadmap ensures that stakeholders remain committed to long-term goals for improving eye health for Indigenous peoples. Stakeholders also noted that this unwavering commitment comes at the cost of listening to emergent inputs and opinions from stakeholders across the eye health pathway or accommodating differing perspectives. Other stakeholders reported that implementing a sector-wide vision is inevitably

going to lead to differences of opinion about the effectiveness of the Roadmap, so some disagreement is an expected output of the sector working together towards a common goal.

> *For the Roadmap they really looked at what's happening in the system and what needs to be done to make the system effective and spread that knowledge. And effectively what we have done as a sector is then argue about the detail. We argue about things like what does coordination mean on the ground, but we don't really disagree on the big messages of the Roadmap.*
>
> Stakeholder working in eye health

> *We came up with the solution, backed with the data and information, the National Roadmap, but then we didn't just present it to government and say, "This is the solution", and then disappear. The important part was we've then stuck around, which was a really powerful thing, because lots of organisations can come up with the solutions but then they just present them, and then that's it, whereas we're around to help and move things along, which I think is a unique situation, or relatively unique.*
>
> Staff member at Indigenous Eye Health

> *I think the whole strategy around it has been quite clever. So they've had this goal, they've identified the need, developing the Roadmap and those key policy positions was extremely useful. In the beginning there was a bit of rigidness. But I see the beauty in having that clear strategy, that clear goal, and applying this collective impact approach. Getting everyone behind this shared vision and purpose was extremely clever.*
>
> Stakeholder working in eye health

> *So what I've observed is that there is a Roadmap and there's a group of people whose goals are vested in that Roadmap being followed. Sometimes I have observed with other people – sometimes Aboriginal and Torres Strait Islander people - have a different perspective on the priorities, and may express those views but they don't fit in with what's in the Roadmap and so I've observed maybe less flexibility or adaptability or less listening. So there's no right or wrong, but at times I've thought maybe they should be listening. Particularly if they're* Aboriginal *and Torres Strait Islander people, actually what do they want? What do Aboriginal and Torres Strait Islander people think is important?*
>
> Stakeholder working in eye health

Stakeholders held differing perspectives on the extent to which the Roadmap was relevant or useful for stakeholders working in regions or communities. Some stakeholders reported that they perceived the Roadmap as a top-down document, more suited for national-level advocacy and policy development. Other stakeholders noted how the Roadmap has provided a flexible framework to support regional implementation.

> *The Roadmap is very top down and that's where I suppose we butt heads a little bit in that sense. We're probably more on the ground working with the Aboriginal health practitioners and nurses and stuff to try and make a change on the ground and make awareness for their community around eye health and then policy change comes in from IEH above.*
>
> Stakeholder working in eye health

The Roadmap hasn't stopped people innovating and trying to change things on the ground, but it's kind of given a strategic direction or platform for people to try and align those in a way that works towards the same goals.

Stakeholder working in eye health

Stakeholders expressed a desire for the Roadmap to be redeveloped to prioritise Indigenous ownership and promote greater community ownership over strategic directions and activities. Stakeholders reported that a desire for greater Indigenous ownership was one of the catalysts that led to the development of the Strong Eyes, Strong Communities document published by Vision 2020 Australia in 2019, which provides a five-year plan for improving Aboriginal and Torres Strait Islander eye health.

The political and cultural environment has also evolved since 2012, when the Roadmap was first developed. There is now a more substantial commitment among stakeholders to promoting Indigenous self-determination and ownership. Stakeholders want to see the Roadmap needs to be updated so that Indigenous peoples can have greater ownership and voice over matters that affect their lives.

There's now an opportunity before the end of the Roadmap to pause and to reconceptualise how it's been rolled out and to make sure that it's Aboriginal community led and I think that's really important to pause, to do that now because when this is all handed over, it's not going to be properly embedded or sustainable unless it is led by local community making their own decisions.

Stakeholder working in eye health

I am sympathetic to the case of the Indigenous Eye Health unit in that they had a document, a Roadmap that was agreed on and that the key people signed off on it. Over time things changed slightly, and we needed to be a bit more open to some different voices to perhaps review that journey. That is perhaps why the Strong Eyes, Strong Communities document ended up being developed. There was a view that the Roadmap needed to be updated essentially.

Stakeholder working in eye health

Effectiveness of collaboration at national and regional levels

IEH staff reported that they consider engagement and collaboration to be critical components of their work. The purpose of engagement is to reach out to services across the eye health pathway, provide information and evidence, generate interest, and then facilitate a connection between relevant stakeholders.

Without even getting into reforms and strategies there is just the benefit of collaborative work straight off the bat. Just the sharing of information and the getting to know each other. Services often find when they're sitting around the table with us that they are sitting next to a service that is up the road from them or a hospital or an ophthalmologist or whatever it might be. And may never have met them before. And there's that breaking down of those sorts of barriers straight up.

IEH staff member

I was also thinking about some of the various achievements on the national level over the last 10 years. A lot of them are born from collaboration and from advocacy, which is strong. It is all born out of collaboration. The structured collaboration is really at the core of our work.

IEH staff member

Stakeholders reported that IEH is effective in assessing and understanding what is happening across the eye health sector to coordinate their work across systems and networks. They are effective at bringing stakeholders together, ensuring that information about eye health information is available to stakeholders and developing and disseminating tools that could assist stakeholders in bridging gaps in the eye health pathway. Stakeholders reported that IEH works collaboratively and are consistently and actively engaged with actors across the sector.

At times when they've had an initiative that they want to roll out, they collaborate and come and chat about what that could look like and would it fit in with what we're doing. In my sense is that they try and work with the parties that are there, and it doesn't always work for everybody, but broadly they are there to try and work with the systems that are in place rather than replicating or duplicating.

Stakeholder working in eye health

Vision 2020 was also starting to bring together players at the same time that IEH were, but I think what IEH did was consult really broadly. And I know we're talking historically, but consulted really broadly to bring everybody's perspective or diverse stakeholders perspectives into developing a coordinated plan.

Stakeholder working in eye health

I'd say they are very highly effective and that has been the consistency. They've been able to bring about a lot of collaboration and assisted us in further collaboration because of the physical presence they've had here. They've not just been on the end of the phone or a meeting - they've come down fairly consistently pre-COVID face-to-face and travelled state-wide meeting with lots of different stakeholders and brought their expertise of even who to talk to. Because to be honest amongst ourselves as eye health stakeholders, we wouldn't have necessarily known that we wanted to get the Spectacle Assistant Scheme guys talking to the Aboriginal Eye Health sector to talk to the ophthalmologist to talk to Aboriginal Health workers. So they were really, really good in actually bringing stakeholders together - highly collaborative.

Jurisdictional fundholder

Effectiveness as advocates

This section describes stakeholder perspectives regarding the effectiveness of IEH's advocacy. We consider three aspects here. Firstly, we consider the effectiveness of IEH's advocacy at the regional level, then we consider the effectiveness of IEH's advocacy at the national level. Finally, we provide stakeholder perspectives on the overall effectiveness of IEH's advocacy efforts.

There are differing perspectives regarding the effectiveness and appropriateness of IEH's role at the regional level. At the regional level, stakeholders reported that IEH are effective and committed

facilitators. Stakeholders reported that IEH effectively engages with advocacy with regional communities and supports regional stakeholders to connect with actors across the pathway and spark conversations about improving the eye health pathway. Some regions engage in the regional implementation of the Roadmap independently after an initial period of support from the IEH regional implementation team. In some regions, the IEH regional team continues to support regional implementation, including providing secretariat support. Some stakeholders expressed that they would like the facilitation of advocacy at the regional level to be led by community and devolved to Aboriginal organisations and local communities. The regional implementation team at IEH supports the view that Indigenous organisations and their communities should lead regional implementation.

> *IEH are using data to influence and drive change and decision-making. I think that they've been very good with the whole regional coordinator thing, and I think that when you've got scarce funding and trying to make decisions and choices about where to put the funding, whether it's in regional coordinators or local coordinators - I know there were great lengthy discussions and debates around all of that, But I think what they've done really well is bringing people together at the regional level.*
>
> Jurisdictional fundholder

> *We have some funding through the Federal Government to do some collective work with community and we worked with members including IEH to decide on the priorities. But the priority was to actually ask community what it felt were the priorities for eye health and vision were, and create a community led priority setting process. That is being led by an ACCHO, who lead the community engagement, so we don't necessarily have IEH involved in work with community. Because my view is if it's community leadership it's not about us, it's about community and we need to actually step back to allow community to take it up as and when and how they want to rather than us telling them. So that's probably an example of where the model and the thinking is changing and the consequence for that is that IEH, like other members who are not in community, may not have the same level of direct involvement that they might've had in the past.*
>
> Stakeholder working in eye health

> *Some of my thinking is that it would be great to provide opportunities for communities to come up with their own resources and materials, to provide funding and support for them to take ownership and come up with a local approach to that. That kind of works well with the sustainability approach and us sort of moving back, trying to strengthen the capacity of communities to do that themselves.*
>
> IEH staff member

Stakeholders consistently reported the view that IEH is effective as advocates with national-level stakeholders. This happens formally through participation in committees and boards and informally through advocacy with peak bodies, NGOs, Federal Government, and politicians. Stakeholders reported that IEH was active and vocal advocates in these spaces.

> *IEH leadership sit on those committees and prosecute their case there as well. That's not to say that there's not lots of different opinions around that table, as to the right way to go about it. But what IEH do really successfully is make sure that the issue is being discussed and the conversations are being had.*
>
> Stakeholder working in eye health

Stakeholders consistently expressed that Professor Hugh Taylor's status with people of influence in the Federal Government and other national actors with power was a key driver of the effectiveness of IEH.

> *In terms of funding - most of that has happened at the national level. Hugh has been instrumental in that. He's not the only player in that game, but he certainly a key one and he's a voice that doesn't go away. And the department [Department of Health] knows Hugh very well.*
>
> IEH staff member

> *I'm thinking of the College of Ophthalmologists. I know how difficult it is to enact a change from within that space. One reform that did happen was because of the push of Hugh Taylor, who is also a member of the colleges. As an example, he pushed the college to have an official position around bulk billing to indigenous services.*
>
> IEH staff member

> *Well, I used to say that Hugh could open any door in Australia, that would be how I'd describe things. So if a minister, including the Prime Minister, got an email from Hugh, then attention would be paid to that. That's a unique position.*
>
> *IEH staff member*

Stakeholders have differing perspectives on the effectiveness of IEH as advocates; some stakeholders reported that IEH are determined and persistent advocates, which is effective at ensuring issues continue to be addressed. Other stakeholders reported that IEH leadership can be overly forthright and authoritative in their interactions. Some stakeholders reported that a more relational approach may be more effective at influencing stakeholders who interact with IEH (and consequently improve the effectiveness of IEH) and create a shared and collaborative agenda. Other stakeholders also noted the value of assertiveness as facilitators of change, meaning that sometimes tricky conversations are needed to effect change.

> *Some members of IEH leadership have a very strong personality and they do tend to dominate discussions, and some people have felt that that makes for a negative collaboration*.
>
> Stakeholder working in eye health

> *When I reflect on it, I actually think generally it's that kind of forthrightness that keeps progress happening and keeps movement happening and also helps bring some of the really difficult issues that otherwise we skate over. And I think a voice like IEH's can be incredibly useful in making people drill down into those issues and actually find a real resolution.*
>
> Stakeholder working in eye health

Effectiveness of disseminating knowledge across the eye health pathway

IEH has invested significant time, effort, and resources into creating and disseminating knowledge and evidence. Stakeholders reported that the promotion of research to support advocacy and improvements to eye health was one of the critical achievements of IEH.

Stakeholders reported that IEH are effective translators of information. Stakeholders reported that IEH staff effectively identify where to collect information from and where to disseminate information to. To do this, they require a detailed understanding of technical eye health matters, public policy, what is happening in Indigenous Health, and what is happening from the regional to the national levels. They also build relationships with the express purpose of collecting knowledge and then disseminating this knowledge to where it is needed.

Stakeholders reported that the regional implementation tools effectively support regional networks to create knowledge about the status Indigenous eye health in their region and that the tools also provide information about improving eye health pathways. Some of these findings about regional implementation are supported by survey findings from ARTD's regional implementation survey:

- 88% of stakeholders in regions across Australia have had opportunities to learn from each other.
- 85% of stakeholders reported that the regional groups are a good way to monitor programs for eye care goals and activities
- 67% of stakeholders reported that the activities of the group were regularly monitored
- 76% of stakeholders agreed that the regional groups are an effective way to collect and review local eye care data
- 71% of stakeholders agreed that regular monitoring of progress at a regional level was helpful
- 83% of stakeholders reported that support provided by IEHU is a key support in their role

Conclusions about the effectiveness of IEH

The following factors were identified as contributing to the effectiveness of IEH:

- IEH is led by a distinguished academic/practitioner in the eye health field who holds a significant amount of influence within academic settings, Federal Government settings, and the eye care field.
- From the inception of IEH, the unit has drawn on, facilitated, or generated credible evidence about the status of eye health for Indigenous Australians, and its activities are guided by credible evidence.
- In part because of the status of its leader and in part because of the credibility of the evidence, IEH has had the good fortune to have secure resources that have provided the initiative with the flexibility to commit to the implementation of long-term goals.
- IEH has focused not just on developing research to describe an issue but has also researched how to resolve an issue. Further to this, IEH has remained committed to implementing the identified solutions to the issue over time.
- IEH has built a team with skills in knowledge translation, community development, marketing and communications, Indigenous knowledge (and cultural knowledge), and eye health care pathways. This has facilitated effectiveness in building collaborations, engaging in effective research transfer, and being practical implementers to reach their goals.
- Many IEH staff are committed to advocating for change, understand that change sometimes involves discomfort, and are willing to engage with and address discomfort.

IEH currently experiences the following tensions, which can simultaneously act as barriers and/or enablers to effectiveness:

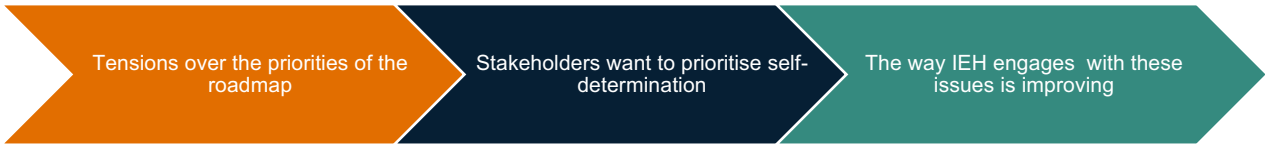
- The Roadmap was based on extensive consultation at one point in time to inform the development of the recommendations. IEH has not engaged in ongoing consultation to ensure that the Roadmap priorities are updated to respond to emergent cultural, social, and political changes.
- IEH staff are identified as effective collaborators and facilitators. At the same time, the unwavering commitment of some IEH staff for their mission results in stakeholders who express frustration with the communication style of some IEH staff.
- IEH enjoyed flexible funding to implement the Roadmap, but regions do not have access to equally flexible funds to support the regional implementation of the Roadmap.
- IEH experience the ongoing tension of intending to act as behind the scenes advocates. At the same time, some of the advocacy activities rely on IEH being front and centre as advocates. This goes beyond just having a prominent leader and speaks to the willingness of IEH to lead works when there are perceived to be gaps in systems, even when they acknowledge this is not their preference. IEH could benefit from further thinking about the implications of this tension and how it enables and hinders effectiveness.

Currently, the most significant challenge affecting the effectiveness of IEH involves how IEH will respond to the expressed desire of Indigenous stakeholders (and other non-Indigenous advocates) to have future priorities and activities for Indigenous eye health be determined by Indigenous communities and led by Indigenous organisations.

4.1.3 KEQ 3 Building Indigenous Leadership

This section responds to *KEQ 3: Building Indigenous Leadership. How has IEH promoted Indigenous leadership? What is the way forward for IEH and building Indigenous leadership into the future?*

The findings in this section were drawn from the perspectives of IEH staff, external stakeholders, and where appropriate, we have included survey findings from the ARTD survey.



This section covers three themes:

- Stakeholders identified tensions between IEH and Indigenous organisations when the priorities of Indigenous organisations do not align with the priorities of the Roadmap
- Stakeholders working across multiple sectors, both Indigenous and non-Indigenous, would like to see greater Indigenous self-determination over eye health policies and greater involvement from Indigenous communities over the implementation of eye health activities in community
- Stakeholders report that the way IEH engages with matters to do with Indigenous self-determination and Indigenous-led activities are improving.

Stakeholders identified tensions between IEH and Indigenous organisations when the priorities of Indigenous organisations do not align with the priorities of the Roadmap

Stakeholders reported that there were sometimes tensions between Indigenous services and IEH when the priorities of Indigenous services did not align with the Roadmap's priorities. Stakeholders reported that Indigenous organisations have limited resources and so sometimes prioritise investment into health issues that are determined to be more urgent and life-threatening. Stakeholders reported that sometimes the relationships between IEH and Indigenous organisations has become strained as a result.

> *There's been a strange relationship between some ACCHOs and IEHU and that's a little bit about the leadership having very different views about where investment should go, how things should be done, who gets to make decisions, and what the way forward is.*
>
> Stakeholder working in the eye health sector

> *The challenge is how, and this is how it's been spoken about in the sector for the last couple of years, how do you get the buy-in from the Aboriginal and Torres Strait Islander leadership and health and community into an issue that's not killing people when there are so many issues that are facing them that are.*
>
> Stakeholder working in the eye health sector

> *And so the struggle that we often have is that you are white led organizations prosecuting an issue that you want to keep pushing forward, even acknowledging that there are other*

things going on, but Aboriginal and Torres Strait Islander led organizations are saying, you have to wait because we're dealing with rheumatic heart disease or suicide or violence.

Stakeholder working in the eye health sector

Stakeholders want to see greater Indigenous self-determination over Indigenous eye health, including greater ownership over the Roadmap

Stakeholders consistently reported a desire for future work around Indigenous eye health to be Indigenous-led and implemented in line with the principles of self-determination.

Whilst the Roadmap was developed in consultation with Indigenous stakeholders, that consultation took place at one point in time. Consultation is not the same as leadership and ownership. Stakeholders expressed a desire for the Roadmap to be redeveloped to prioritise self-determination, Indigenous-led activities and greater community ownership over the implementation of the Roadmap.

Look, I think if we genuinely are committed to the principles of self-determination, what it means is that it's delivered in the future; however, it's Indigenous-led. That means that the investment into Aboriginal Torres Strait Islander eye health research should be Indigenous led and shaped, however that's done.

Stakeholder working in eye health

I think the logical consequence of the policy decisions that are being made now is that the non-Indigenous eye health and vision sector become expert advisors and technical supporters as required. And doing everything we can to build that capacity in community and allow self-determination to reach its true promise. It would involve building an Indigenous led and ideally Indigenous staffed organisation, and the steps that you take to get it there. But to achieve this there is a lot of deliberate action required.

Stakeholder working in eye health

Some stakeholders reported that there is now an opportunity for IEH to support and assist interested Indigenous peoples and organisations in establishing structures that could lead to an Indigenous-led entity that focuses on eye health for Indigenous peoples. Stakeholders expressed a desire to develop a sector-wide Indigenous-led reference group that can lead strategy and policy around Indigenous eye health. IEH recently established an Indigenous reference group to oversee the implementation of the regional implementation evaluation (conducted by ARTD). Some stakeholders saw the establishment of this group as an opportunity to begin to build an Indigenous-led group that could provide leadership in the Indigenous eye-health sector.

Some of us would like the reference group at IEH to evolve, and to expand and to take on that role within the eye health and vision care sector to provide advice and guidance across the sector. You know, become a resource for other organizations and all of their activities. We could formalize it, put structure around it. We have thought about this concept around what an Aboriginal community controlled organization within the eye health and vision care sector could look like.

Stakeholder working in the eye health sector

I think having a focus on maybe strengthening capacity of the sector, of the workforce and supporting Indigenous leadership or emerging leaders is a good way to maybe get to that end point. I really think that that's the key. It's building leadership in their community controlled health organizations.

Stakeholder working in the eye health sector

The Roadmap itself is fine I think, but it's recasting it within a different implementation strategy and refreshing it and having a team of Aboriginal people who are familiar with the space getting together and driving the redesign of the implementation, embedding that. So kind of going back and co-designing.

Stakeholder working in the eye health sector

Stakeholders reported that the way that IEH is addressing self-determination and promoting Indigenous-led activities is improving

Stakeholders reported that IEH is improving in the way they work with and engage with self-determination and promotion of Indigenous-led activities. Stakeholders reported that IEH advocates for Indigenous representation at formal events and ensure that Indigenous voices are present. The conference was also noted as being implemented in a culturally safe and appropriate way and held in partnership with Indigenous organisations.

IEH have been advocates for making sure that Aboriginal voice is included in every conversation. So in their round tables, in their workshops, in their conferences, they have made sure that Aboriginal and Torres Islander voices, Aboriginal and Torres Strait Islander perspectives are included, and that has become a really core piece of their work. And when we are sitting around a table, they are the first people to point out if we don't have that representation as part of the conversation, or if we need it, they hold us all very accountable for that.

Stakeholder working in eye health

I think that across the sector, in the last probably three years, there's been a really powerful shift towards recognition of the need self-determined responses to eyecare. And I think it really should be acknowledged that IEH have really come on that journey to the point that they are now key advocates for that. And I think that's been probably a bit of a shift in their perception, but it's, yeah, I think it should be commended.

Stakeholder working in eye health

Staff who work at IEH reported that the unit could improve the effectiveness of their activities by working on strategic approaches which focus on increasing Indigenous ownership and leadership of Indigenous eye health policy and advocacy. Examples offered by staff included focusing on strategies that promote workforce development to support Indigenous peoples and organisations to lead eye health advocacy and policy and redeveloping approaches to working with communities to focus on supporting Indigenous organisations to facilitate action on eye health. Some IEH staff also expressed a desire to recruit Indigenous staff who could concentrate on building Indigenous leadership in the eye health sector and strengthening relationships with Indigenous-led organisations. Some staff reported that there was a risk that the unit, as it currently operates, may not be a culturally safe space for Indigenous people, and so

some further work could be undertaken to strengthen the cultural safety of the unit. Staff expressed a desire for IEH to implement strong and effective mechanisms to support Indigenous governance in IEH.

> *I think Aboriginal community-controlled health organizations play a big role. I think having a focus on strengthening capacity of the Aboriginal health sector, of the workforce and supporting Indigenous leadership or emerging leaders is a good way to maybe get to that end point. I really think that that's the key. It's in their community controlled health organizations.*
>
> IEH staff member

> *What else can we do? Certainly build Indigenous leadership, share our work and strengthen as much as we can. Particularly around workforce development over the next few years, with various organizations to strengthen our relationship with them to maybe take some of the focus around eye health into their work and then get a better understanding of data and indicators, and how regions and community can work better with the data. I think that's been a challenge for a lot of regions, so we can try and work through that with them. That would be good.*
>
> IEH staff member

Conclusions about building Indigenous leadership

When considering IEH historically, IEH did not always meaningfully consider the evolving implications of being a non-Indigenous organisation working in an Indigenous space. It did not always meaningfully consider the difference between consultation, leadership. While there has been ongoing engagement and consultation with Indigenous organisations and people, this has not been at a deep enough level. It did not act on considerations that the Roadmap and its recommendations may have benefitted from ongoing consultation and redevelopment rather than being a static document informed by consultation at the point of development. In its early days, IEH did not substantively consider how to meaningfully contribute to building Indigenous leadership so that Indigenous peoples could control how eye health is delivered in their communities.

IEH acknowledges these historical shortcomings, and the IEH staff today engage in robust discussions regarding the future of IEH and what it can do to promote Indigenous leadership and self-determination over Indigenous eye health. There is strong internal will and desire to improve this aspect of the unit. Despite this, external stakeholders report ongoing tensions between IEH and Indigenous organisations when their priorities do not align. To guide these matters, IEH would benefit from strengthening the Indigenous governance of the unit.

There is a strong stakeholder will to promote Indigenous ownership over advocacy and policy endeavours that could improve Indigenous eye health and manage Indigenous eye health activities. Most stakeholders could not provide much in the way of clear insight or guidance as to how this should be facilitated or what it would look like.

Some stakeholders expressed a desire for the establishment of an Indigenous-led organisation that is community-controlled and which focuses on eye health. Any Indigenous person or organisation wishing to embark on such a project would do well to consider the lessons learned from the implementation of IEH and reflect upon the implications of these lessons when considering how such an Indigenous-led organisation might work. The lessons learned by IEH that future Indigenous leaders could consider include:

Advocacy

- Thinking about a blend of advocacy that includes visible and influential public advocacy combined with behind the scenes facilitation and support.
- Considering what type of policy and funding reform would be needed to resource Indigenous ownership and leadership over eye health properly, and what funding is required to support collaboration as opposed to just funding delivery of eye services
- The role and value of a prominent advocate when pursuing policy and funding reform

Funding

- Seeking funding that allows the organisation to exercise self-determination in how it runs and delivers activities

Staffing

- Recruitment of a multi-skilled team that can respond proactively across diverse environments
- Recruitment of staff who can sit in uncomfortable spaces and pursue advocacy in this discomfort

Building the credibility of Indigenous knowledge

- Developing a clear understanding of the Indigenous expertise within the organisation and how it contributes to effectiveness and advocating for the credibility of this Indigenous knowledge and its value with external stakeholders

Being intentional and strategic when working with allies

- Strategically drawing on non-Indigenous allies as needed to achieve goals

Engagement

- Engaging with Indigenous organisations as a mechanism for promoting Indigenous leadership as opposed to engagement being a mechanism for consultation or to purse a policy agenda

4.1.4 Sustainability

This section responds to KEQ 4: *Sustainability. If IEH were to cease work, what would be the enduring impact of its work?*

The vision of the IEHU is that it will cease its work once the Roadmap is implemented and embedded. The theory is that once the Roadmap and its recommendations are implemented, IEH will contribute to improving Indigenous eye health at a population level. The sustainability question wants to test this theory.

There are two aspects to take into account when considering the issue of sustainability of IEH. Firstly, were the recommendations in the Roadmap the proper recommendations that would lead to enduring change? Secondly, what are current stakeholder perspectives regarding creating sustainable change that would lead to enduring changes in Indigenous eye health?

Stakeholders reported that since the Roadmap was developed in 2012, there have been social and cultural changes in understanding how to create sustainable change for Indigenous communities. The sustainability of programs is now considered strongly linked to strategies that promote Indigenous leadership and self-determination. Consequently, many stakeholders reported a desire for the Roadmap and its recommendations to be redeveloped to promote Indigenous leadership and self-determination.

IEH expressed their interest in beginning to consider how the legacy of their work will be enduring once IEH finishes its work. From the staff's perspective, this involves identifying stakeholders who could continue the work of some of the activities of IEH once IEH ends. IEH staff identified the following matters for consideration when considering sustainability:

- Redevelopment of the Roadmap so that it emphasises Indigenous self-determination, leadership, and community ownership
- Dedicating time to investigate which people and organisations could continue the work of IEH, including reviewing how regional implementation could continue to be supported. Some IEH staff expressed that many regions will not sustain eye health activities once IEH no longer supports them.
- Supporting Indigenous peoples and organisations who wish to establish Indigenous-led groups that focus on eye health
- How supporting Indigenous-led eye health collaboration and coordination could be appropriately resourced and funded. This involves reconsidering what kind of funding is required to help Indigenous-led organisations to support and coordinate activities that improve accessibility to eye health care for Indigenous peoples in their communities.

Conclusions about sustainability

Stakeholder views on what could strengthen the sustainability of the outcomes of the Roadmap have changed since the Roadmap was first released in 2012.

Stakeholders expressed that the sustainability of the outcomes that IEH have contributed to are now directly linked to supporting the development of activities that promote Indigenous leadership and self-determination over eye health.

IEH has advocated for changes in policy and funding that led to changes in how eye health services were delivered to Indigenous peoples. When considering sustainability, both IEH and Indigenous organisations who might want to lead the future coordination of eye health activities for Indigenous populations should consider what kinds of funding mechanisms would promote Indigenous ownership over the delivery of eye health activities. What funding is needed to support and sustain Indigenous-led and owned collaboration of eye health activities in Indigenous communities?

4.2 Findings 2: assessing IEH as an intermediary

This evaluation was asked to investigate the extent to which IEH could be described as an intermediary, and if so, how and what this looked like. Outside of collective impact literature on backbones, there is no broad selection of literature on what intermediaries look like and how they should function.

This section provides a high-level analysis of the extent to which IEH can be identified as an intermediary that has contributed to a robust sector. To conduct this analysis, the evaluation team drew on the field catalyst model developed by Taz Hussein, Matt Plummer and Bill Breen.

We chose the field catalyst model as the framework for assessing the extent to which IEH acts as an intermediary because the evaluation team assessed that this model is the closest fit to the theory of change that Clear Horizon and the IEH team developed at the beginning of the evaluation. (We would like to note here that while the field catalyst model does not provide criteria for working in Indigenous fields, the IEH theory of change focuses on working with Indigenous stakeholders and contributing to self-determination, this is a distinct point of departure between the two models).

The authors of the Stanford Review article conceptualise intermediaries as a process that contribute towards an outcome: a robust field. Understanding the extent to which IEH successfully functions as an intermediary should include an analysis of the extent to which IEH has contributed to a robust field. To conduct this analysis, we chose the Bridgespan Group's five criteria for contributing to a robust field because these criteria were developed by the same organisation that developed the field catalyst model.

This section assesses the extent to which IEH conducts the same types of activities as field catalysts and assesses the extent to which IEH shares the same characteristics as field catalysts. We then consider the extent to which IEH has contributed to a robust field.

4.2.1 The extent to which IEH shares the same characteristics as a field catalyst

A field catalyst has four identified characteristics. In the table below, we outline the four characteristics and summarise the extent to which IEH shares these characteristics.

Focus on achieving population-level change, not simply scaling up an organisation or intervention	IEH shares this characteristic. The Roadmap, the key guiding document for the unit, has a focus on achieving population-level change. The overall aim of the document was to develop a model of eye care for Indigenous Australians. The research and consultation that informed the Roadmap identified key components in enhancing the care pathway for the provision of eye services for Indigenous peoples and was focused on generating policy changes to support these enhancements. IEH has remained committed to achieving the population-level changes as outlined in the Roadmap over time. It envisions collaboration and facilitation with other actors in the field as a key mechanism for implementing the Roadmap. The regional implementation was intended to support the implementation of the Roadmap recommendations (and therefore achieve population-level outcomes) through providing technical support to regional providers to implement the Roadmap. In practice, the regional implementation team has provided more support to regions to implement regional implementation than

	was anticipated. This is often due to a lack of human or financial resources to support regional implementation.
Concentrate on getting things done, not building consensus	IEH sometimes shares this characteristic. While the Roadmap was developed after significant consultation, stakeholders report that IEH has been strong and unwavering advocates for implementing the Roadmap and its recommendations, even when stakeholders have expressed a desire for alternative approaches and recommendations. Stakeholders reported that IEH has focused on the implementation of the Roadmap over and above building consensus. Some stakeholders reported that IEH sometimes focuses on the implementation of the Roadmap at the expense of listening to Indigenous voices, promoting Indigenous-led activities, or facilitating self-determination. Stakeholders reported that IEH leadership has a reputation for robustness and forthrightness. This sometimes results in an IEH that is effective at advocating for change regardless of the consensus. However, stakeholders also reported that IEH can be effective collaborators and facilitators and effectively build consensus.
Are built to win, not to last. The set to achieve change in a field, contribute to population-level goals, but they do not seek to become a feature of the field.	IEH shares this characteristic. The Roadmap was developed in 2012 with the intention of being finalised in the next five to ten years. The purpose of the Roadmap was to implement the recommendations, thereby contributing to population-level change and then close.
Influence the actions of others rather than acting directly themselves. They often prefer their work to go undetected.	IEH sometimes shares this characteristic. The stated goals of the IEH team are to focus on collaboration and facilitation, to focus on providing technical support and other support to stakeholders across the eye health pathway to facilitate implementation for stakeholders. IEH has a strong focus on collaboration at national, state, and regional levels, and they leverage networks, resources, and knowledge to influence and advocate. Stakeholders reported that IEH are effective behind the scenes facilitators. IEH is not always successful at avoiding direct action. Some of the advocacy work at the national level, especially with the Federal Government, has been implemented directly by IEH leadership, and this approach has been effective in contributing to policy and funding reform. Sometimes the regional implementation staff will take direct action in regions where support is needed.

4.2.2 The extent to which IEH can be described as a field catalyst

Field catalysts conduct three key sets of activities. Below we outline these activities and assess the extent to which IEH undertakes the same activities and approaches.

Collaboration, knowledge, advocacy	IEH undertakes these identified activities and approaches.

Help field meet evolving needs by filling key capability gaps. Span traditional organisational boundaries Conduct research, build public awareness, assess field strengths and weaknesses, advance policy, contribute to technical support to direct-service providers Collect, analyse, and share data	One of the activities of a field catalyst is to fill capability gaps. IEH fills capability gaps by disseminating research and knowledge across the eye health pathway that identifies the needs of the fields and the gaps. The regional implementation team has an implementation toolkit that focuses on assessing the eye health pathway in a given region so that the regions can identify gaps on work on solutions to address them. IEH does span traditional organisational boundaries. It is one of the few stakeholders of its type that focuses on one field and works at national, regional, and state levels. It also collaborates widely, at the national level, with peak bodies and the Government. At the state level with participation or facilitation of committees. And at the regional level to facilitate regional implementation. Stakeholders reported that they relied on IEH to be conduits of information across stakeholder groups and place. IEH has conducted extensive research. The most notable research examples are the National Eye Health Survey, the Roadmap, and the ongoing publication of technical reports. It also facilitates sharing of information among stakeholders. IEH facilitates information sharing informally through collaboration. Formally IEH shares information through regional implementation, roundtables, workshops, and the conference. IEH uses its extensive networks and knowledge to provide technical support. IEH relies on its research to advance policy. This is often effectively leveraged to achieve changes in policy and funding because of the relationship between IEH leadership and Federal Government. IEH uses networks and its position as an academic unit to be a repository of data. IEH publishes regular reports on eye health and updates on the Roadmap. It is currently a leading publisher and repository of online information on the subject of Indigenous eye health.
Funding Appeal to multiple funders. Secure multiple funding sources. Earn credibility and win enough trust the influence the fields other actors Steers funding streams without controlling them	As an organisation, IEH has facilitated relationships with its University partner and leveraged funding from philanthropic organisations that has allowed it to operate with a relatively unusual level of independence and flexibility. This will enable IEH to focus on its commitment to implementing the Roadmap and remaining committed to the achievement of population-level outcomes. Regarding leveraging funding for eye health for Indigenous peoples, IEH has been regarded as influential in securing key policy and funding reforms that have contributed to increased resources for eye health services for Indigenous peoples. IEH does not control these funds, they are facilitated by Government, who then direct them to services on the ground. IEH as a unit has earned credibility among the eye health pathway. Still, stakeholders report that IEH can be perceived as a controversial organisation due to the forthrightness of some staff, its unwavering commitment to the Roadmap, and the tension when IEH goals do not align with the goals of Indigenous organisations. (Noting here that being controversial does not necessarily make IEH uncredible.) There are tensions at times between IEH and Indigenous organisations when their priorities do not align.
Consult with many, but make decision within a small group.	This evaluation cannot make a judgement regarding the extent to which IEH undertakes these approaches but can report the following evidence:

Seek input from many but limit decision making to a comparative few.	• The Roadmap was the result of extensive consultation. Once it was developed, IEH remained committed to its implementation. Stakeholders report that IEH could benefit from continuing to consult about the Roadmap instead of treating it as a static document that does not require further consultation. • Stakeholders report that IEH are effective collaborators and facilitators. Stakeholders also report that IEH are perceived at times to be leveraging collaborations to pursue advocacy goals and agendas related to the Roadmap at the expense of achieving consensus. • Stakeholders reported a perception that the policy reform and funding reforms attributable to IEH were significantly influenced by the relationship of IEH leadership to the Federal Government. The implication here is that few people who hold much power made a significant contribution to creating policy and funding changes that have impacted and benefited resources for and access to eye care services for Indigenous peoples.

4.2.3 Assessing the contribution of IEH to a robust field

Below we share our assessment of the extent to which IEH has contributed to a robust field using the five criteria as defined by The Bridgewater Group, which conducted early research into intermediaries

A shared identity that is anchored in the field. Individuals and organisations identify as a field and have a shared vision of what the field is trying to accomplish. A shared identity can also assist in connecting organisations with diverse and distinct practices and goals.	Stakeholders reported that IEH has contributed to the development of a sector that focuses on Indigenous eye health. The Roadmap created a shared vision and set of goals for contributing to population-level change through improving access to services and contributing to a connected eye health pathway. The regional implementation of the Roadmap, where it is effective, has contributed to a more unified sector. Stakeholders also reported that the annual conference has contributed to the development of a sector. Stakeholders reported tension where Indigenous organisations and actors have goals that do not align with the goals of IEH. Stakeholders reported that the Roadmap should seek to be Indigenous-led and promote Indigenous ownership and self-determination.
Codified practices. These refer to established processes to ensure quality of implementation.	IEH has made a significant contribution to codified practices by developing the Roadmap, the Regional Implementation Toolkit, the Trachoma Story Kit, and the publication of numerous research and policy papers. Stakeholders corroborated that IEH has made significant contributions to eye health care by codifying strategies, goals, tools, and approaches.
A well-developed knowledge-base built on credible research and which is widely disseminated among the field. This informs the efficacy of practices in the field.	IEH has made a significant contribution to creating a credible knowledge-base to inform understanding about Indigenous eye health and research about how to improve eye health pathways. Key research conducted or facilitated by IEH were the National Eye Health Survey and the research and consultation that informed the Roadmap. IEH is led by a distinguished academic in a unit in a respected academic institution, which lends credibility to the research activities of IEH.

	IEH is also effective at research translation and in gathering information about eye health through collaboration and are effective disseminators of information.
Leadership and grassroots support that advances the field. A robust field has influential leaders and exemplary organisations working to advance the field. The field has a broad base of support.	Regional implementation is the key mechanism that connects IEH to grassroots support. Stakeholders report varying effectiveness of IEH engagement with grassroots actors from region to region. Stakeholders reported that IEH has had inconsistent relationships with ACCHOs – who are most the likely Indigenous health organisation to have grassroots connections in community. Stakeholders reported tension between IEH and ACCHOs when their goals do not align. Stakeholders report that IEH are well known and respected in the field and are influential. Stakeholders expressed a desire for advances in the eye health field to be Indigenous-led.
Sufficient funding and supportive policies. The field has sufficient funding to support it's goals and a supportive policy environment. The field is actively involved in improving the policy and funding environment.	IEH has been effective in pursuing changes in policy and funding reforms that have led to increased resources for the provision of eye health care for Indigenous Australians. Stakeholders unambiguously attribute these changes to the work of IEH and, in particular, the efforts of its leader. Future advocacy in policy and funding reform could focus on policy and funding mechanisms that support Indigenous organisations to facilitate community collaborations that focus on the community-led development of eye health pathways in their communities.

Conclusions: assessing IEH as an intermediary

This evaluation finds that IEH has contributed to Indigenous eye health across all five criteria of building a robust field. It has made significant contributions to creating a shared identity for a sector, codifying practices, creating a well-developed and credible knowledge-base, and identifying sufficient funding and supportive policies. It has effectively provided leadership and grassroots support, but this contribution is mitigated by tensions between IEH and some Indigenous organisations when their priorities do not align.

When using the field catalyst model as a framework for assessing the extent that the IEH could be considered an intermediary, this evaluation assesses that IEH essentially shares the same characteristics of a field catalyst and broadly undertakes the same types of activities:

- It focuses on achieving population-level change and works within existing health systems to do so, which enhances the sustainability of activities.
- It concentrates on getting things done, not on building consensus. The organisation does tend to consult widely but make decisions within a small group. Stakeholders reported differing views on the extent to which these field catalyst characteristics and actions enable or hinder changes in a field. When a non-Indigenous organisation is working across an Indigenous issue, consistent consensus-building with Indigenous stakeholders over time is something that a non-Indigenous organisation should be working towards.
- IEH was built to win, not to last. When working across Indigenous issues, field responders should consider contributing to building Indigenous leadership in the sector and fostering structures that support self-determination. So, the focus here for a non-Indigenous field responder in the Indigenous space should be 'supporting others to win *and* to last'.
- IEH does prefer to influence the actions of others rather than acting themselves directly. Still, it is recognised that the presence of a highly visible, respected, and influential non-Indigenous lead at the head of IEH has contributed to direct action, particularly concerning changes in funding and policy structures at a national level. Securing funding and influencing actors is a component of the field catalyst model. Still, in the case of IEH, these behind the scenes efforts come at the expense of Indigenous ownership and involvement in advocacy efforts.
- IEH does step in when work needs to be done, and this could be viewed as hindering local or Indigenous ownership over changes or as a valuable stopgap whilst the sector develops. The field responder model allows field responses to meet evolving needs by filling critical capability gaps, as IEH has done. But when working in the Indigenous space, filling capability gaps should happen strategically in tandem with strategies that promote self-determination and Indigenous leadership goals.

The following issues are barriers to assessing the extent to which IEH functions as an intermediary (and the effective functioning as an intermediary in this context):

- The scope of the work of IEH, the different ways the IEH team works in different environments and diverse places, and the multiskilled composition of the IEH team has resulted in diverse stakeholder perspectives as to the characteristics of IEH. This evaluation could identify stakeholder perspectives for and against IEH matching the criteria of a field catalyst across several constructs.
- Conducting an assessment of IEH as an intermediary and how effectively it has contributed to a robust field is complicated because IEH is a non-Indigenous organisation working in an Indigenous space. The field catalyst model is not calibrated to consider criteria to assess the extent to which the intermediary function contributes, or could contribute to, good practice in working with Indigenous peoples on Indigenous issues. It does not consider what a robust field would look like in the Indigenous context. The criteria do not address qualities such as Indigenous leadership, self-determination, truth-telling, reconciliation, cultural safety, cultural appropriateness and other measures that could arguably comprise an effective and robust field working together on Indigenous matters.

4.3 Findings 3: the IEH river

The theory of change for IEH is conceptualised as a metaphor of a river passing through a waterfall. The river has five parts:

1. **Upriver**. This is the source of the river. This shows how the water used to be before it came into contact with the waterfall.

2. **Water**. The water in the river represents all the stakeholder groups who interact with IEH to achieve outcomes or who are changed in some way by the activities of IEH. The water is driven by waves and currents, which are the guiding force of the river.

    a. **Currents**. The river has currents under the surface, which represent the values of different stakeholders. We don't always see or notice the currents, but they can be very powerful.
    b. **Waves**. On the surface of the water, we see waves. The waves represent what we know. The waves represent the knowledge of the stakeholders in the eye health sector. Waves are often shaped by currents that we can't see.

    The currents and waves can run in different or parallel directions, but they share a space in the same ecosystem.

3. **Waterfall**. In this metaphor, the waterfall represents IEH and what they do. When the water travels through the waterfall, the waves and currents get mixed up and change direction. This represents the merging of values and knowledge of different stakeholder groups.

4. **Standing waves.** At the bottom of the waterfall, turbulence is caused when currents and waves merge and change form. Standing waves happen when currents and waves that go in different directions now change direction and approach each other. This represents the direct impact that IEH has on Indigenous eye health and represents the merging and creating new of networks and collaborations. This can be turbulent, but it creates new energy.

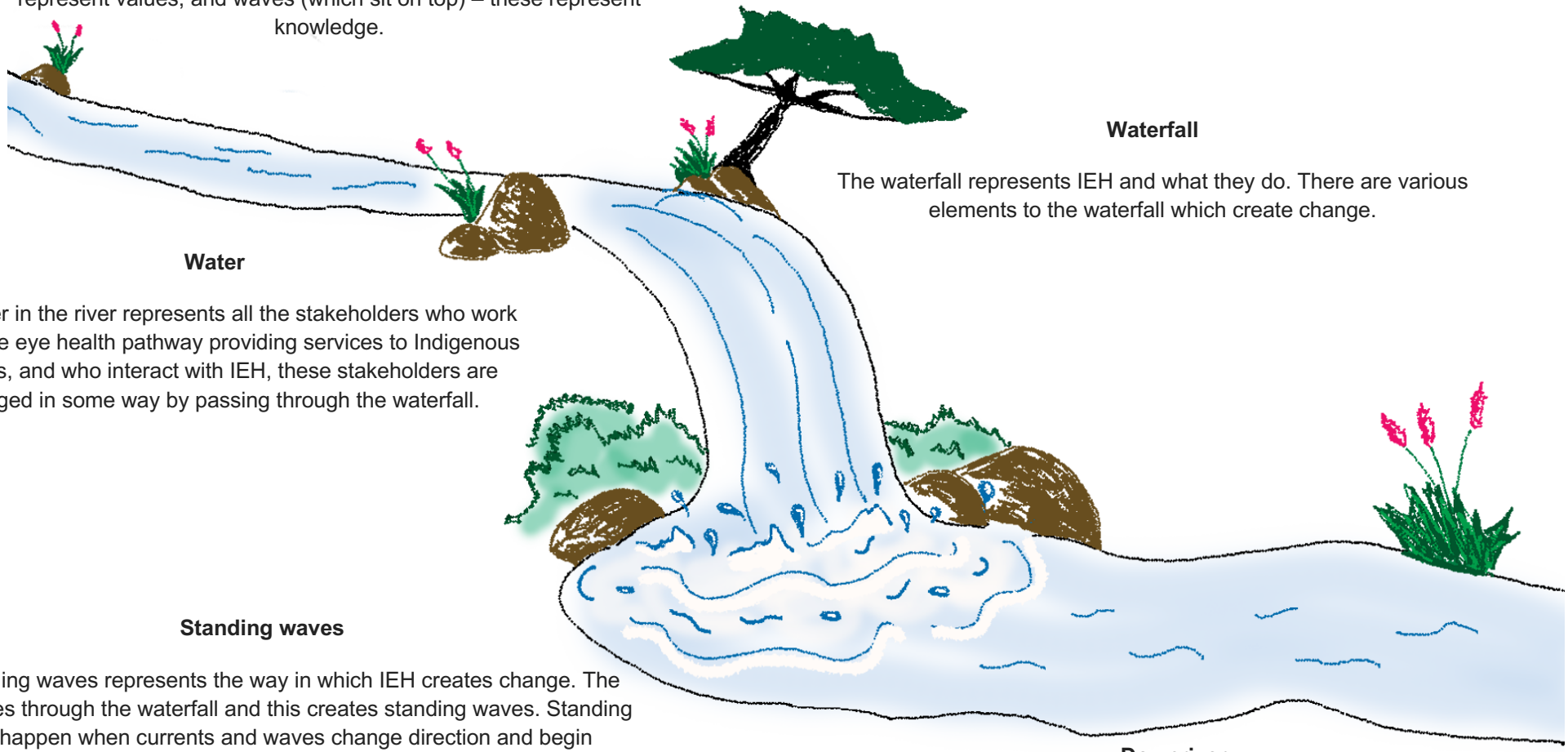
5. **Downriver**. This represents the ongoing ripple effect of the merging of the currents and waves.

    In this metaphor, the idea is that the impact of the waterfall has an impact on the direction of the water, forever altering its direction. It is easy to observe the changes in the currents and waves in the water at the site of the waterfall. As the water travels down the river, the waves and currents are forever changed, and the further you go downriver, the harder it is to observe the effect of the waterfall.

River of change

Upriver

This shows how the water used to be, before it came into contact with the waterfall. Water has currents (which sit underneath) - these represent values, and waves (which sit on top) – these represent knowledge.



Waterfall

The waterfall represents IEH and what they do. There are various elements to the waterfall which create change.

Water

The water in the river represents all the stakeholders who work across the eye health pathway providing services to Indigenous peoples, and who interact with IEH, these stakeholders are changed in some way by passing through the waterfall.

Standing waves

The standing waves represents the way in which IEH creates change. The water comes through the waterfall and this creates standing waves. Standing waves happen when currents and waves change direction and begin approaching each other. It can be turbulent, but new currents and waves are created. Standing waves create energy and can reinvigorate a river.

Downriver

The river downstream is affected by the currents and waves that are changed at the point of the waterfall. The water downriver is directly impacted by the standing waves, but the further you go down the river the harder it is to observe the impact of the waterfall.

Using the analogy of the river to make sense of impact

When making sense of impact, we considered how to present findings about impact in a way that helps us understand IEH contribution to the observed impacts. To assist us in this consideration, we drew upon our river/waterfall analogy to describe how change happens.

In the river analogy, the waterfall represents how IEH influences stakeholders and creates change. The water in the river represents different stakeholders in the eye health pathway. The water has waves and currents: waves represent the knowledge of various stakeholders, and the currents represent various stakeholders' values. When the water passes through the waterfall (which represents the actions of IEH), it merges and blends the waves and currents. This signifies changes in knowledge and values among stakeholders. The waterfall's new waves and currents represent how stakeholders' knowledge and values are changed by their interaction with IEH. The waves and currents then continue downstream and are forever altered by the waterfall.

The river as a metaphor for change

We can think about observing the impact of IEH for this evaluation the same way we think about following the impact of the waterfall on the waves and currents over time:

- The waterfall has very clearly impacted changes in the waves and currents that happen at the waterfall
- As you go further down the river, the less likely you are to understand how the waterfall reshaped the waves and currents in the river. Go even further down the river, and you may not even know about the waterfall – even though you feel its effects.

What was happening upriver

Upriver represented various stakeholders working across eye health, public health, Government, policymakers, Indigenous communities, and Indigenous organisations. All of these stakeholders were represented in the water by waves and currents. Some of the waves and currents of these stakeholder groups were stronger and more dominant than others. The direction of the water in the river tended to be dominated by certain types of waves and currents. Not all of the waves and currents had equal power over the direction of the water in the river.

IEH as waterfall and how it creates change

IEH is represented in this metaphor as a waterfall. The waterfall is the mechanism that causes the waves and currents in the river to blend and merge. The extent to which the waterfall can merge currents and waves depends on the strength of the waterfall. The stronger the waterfall, the greater the change in the waves and currents in the water. When the waterfall causes waves and currents to merge, it creates standing waves. These waves can be turbulent, and the stronger the waterfall, the greater the turbulence.

These are the findings we found about how the waterfall created change:

- the IEH waterfall successfully merged waves (which represent knowledge). By doing this, IEH distributed knowledge about improving eye health services across the body of water in the river.
- the IEH waterfall was not as successful at changing the direction of the currents in the water (which represent values), there was less sharing of values across the body of water

- the IEH waterfall was not strong enough to reduce how dominant some of the waves and currents in the river were. Waves and currents that were dominant upriver continued to be dominant after they went through the waterfall.
- despite not being strong enough to change the dominance of some waves and currents, the waterfall was successful in producing energy. This ensured that the water in the river did not go stagnant. The waterfall effectively kept the river flowing and generated new resources to keep the water going on its journey and create new life in the river.

Standing waves

Because of the energy created by the waterfall, it made standing waves, and these standing waves created some turbulence. This meant that some of the waves and currents experienced a period of turbulence, but this is to be expected when bodies of water are merging and changing. It looked turbulent, and whist the turbulence has affected the flow of water it has also allowed the water to continue its journey.(1)

Who should continue to care for the river?

Rivers are at their healthiest when they are well cared for by the people who live on the river and have the deepest and most profound connection to the river. People who have grown up on and near rivers have a deep understanding of the ecosystem around the river. They understand how to care for the river and how the ecosystem works to support river life. Rivers should be entrusted to those peoples who have the most profound understanding of how the river operates. (2)

(1) For example, the unwavering commitment of some IEH staff for their mission results in stakeholders who express frustration with the communication style of some IEH staff. Additionally, stakeholders are ambivalent about IEH dual role of being front and centre advocates whilst at the same time aiming to be effective behind the scenes facilitators and advocates

(2) This speaks to the need to focus on building Indigenous leadership and self-determination. Eye health care for Indigenous communities can be entrusted to Indigenous peoples who are supported by non-Indigenous allies.

5 Conclusions

5.1 Contributions to Indigenous eye health

IEH has made significant contributions to creating knowledge to support the Indigenous eye health field. It has significantly contributed to advances in knowledge about the status of the eye health of Indigenous Australians. It has significantly contributed to advances in knowledge that have codified standards and practices for improving the delivery of eye health services for Indigenous peoples.

IEH has made significant contributions to creating a multi-disciplinary and multi-sectoral consortium that focuses on eye health. IEH has supported the formal and informal sharing of information and evidence across the national, state, and regional levels and has been an effective facilitator of stakeholder groups spanning sector, discipline, and place. It has significantly contributed to the establishment of a vision that has unified a broad range of stakeholders. It has contributed to a shared understanding that improving access to eye health services involves collaboration with various stakeholders working across a health pathway. This has contributed to creating networks and collaborations that focus on improving access to Indigenous eye health services. This improved collaboration has occurred vertically (from national to regional) and horizontally (within and between regions).

IEH has directly contributed to the facilitation of changes in policy and the increasing of funding at the Federal level, which has directly contributed to improvements in the way eye health services are delivered to Indigenous peoples and increasing the number of eye health services provided to Indigenous peoples. Stakeholders attributed IEH's success in changing policy and funding to the actions of its leader, who is well-known and regarded among people working for the Federal Government at the highest levels.

5.2 The conditions that facilitated effectiveness

The presence of a well-regarded and distinguished leader led to opportunities that enabled supporting conditions to engage in long-term work. Working for a university, and receiving a large amount of philanthropic funding, has meant that IEH has been in the unique position of having an unusual amount of freedom in its operations. This allowed IEH to focus on the achievement of long-term goals and remain committed to the implementation of the Roadmap.

Stakeholders identified IEH as effective research to practice translators. IEH did not just focus on research; they focused on solutions and supporting stakeholders to participate in the identified solutions. The IEH has remained committed to facilitating the evidence-based implementation of activities. The multi-skilled and multi-disciplinary team that works in IEH, combined with relatively unrestrained resourcing, provided IEH with the opportunity to implement effective research translation practices.

IEH created a codified set of practices to support the regional implementation of the Roadmap. A skilled and collaborative team supported the regional implementation. The success of implementation varied from region to region. The regional implementation team would sometimes take up secretariat roles in regions, countering its philosophy of facilitating local stakeholders. The evaluation assesses that while the Roadmap was well funded, funding for much of the coordination activities required for regional implementation was not funded. This may have impacted the effectiveness of regional implementation.

Stakeholders consistently identified IEH as effective collaborators and facilitators. Stakeholders reported that IEH staff work effectively as behind-the-scenes facilitators. IEH uses these collaborations to gather and share information, connect stakeholders, and advocate for the Roadmap. Stakeholders reported that

many IEH staff are very well known in the eye health field. Stakeholders reported that IEH is very generous and collaborative. Stakeholders also reported that IEH leadership could be forthright and robust, which sometimes was at the expense of collaboration but also could be effective at advocating for change.

5.3 Engaging with Indigenous peoples

Stakeholders identified the Roadmap and its recommendations as a significant achievement of IEH. Stakeholders reported that the Roadmap was evidence-based, practical, and focused on solutions. The Roadmap was developed after substantial consultation across Australia. This consultation happened at one point in time, and the Roadmap may have benefitted from ongoing phases of consultation and redevelopment so that it remained relevant to the emerging priorities of Indigenous peoples.

Historically, IEH has not meaningfully engaged with the implications of being a non-Indigenous organisation working in an Indigenous space. It did not meaningfully consider how IEH could contribute to building Indigenous leadership and self-determination. IEH acknowledges these historical shortcomings and the IEH staff today engage in robust discussions regarding the future of IEH and what it can do to promote Indigenous leadership and self-determination over Indigenous eye health. There is strong internal will and desire to improve this aspect of the unit. Despite this, external stakeholders report ongoing tensions between IEH and Indigenous organisations when their priorities do not align. IEH would benefit from strengthening the Indigenous governance of the unit.

5.4 Future challenges

Currently, the most significant challenge affecting the future effectiveness and sustainability of IEH involves how IEH will respond to the expressed desire of Indigenous stakeholders (and other non-Indigenous advocates) to have the priorities for Indigenous eye health be determined by Indigenous communities and led by Indigenous organisations.

5.5 Building Indigenous leadership

There is strong stakeholder will to promote Indigenous ownership over advocacy and policy to improve Indigenous eye health and manage Indigenous eye health activities. Some stakeholders expressed a desire to establish an Indigenous-led organisation that is community-controlled and focuses on eye health. Despite expressing this wish, many stakeholders could not provide clear insight or guidance as to how this should be facilitated or what it would look like. Any Indigenous person or organisation wishing to embark on such a project would do well to consider the lessons learned from the implementation of IEH and determine the implications of these lessons when considering developing an Indigenous-led eye-health organisation and how it might work.

IEH has advocated for changes in policy and funding that led to changes in how eye health services were delivered to Indigenous peoples. Indigenous organisations who want to lead the coordination of eye health activities in the future should consider what kinds of funding mechanisms would be needed to promote Indigenous ownership over the delivery of eye health activities. What funding is required in order to support and sustain the Indigenous-led and owned coordination of eye health activities for Indigenous peoples in their communities?

5.6 Assessing IEH as an intermediary

This evaluation was asked to assess the extent to which IEH acted as an intermediary and the potential contribution of this function.

When using the field catalyst model as a framework for assessing the extent that the IEH could be considered an intermediary, this evaluation assesses that IEH largely shares the same characteristics of a field catalyst and broadly undertakes the same types of activities. This evaluation finds that IEH has made contributions to Indigenous eye health across all five criteria identified in the Bridgespan framework. It has made significant contributions to creating a shared identity for a sector, in codifying practices, creating a well-developed and credible knowledge-based, and identifying sufficient funding and supportive policies. It has effectively provided leadership and grassroots support, but this contribution is mitigated by tensions between IEH and some Indigenous organisations when their priorities do not align.

The scope of the work of IEH, the different ways the IEH team works in different environments and in diverse places, and the multiskilled composition of the IEH team has resulted in diverse stakeholder perspectives as to the characteristics and achievements of IEH. This evaluation could identify stakeholder perspectives for and against IEH fitting each of the criteria of a field catalyst or a robust field.

Conducting an assessment of IEH as an intermediary is complicated by the issue that IEH is a non-Indigenous organisation working in an Indigenous space. The field catalyst model and the robust field models are not calibrated to consider criteria to assess the extent to which the intermediary function contributes, or could contribute to, good practice in working with Indigenous peoples on Indigenous issues. Other criteria need to be considered, such as the extent to which the Intermediary facilitated Indigenous-led activities, Indigenous ownership, self-determination, and was culturally sensitive and appropriate.

6 References

Australian Institute of Family Studies. *Collective Impact: Evidence and Implications for Practice.* CFCA Paper No. 45 – November 2017.

Cabaj, Mark; Weaver, Liz. *Collective Impact 3.0. An Evolving Framework for Community Change*. Community Change Series 2016. Tamarack Institute.

Hussein, Taz; Plummer, Matt; Breen; Bill. *How Field Catalysts Galvanise Social Change.* Stanford Social Innovation Review. Winter 2018.

Preskill, Hallie; Parkhurst, Marcie; Splansky Juster, Jennifer. *Guide to Evaluating Collective Impact.* The FSG.

The Bridgespan Group. The Strong Field Framework. https://irvine-dot-org.s3.amazonaws.com/documents/64/attachments/strongfieldframework.pdf?1412656138 2009

Turner, Shiloh; Merchant, Kathy; Kania, John, and Martin, Ellen. *Understanding the Value of Backbone Organisations in Collective Impact.* Stanford Social Innovation Review.

7 Appendices

7.1 Appendix one: evidence tables

This section contains four evidence tables:

1. Evidence for rationale for program
2. Evidence about activities of IEH
3. Evidence against the key evaluation questions
4. Evidence to assess the effectiveness of IEH as an intermediary and assess its contribution to the Indigenous eye health field

Evidence table – background and rationale

Rationale
Rationale for Indigenous Eye Health Indigenous Eye Health Survey was published in 2009. The last national data came from the National Trachoma and Eye Health Program 1976-1980 when blindness rates were 10 times higher than mainstream. The 2009 survey determined the magnitude, distribution, and causes of vision loss in Aboriginal and Torres Strait Islander communities. Blindness rates were six times more than mainstream and low vision three times higher. The main causes of vision loss were cataract, refractive errors, diabetic eye disease and trachoma. 94% of vision loss is preventable or treatable but 35% of Indigenous Adults have never had an eye examination.[i] The National Indigenous Eye Health Survey showed that although Indigenous children have better vision than mainstream children, Indigenous Australians aged 40 and above have six times the rate of blindness compared to mainstream Australians. 94% of eye loss is preventable. High unmet need for eye care services among Indigenous Australians. Significant shortfall in provision of eye care services in remote Australia. Eye services are underutilised. Indigenous peoples in urban and rural areas have similar rates of vision loss to those in more remote areas, even when eye health services are available. Services need to be better coordinated and organised.[ii] **Current status of eye health for Indigenous Australians in 2017[iii]** Trachoma • Australia is the only high income country to still have trachoma. In 2015, of 233 communities identified to be at risk in 2008: 169 are trachoma free. 16 have a prevalence of 0-5%. 40 Communities still have trachoma. 24 communities have a prevalence of 5 to 20%. 16% of communities have a prevalence of greater than 20%. Cataract • The number of people with blindness from cataract has been reduced. The 2016 National Eye Health Survey shows that cataract remains the leading cause of blindness and surgery rates are still lower than non-Indigenous Australians. While rates of developing cataract are the same, in 2008 the risk of blindness was 12x that of the non-Indigenous population and the cataract surgery rate was 7x less than the national rate Diabetic retinopathy

- An irreversible cause of blindness. Yet, only 20% of Indigenous Australians with diabetes received screening in 2008. MBS item 12325 will start to bridge this gap by providing funding for local providers to perform eye examinations commencing November 2016. In addition, funding has been provided for screening equipment and training.

Refractive error

- Only 20% of Indigenous adult were wearing glasses for distance vision compared to 56% of non-Indigenous adults (2008). VOS funding has increased and a national subsidised spectacle scheme is being investigated. The subsidised spectacle scheme has provided over 7,000 spectacles since 2013.

Challenges to eye care:

- The referral pathway is currently a leaky pipe, meaning that it can be inefficient and that individuals may drop out of services
- Coordination and links between Aboriginal Health Services, clinics and hospitals could be better
- Referral for those found to have eye disease not prompt enough[iv]

The value of Indigenous sight. An economic analysis. Author: PWC (2015) [v]

- Intended to quantify the case for the Roadmap.
- In 2015-2016, the Australian, state and territory governments will spend approximately $40 million on Indigenous eye care. This is made up of: capped and uncapped costs to provide services to address cataract, refractive error, and diabetic retinopathy. Some coordination, governance, and evaluation costs. Funding for trachoma elimination and health promotion programs.
- PWC estimated that an addition $24 million was needed to further regional and national collaboration and coordination, improve care pathways and support, enhance data collection and monitoring, accountability, and oversight.
- Impact of two scenarios: the impact of current eye services and programs, and the impact of activities set out under the Roadmap.
- Benefits generated under each scenario:
    - Current eye care services and programs: $278 million.
    - Implementation of the Roadmap: $587 million.
    - Combined scenarios: $865 million
    - Conclusion is that the Roadmap will increase the overall economic benefit from investment in eye care for Indigenous Australians and increase the efficiency of eye care services and programs (generate more benefit for less cost)

- Currently, for every $1 spent on eye care the return to the Australian economy is 0.90. The implementation of the recommendations set out in the Roadmap is intended to address the challenges and barriers to effective and efficient eye care service provision and so is anticipated to provide a return on government investment of $2.50 for every additional $1 spent. Overall, the elimination of unnecessary vision loss will generate and estimated return of 1.60 for every $1 funding for eye care.
- The elimination of unnecessary vision loss for Indigenous Australians has the potential to generate close to $900 million in economic benefits for Australia over a 10-year period from 2015-2024, and a net benefit of $321 million.

History of activities to improve eye health for Indigenous peoples

Key activities along the Indigenous Eye health pathway since 1980[vi]

- 1975 Introduction of the Visiting Optometrist Scheme (VOS) to improve access to optometry services in rural and remote communities. [vii]
- 1970s and 1980s: National Trachoma and Eye Health Program recommended ongoing specialist visits to rural areas
- 1980s: Trachoma and Eye Health Report provided high level recommendations on resources, governance, and funding
- 1980s: National Trachoma and Eye Health Conference implemented a WHO grading system for trachoma
- 1980s: The National Aboriginal Health strategy recommendations included community control and participation and focus on public health integration of primary and specialist programs
- 1990s: 68 community-controlled AHS and 44 clinics set up with Commonwealth support through ATSIC
- 1990s: Indigenous Eye Health Review gave recommendations on models of eye care delivery
- 1990: creation of Regional Eye Health Co-Ordinator positions based in Aboriginal Health Services. In 2008, less than half the original 34 regions had a REHC and many staff work part-time and have insufficient time to fulfill their role. One role not enough to cover gaps in pathway of care.[viii]
- 1997 Major review of Indigenous Eye Health drew attention to continuing issues of unattended refractive error, cataract, diabetic retinopathy, and trachoma. Showed that blindness happened 10 times more frequently among Aboriginal and Torres Strait Islander groups.[ix]
- 1998: National Aboriginal and Torres Strait Islander Eye Health program set up to implement IEH review recommendations by increasing workforce capacity and infrastructure, establishing REHC positions, and providing ophthalmic equipment .[x]
- 2003: Review of the NATSIEH program recommendations included integrated delivery of eye program into primary care, global funding at ACCHS level, linking with mainstream providers
- 2005: The Australian Health Ministers Conference (AHMC) endorsed the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss – Aboriginal and Torres Strait Islander communities were not specifically identified in the framework.
- 2008: National Indigenous Eye Health Survey defined the size of the problem. The extent of existing eye services and remaining gaps were published in four documents, including Access to Eye Health Services Among Indigenous Australians.

Evidence table – description of IEH and what it does

Description of IEH and what it does
WHAT IS IEH IEHU established in 2008 under the leadership of Professor Hugh Taylor AC, Melbourne Laureate Professor and Harold Mitchell Chair of Indigenous Eye Health **ABOUT THE IEH TEAM - 2021**[xi] Maintains a culturally diverse, multi-disciplined and multi skilled team. From IEH staff: IEH maintains a culturally diverse, multi-disciplined and multi-skilled staff team. The breadth of skill and experience base allows consideration, planning and action to the complex challenges in Indigenous eye health. The team includes skills and experience in ophthalmology, optometry, nutrition, naturopathy, workforce policy, government relations, photography, community engagement, consultation, service and education, health promotion, politics, project management, health policy and communications. A clear and demonstrated strength of the team is the capacity to respectfully engage Aboriginal and Torres Strait Islander people and organisations and other stakeholders from across all of Australia and at all levels in the health system. Leader: [From the IEH staff] Professor Hugh Taylor has been involved in Indigenous eye health since the 1970s and is an internationally renowned leader in ophthalmology and public health. He has been the Harold Mitchell Professor of IEH at the Melbourne School of Population and Global Health since 2008. Professor Taylor's research interests include blindness prevention strategies, infectious causes of blindness and the development of health policy. He has extensive experience working with Indigenous leaders and organisations including for the 'Barriers to the provision and utilisation of eye health services for Indigenous Australians' project, which lead to the development of The Roadmap to Close the Gap for Vision, following comprehensive national engagement with stakeholders from Aboriginal health and the eye care sector. Professor Taylor has served on numerous national and international Boards and Advisory Councils including the Fred Hollows Foundation and Vision 2020 Australia and as an advisor to the WHO. Other staff: • Deputy Director and Associate Professor. Joined 2010. Optometrist, Academic and Public Health Practitioner with extensive experience working collaboratively across eye care and health sectors and leads a number of national advisory committees • Trachoma Community Engagement Officer. Joined. 2020. Aboriginal man located in Alice Springs with extensive experience in community engagement and consultation • Assistant to Hugh Taylor. Joined 2019 with 15 years' experience in tertiary education sector • Multimedia Administrator. Joined 2010. Supports implementation of health promotion activities. Has Diploma of Arts in applied photography. Maintains IEH and social network sites. • Academic Specialist in Indigenous Eye Health Policy. Joined in 2018. Obtained PhD – dissertation on the early history of the Aboriginal Community Controlled Health Services Movement in Australia.

- Translation research scholar. Joined 2010. Works with Government, ACCHOS, NGOS to develop engaging health promotion and multimedia strategies that are being used to support elimination of Trachoma in Australia. Masters Public Health.
- Trachoma Community Engagement Officer. Joined 2019. Located in Northern Territory. Experience in community health and health promotion.
- Research Fellow. Joined 2017. Supports regional implementation of the Roadmap. 15 years' experience working in health and primary health care project management. PhD examining complexities of Indigenous identity politics.
- Senior Research Fellow. Joined 2016. Currently completing PhD. Supporting regional implementation of Roadmap. Background in rural health workforce policy.
- Senior Research Fellow. Joined 2009. Deputy Director. Leads trachoma elimination. Experience working in health sector.
- Academic Specialist : Indigenous Eye Health Leadership. Joined 2021. Aboriginal man. Background as Aboriginal Health Worker. Extensive experience in primary health care and passion for eye health services in Indigenous communities.
- Marketing and Communications officer. Joined 2018. Aboriginal man. Engaging stakeholders with a particular focus on trachoma.
- Translation Research Scholar – Health Promotion. Joined 2014. Leads diabetes eye care work. Supports regional implementation. 15 years experience working in health program management and evaluation.

KEY ACTIVITIES OF IEH[xii]

Roadmap to close the gap for vision

The Roadmap to Close the Gap for Vision was released in 2012 and comprises 42 interlocked recommendations to improve Indigenous eye health over nine domains of specific activity. This identified barriers to accessing care. 42 recommendations. Informed by 10 focus groups with 81 Indigenous community members, 289 staff in field interviews across 21 sites. 86 people provided input through three stakeholder workshops. 38 meetings with 75 people representing 56 stakeholder organisations.

Overall aim of the document was to develop a model of eye care for Indigenous Australians for presentation to the Australian Government. The project objectives included the identification of the specific limitations and restrictions of the current funding mechanisms that support visiting eye care services to remote areas, the identification of batters to access for Aboriginal and Torres Strait Islander people to existing eye care services in urban and rural areas and ways to overcome them. The Roadmap identified key components in enhancing the pathway of care for provision of eye services throughout Aboriginal Health Services, identification of economic implications of proposed policy changes.[xiii]

Some key research findings from Roadmap consultation:

- A number of primary health care staff had poor knowledge of eye conditions and providers
- Poor understanding among primary health care staff about referral pathways and linkages with providers. Delivery of services in primary eye health care appears to be inefficient.
- Aboriginal Health Workers are interested in eye health care but did not know where to get information. Could benefit from additional training in understanding eye health and eye health pathways.
- Majority of eye health guidelines were disease specific and treatment focused and did not focus on pathway of care.

- Eye care should be an essential component of primary eye care. Primary care is a coordinated system of services and not just the provision of specialist medical services.
- Primary health services require appropriate equipment such as retinal cameras, portable lasers. Very little use of technology in primary care.
- Mainstream providers do not understand the barriers for Indigenous peoples in accessing services.
- Indigenous peoples are reluctant to use services that are not perceived as being culturally safe.

Purpose of Roadmap

Program logic developed at time of the Roadmap had following theory:

Changes for Indigenous groups

- Improve awareness of eye health and eye health services
- Change attitudes: see eye health as a priority
- Have increased access to services
- Overcome barriers to services
- Access services
- Follow advice of service system

Changes for eye health pathway

- Improved commitment to eye health for Indigenous Australians
- Improved promotion of services
- Capacity building for individuals
- Services are available, accessible, accommodating, affordable, and culturally sensitive
- Service system is sustainable, monitored, and evaluated
- Service system is efficient and responsive and well staffed
- Improved coordination of services

Nine broad domains of recommendations[xiv]

- Primary Eye Care as Part of Comprehensive Primary Health Care. To improve identification and referral for eye care needs from primary care.
- Indigenous access to Eye Health Services. To enhance access to Aboriginal and mainstream eye services.
- Co-ordination: improve co-ordination of eye care services and the successful navigation of referral pathways.
- Eye Health Workforce: To increase availability and improve distribution of eye health workforce.
- Elimination of trachoma, To eliminate blinding trachoma from Australia.
- Monitoring and evaluation. To capture and report information about progress and improvement of services and outcomes in Indigenous eye health.
- Governance. To ensure that there is oversight for the national delivery of Close the Gap for Vision
- Health promotion and awareness. To improve awareness and knowledge of eye health in communities to support self-empowerment.

- Health financing: to ensure adequate funding is allocated to Close the Gap for vision.

Four key 2020 goals of Roadmap[xv]

- Elimination of Trachoma
- Cataract: sight restoration for 4000 Indigenous Australians with cataract each year
- Diabetic retinopathy: blindness prevention in 23,000 Indigenous Australians with diabetic retinopathy each year
- Refractive error: sight enablement for 42500 Indigenous Australians each year by giving them glasses

Regional implementation of the Roadmap.
Establish regional collaborative network of stakeholders. IEH provides a template for coordination and integration of health care for other conditions to meet population-based need including: local planning and coordination of visiting specialists. Integration of primary care and secondar specialist care. Identify and support regional project officers to facilitate regional planning and reporting, undertake needs analysis comparing current eye care services with population-based needs. Eye care support workforce needs identifies to set up support staff roles. Need for additional visiting eye care providers identified and funded through RHOF and VOS. Identify patient support roles required to support the patient through the pathway of care. Support chronic disease coordinators to coordinate surgery and management of those with diabetes. Develop regional service directory and referral protocols. Introduce regional health promotion and awareness. Establish regional data collection and monitoring systems. Ensure local accountability and oversight.[xvi]

Publications that support regional implementation include:

- **Asking the question:** a Toblerone shaped desktop resource and information sheet that aims to highlight ways to improve eye care service delivery in mainstream practices and clinics with appropriate identification of Aboriginal and Torres Strait Islander status. The need to bring light to this issue has been raised by many regions across Australia working under the guidance of the Roadmap to Close the Gap for Vision.[xvii]
- **Regional implementation Toolkit.** [xviii]This kit provides a range of resources to assist communities and services to calculate, plan, and monitor improved eye health outcomes for regional area throughout Australia. Includes a 'how to' guide, a regional implementation checklist, regional implementation equipment checklist, service directory template, regional hospital checklist, referral pathway template, regional implementation data template. It also provides an **eye care services calculator** that estimate the eye health delivery needs of a region based on the population of Aboriginal and Torres Strait Islander people in a given region.

Trachoma Story Kit.

In 2010, IEH developed The Trachoma Story Kit resource to support community health promotion and social marketing for the elimination of trachoma and provides ongoing technical support in the trachoma programs across the country. A key feature of the kit is Milpa the Goanna, who is a mascot for healthy eyes and good health across the Northern Territory. IEH does not hold IP over Milpa and other organisations can use this resource.

Check Today See Tomorrow.

In 2015, the IEH launched the 'Check Today, See tomorrow' resources to raise the awareness of diabetes-related eye health and promote Aboriginal and Torres Strait Islander people with diabetes to get annual eye checks to reduce their risk of vision loss. Up to 98% of blindness from diabetes is preventable with early detection and treatment.
Resources. A resource kit with 50 diabetes eye care brochures, 1 diabetes flip chart. 2 community posters. 1 x MBS item eye check card. Also offer multimedia and social media resources. [xix]

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)

Pursue policy goals

Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[xx]
Collects and disseminates evidence. State and national health outcomes and process indicators adopted and reported. Advocating to establish diabetic eye screening rates as a key performance indicator for Primary Health Networks.[xxi]

Development of resources about eye health

Resources

Annual Roadmap updates

IEH produces annual updates on the implementation of the Roadmap to high progress on regional implementation. Since 2011, IEH has produced nine annual updates (the most recent was published for 2020). These updates illustrate context, track process and health indicators, and track extent of implementation of the recommendations.

Technical publications produced by IEH[xxii]

2009 reports:

- Diabetic retinopathy, accuracy of screening methods
- Outreach eye services in Australia
- National Indigenous Eye Health Survey

2010

- Trachoma Antibiotic Treatments: A Systematic Review
- Access to Eye Health Services Among Indigenous Australians
- Provision of Indigenous Eye Health services

2011

- The Cost to Close the Gap for Vision
- A Critical History of Indigenous Eye Health Policy-Making
- Projected Needs for Eye Care Services for Indigenous Australians

2013
- Software Roundtable Report

2014
- Health promotion roundtable report
- Regional Implementation Roundtable Report

2015
- National Diabetes Eye Care Health Promotion Workshop Report

2016
- Fundholder forum report
- Non Mydriatic Retinal Photography Roundtable Report
- Planning Sustainable and Coordinated Indigenous Eye Health Services Roundtable Report

2018
- Jurisdictional snapshots were published for each state and territory. These snapshots provide information on provision of eye services, and information about primary health care networks.[xxiii]

2020
- Victorian Aboriginal Eye Health Regional Stakeholder Forum Report

Position papers prepared by IEH[xxiv]
- Fundholders and Outreach Funding
- ACCHOs and Good Eye Care Services
- PHNs and Indigenous Eye Care
- National Oversight
- National Leadership
- Role for Jurisdictions
- Mandatory MBS 715
- Cataract Monitoring
- Clinical Practice Software
- Indicators
- Sector Linkage
- Education and Trachoma
- Training, workshops, and events

Development of training resources

Training resources[xxv]

Self-directed online learning courses
- Remote Area Health Corps: Trachoma Module

- Remote Area Health Corps – Trichiasis
- Remote Area Health Corps – Eye Health and Diabetes
- Trachoma Grading Self-Directed Learning
- Diabetic Retinopathy Screening Card
- Diabetic Retinopathy Grading Course

Convening of roundtables and workshops

Roundtables and workshops convened by IEH[xxvi]

- 2013 - Software Roundtable
- 2014 – Health Promotion Roundtable
- 2014 – Regional Implementation Report
- 2015 – National Diabetes Eye Care Health Promotion Workshop
- 2016 – Non Mydriatic Retinal Photography Roundtable
- 2016 – Fundholder Forum
- 2020 – Victorian Aboriginal Eye Health Regional Stakeholder Forum

Collaboration with partners

Endorsed by NACCHO, Optometry Australia, RANZCO, Vision 2020. Collaboration with Australian College of Rural and Remote Medicine, Brien Holden Vision Institute, cbm, Crana Plus, Diabetes Australia, The Fred Hollows Foundation, Royal Australian College of General Practitioners.

- Participate Vision 2020 Australia
- Chair the Optometry Australia Aboriginal and Torres Strait Islander Eye Health Advisory Group
- Chair the OCANZ Indigenous Strategy Taskforce
- Sit on following project committees: National Subsidised Spectacles Scheme, National Eye Care Equipment Inventory, and Strong Eyes, Strong Communities implementation projects

History of funding for IEH [xxvii]

2008

- Harvard Mitchel
- Ian Potter
- Cybec
- CBM

2013

- 16.4 million from federal Government for Trachoma
- Gandal Foundation
- Q Elizabeth Diamond Jubilee Funds
- Anne Miller

2014
- DOH grant for Roadmap 2014-2016

2015
- DOH grant for trachoma 2015-2017

2016
- DOH grant for Trachoma 2016-2019

2017
- DOH grant for Trachoma 2017-2021
- Paul Ramsay Funding 2017 – 2021
- Minderoo Funding 2017 - 2021

2019
- DOH Grant for Trachoma 2019-2023

Evidence table – key evaluation questions

Impact
Changes in knowledge *Staff notes* Mainstream services are demonstrating increased awareness of how to deliver services for Indigenous populations. (S2, S3) Example: improved cultural curriculum in optometry and orthoptics colleges. Example: IEH facilitating development of RAPs with some national eye health actors. More people working at primary health care level have better knowledge of how to operate cameras as a result of changes in MBS. (S3) Regional implementation has improved community knowledge in how to access eye health services. Often through sharing information at community events, (S3) *External stakeholders* Improved knowledge and understanding of the eye health status of Indigenous Australians. (E1EH) A lot of communities don't yet have the capacity to be able to apply and implement the Roadmap. (E5EH) Greater number of actors have access to eye health that is tailored and accessible. (E5EH) Increased understanding of gaps in service delivery (E7JF) Raising awareness on the state of eye health for Indigenous Australians. (E3EH) Improved awareness of how to improve eye health issues for Indigenous Australians. (E5EH) *Impact of the Trachoma Health Promotion Program*[xxviii] • Few people appear to understand that trachoma is a transmittable disease, with many believing it is attributed to bush living conditions. • 77 out or 133 participants indicated that they face no obstacles to keeping their face clean. 45 participants reported barriers including: no running water or no hot water. **Changes in networks** Conference has provided opportunities for people to connect. (S1) Regional implementation creating or influencing collaboration across eye health care networks. (S3) Roadmap has contributed to creating unity of purpose and a less siloed sector. (S3) **Changes in policy** Was the intention of IEH that the Roadmap would lead to changes in policy and structures. (S2). This was the reason for the long-term approach of the Roadmap, with its emphasis on advocacy and technical support. (S2). Want to be advocates for policy change rather than doing work ourselves. (S2) Having strong relationship with Government has been key in leveraging policy change. (S2) This is attributable to status of Leader. (S2)

Broadly considered by external stakeholders to be instrumental in putting forward an advocacy agenda for Indigenous Eye Health. (E2EH) (E4JF)

Changes in resources
Service reforms at regional level as a result of regional implementation have lead to improved access to eye health care services for the Aboriginal community. Attributed to identifying and addressing gaps in service pathway. (S3)
Changes in funding at national level have lead to improved access to eye checks, camera checks, cataract identification/support,. (S3, S5) (E5EH)

Funding changes that can be attributed to the advocacy efforts of IEH:[xxix]

2015	Commonwealth funding: • $4.6 million for eye health coordination over four years • Funding approved for annual data reporting as part of national oversight over three years • $1.6 million for Trachoma health promotion over two years
2016	Commonwealth funding: • $3.5 million for eye and ear surgery support initiatives over two years • $5.1 million for audit of eye health equipment, provision of equipment to screen for diabetic retinopathy and associated training • $0.3 million for other eye health equipment to NGOs • $33.8 million for Medicare item for retinal screening over four years • $2.52 million for IEH to continue activities to improve Indigenous eye health outcomes over three years
2017	Trachoma health promotion funding: • New cataract surgery initiatives • VOS funding 2017-2020 • Medical Outreach Indigenous Chronic Diseases Program (MOICDP) and Rural Health Outreach Fund (RHOF) 2017-2020 • Retinal camera and equipment rollout
2018	Commonwealth funding • $4 million to boost ophthalmology services through the MOICDP • $2.5 million for additional sites for camera and training rollout • $0.5 million for cataract surgery through Eye and Ear surgical support • $2 million to improve access to subsidised spectacles

	• $0.9 million for Indigenous Diabetes Eye Screening
2020	Commonwealth funding • $1.5 million to Vision 2020 for the National Subsidised Spectacles Scheme • Eye care outreach funding for VOS, RHOF, and MOICDP secured for 2023-2024

Stakeholders reported that key achievement of IEHU has been in securing funding. (E1EH) (E4JF) (E5EH)
Regions have greater access to resources to improve eye health care pathways.
Stakeholders reported using the Roadmap as a resource in their work. (E4JF)
The changes in funding have led to increased delivery of services at ACCHOS (E4JF)
Some regions have struggled with additional resources: cameras are hard to get to remote areas. GPs need to sign off screenings and are not always available in remote areas. (E6Jf) (E9EH)
Issue with targeted funding, it doesn't allow for adaptation on ground if it is closely tied to body parts, so it may meet national priority but not community priority. (E7JF)

ARTD survey: [xxx]
69% of stakeholders agreed that Aboriginal and Torres Strait Islander people can more easily access eye care

Key reforms:[xxxi]

- Visiting Optometrist Scheme (VOS)
- Rural Health Outreach Fund (RHOF)
- Sector funding bids through Vision 2020 Australia
- MBS categorisation
- National Eye Health Survey (2009)

Population-level impacts
IEH staff report that Indigenous people report that they continue not to access services as they don't find services culturally safe. (S3)

Population level impacts - 2017[xxxii]
The rate of blindness in Indigenous Australians has gone from 6x (2008) to 3x (2016 the rate seen in non-Indigenous Australians)
The prevalence of trachoma in Indigenous children has gone from 21% (2008) to 4.6% (2015) after implement of WHO'S SAFE Strategy

Effectiveness

Freedom and flexibility
Staff notes

IEH has had access to independent funding, philanthropic private funding. University has been very flexible. Has allowed IEH to be flexible, innovative, and adaptive. (S2)
IEH team has breadth and experience. Means team is flexible and open, multi skilled and can make multiple contributions. (S2)

External stakeholders
External stakeholders also commented on IEHUs unique position of independence and agility (E2EH)
Being part of a university gives them credibility and influence (E8EH)

Example of benefit of flexibility from staff member working on Trachoma team:
I think sometimes we're the ones with a bit like a scissor where we can cut through some of the red tape and not get caught up in that. The university's in a unique position where we're not government, we're not restricted. We can actually go in and clear the way for different things that need to happen in terms of health promotion. An example is with our food stores, we put submission into the senate inquiry into food pricing and security, and now that's opened the door really where our stores are coming to us and wanting to see what we can do with them in partnership to fix things in remote community stores and promote hygienic products. So I think the university's in a unique position where we can actually get through some of that red tape and bring people together and find solutions S4

Setting a strategic vision
Staff notes
IEH invested significant time and effort in development of the Roadmap. Significant consultation and review of data and evidence and review of population-level data. Invested significant time in getting buy-in and codesigning solutions. This formative work was done in 2008. (S2)
IEH have remained committed to the implementation of the Roadmap over time. (S2)

External stakeholders
External stakeholders recognise the amount of consultation that went into the Roadmap. (E1EH)
External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)
Perception from external stakeholders that the Strong Eyes Strong Communities document is a response to the Roadmap not adapting to the needs of Indigenous communities. (E1EH) (IE2) Strong Eyes Strong Communities fills the gap of working with Indigenous communities (IE2) NACCHOS and ACCHOS should have greater leadership over the Roadmap and the Roadmap should be community-led (E1EH, E2EH)
Roadmap is effective because it is funded. (E1EH)
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
Provided clear, concrete tasks. (E5EH) (E2EH)
Roadmap has contributed to idea that community needs to be involved in the eye health pathway (E5EH)
Stakeholders refer to it to measure progress (E6JF)
Would like to see more flexibility in Roadmap (E7JF)
Challenge for Roadmap to meet complexity of each area. (E8EH)
Roadmap is top down (E9EH)

Establishment of plan (Roadmap) that is evidence-based has been a key role in unifying a sector around Indigenous eye health (S2) (IE1)
Quantifies the size of the gap (IE1)

ARTD survey results about effectiveness of products of the IEHU
80% of stakeholders reported that the Roadmap was a key support
76% of stakeholders reported that the annual Roadmap updates were a key support

Gathering and disseminating information
Staff notes
Working effectively in community requires strong understanding of community and linkages. (S1)
Regional Implementers able to use access to regions to monitor provision of eye heath services for Indigenous people in regions (S2, S3) Feed information at regional level into state-wide and/or national advocacy. (S3) (DOH)
Use data and evidence to influence (S3) IEH uses knowledge and sharing of knowledge between groups as a way of facilitating collaboration. (S5)
Use the annual Roadmap update as an engagement tool with regions. (S3)

External stakeholder notes
External stakeholders reported that key achievements or IEHU have been about research. (E1EH) (E4JF)
Reported that IEHU use data to inform improvements (E1EH) (E3EH). Get out there and do things.
Reported that regions use IEH resources and they are effective and very practical (E2EH) Materials are presented in accessible way, makes them more accessible. (E2EH) Very solution-focused (E3EH) Very approachable (E6JF)
Groups depend on IEH for information (e.g. Federal to regional and regional to Federal) (DOH)
Regional Implementation tools and resources really effective. (E7JF) Calculator is a practical tool. (E6JF) Communities can use it to advocate for resources (E6JF)
Have been effective in trachoma space getting key messages and resources out. (E6JF)
IEH see their role is to help and support (E8EH) Very good at research translation. (IE2)

ARTD Survey Results about regional implementation
88% of stakeholders in regions across Australia have had opportunities to learn from each other.
85% of stakeholders reported that the regional groups are a good way to monitor program for eye care goals and activities
67% of stakeholders reported that the activities of the group were regularly monitored
76% of stakeholders agreed that the regional groups are an effective way to collect and review local eye care data
71% of stakeholders agreed that regular monitoring of progress at a regional level was helpful
83% of stakeholders reported that support provided by IEHU is a key support in their role

Effectiveness of the Trachoma Health Promotion Program[xxxiii]

- Level of engagement of community members with the THPP is high.
- Recognition of Milpa varied to some degree across the communities but there is a high level of recognition of the messages being promoted by THPP among the people who participate in the research. 77% had seen Milpa. 75% know that Milpa meant good hygiene/eyes/faces. 86% understand what Milpa is saying.
- Survey respondents indicated that participation in community events was the most effective way to impart information about trachoma

Facilitating collaboration

Staff notes

Primary Health Care not good at providing flexible services. Creates barriers (S2) Focus should be on promoting coordination of primary care services (S2)

Regional implementation is creating or strengthening collaboration in some regions. Improving understanding in community around how to access services. (S3) Regional implementation has expanded quickly over the past few years. (S3) IEH would prefer to facilitate a system rather than lead a system. Efforts are focused to avoid duplication (S2, S3) Focus is on using tools to support facilitation. (S3)

Sometimes RI facilitators ending up leading more than they would like in regions (S3) Units role is facilitate implementation rather than actually implement. (S2) Community engagement work is labour intensive. (S4)

ARTD interviews

Regional stakeholders reported that IEHU have been supportive and motivated. Reported that IEHU do important background work and are important connectors. (R1, R4, R7, R8)

Regional stakeholders reported that the support form IEHU was beneficial in part because it highlighted things they do well already. Supports groups to be strategic and not reactive. Regional groups performing well have less need for IEH (R3)

Regional stakeholders reported that lack of funding to implement the Roadmap at the regional level can be a barrier to implementation (R8)

External stakeholders – regional implementation

Regional implementers have skillset of coming in as an outside and bringing everyone together. (E6JF)

Mapping at regional level actually identifies where there is gaps in service delivery and issues that come up. (E6JF)

Been effective at bringing in wider group of stakeholders and creating idea that a whole pathway of people need to be involved (E7JF)

Regional implementation tools helpful (E7JF)

Reported that IEH effectively use data to encourage collaboration at regional level. (E4JF)

Regional implementation team fantastic at bringing stakeholders together (E4JF)

Stakeholders expressed the regional implementation should be run and owner by communities, even if this means they don't prioritise eye health (E5EH)

Not always needed in regions but stay connected to gather information about what is happening in regions and facilitate use of this information. (S3)

ARTD Survey Results

87% of respondents felt that voice and perspective was values in groups they participate in

63% of respondents agreed that regions from across Australia has opportunities to learn from each other

63% of respondents agrees that regional groups were adequately supported to achieve their goals

Following activities have been helpful

82% agreed that participate in local/regional eye health stakeholder meetings were helpful

80% agreed that mapping pathways of care for eye conditions at a regional level was helpful

External stakeholders – general notes on collaboration

IEH has created idea that there needs to be broad stakeholder input into a well coordinated and comprehensive plan to improve eye health (E2EH)

External stakeholders reported that IEH staff are well known among the eye health sector. (E2EH)

ES reported that IEH intends to facilitate rather than duplicate (E1EH)
Reported that IEHU work very effectively at the national level (E1EH, E8EH, E6JF) Very effective at engagement with Federal Government (E6JF)
Reported that IEHU are known as effective collaborators (E1EH) (E2EH) (E4JF) (E8EH) (E6JF) Bring relevant stakeholders to relevant discussions (E1EH)
Reported that IEH are effective behind the scenes advocates (E2EH)
Only body working at national, state, regional levels (E2EH) Connects regional to national in a way that other organisations don't
IEH staff have a lot of personal connections (E5EH)
Very generous (E5EH) Very good at engaging services (DOH) See their role as to help and support (E8EH)
Bring people together to facilitate discussions (E8EH)
Need to listen to field more (E9EH)
IEH has strong partnerships at National level with NACCHO, Vision 2020 Australia, RANZCO, Optometry Australia. (S2) Strong relationships at Federal Government level. (S2)
IEH staff have found it tricky to engage clinicians, such as optometrists and ophthalmologists. (S3) Ophthalmologists and optometrists want to be able to deliver services to Indigenous populations, it is about designing a system that can deliver. (S3)

Conference
Conference: staff perceive that it has led to the collaboration of a sector. (S1) Also hold events, forums, roundtables that provide opportunities for collaboration. (S3)
External stakeholders
External stakeholders commented on the cultural appropriateness of the conference. (E1EH)
Conference effective way to get regions to collaborate. (E1EH)
Conference brings people together (E2EH) (E4JF) (E6JF)

ARTD survey
72% of respondents reported that attending the conference or roundtable has been helpful

Impact of IEH leadership
has been influential in not framing IEH through a traditional research structure. (S2)
pushes barriers and it can interrupt relationships with stakeholders, particularly in the Ophthalmology sector (S2, S3, R4, E2EH, E3EH)
has been effective in nurturing relationships at the Federal Government level. He has been developing these relationships for many years. (S2) (E2EH) (E3EH) (E6Jf) (E7JF) (E9EH) (IE2)
Some external stakeholders reported that this forthrightness is effective at creating change (E2EH)
Discussion around who could replace leader and his influence. (E3EH)

Advocating for change
IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)
Regional Implementation stakeholders reported that IEH are successful at maintaining interest. (R4) Put spotlight on issues (E8EH)
External stakeholders expressed that IEH are strong advocates (E2EH)
Very effective advocates in government (E1EH)

Effective advocates who drive significant investments in funds (E7JF) Raising profile of eye health (E8EH) Put a spotlight on issues. Leverage networks to facilitate advocacy. (E8EH)
Question if they advocate for the Roadmap or for the community. (E9EH) Would like them to listen to community more (E9EH)
Access to lots of different tiers to influence policy (IE1)
Can be pushy (IE2) Some stakeholders find this frustrating and feel it interferes with collaborative communication. (E3EH)
Very good at sharing information and getting it out. (E1EH)

Sustainability

Indigenous ownership
Sustainability of the intermediary not at forefront when developing Roadmap. (S5).
IEH needs to start having conversations around sustainability and working with regions to consider how to begin the process of thinking about sustainability. (S5)
Staff expressed opinion that it is difficult to identify the ideal people or organisations to take this work and make it Indigenous-led. (S1, S2) Issue of how this work can become Indigenous-led. (S2). NACCHOS and ACCHOS are important players. (S2, S1) ACCHOS have close connections to communities and so are better placed to do long-term intensive community engagement. (S1)
IEH staff expressed opinion that NACHHOS and ACCHOs are more concerned with delivery of primary care rather than specialist services. (S2)
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)

External stakeholder notes
External stakeholders also expressed opinion that it would be difficult to find an appropriate Indigenous-led organisation (which current exists) that could take on the responsibilities of the intermediary. (E1EH)
External stakeholders expressed opinion that ACCHOS should be leading regional implementation (E1EH)
Relies on building capacity of Indigenous peoples from a very young age to be able to participate in the kinds of networks and groups that can improve the lives of Indigenous communities (E7JF)
Need to start preparing the next generation. (E1) Need to evolve skills to community (IE1)
There are Indigenous -led vehicles are available, but not enough Aboriginal people sitting in the eye health roles. (IE1)
Next step is to support creation of Indigenous -led intermediary. (IE1)

Building Indigenous Leadership

Staff at IEH want to strengthen Indigenous representation
Being Indigenous in this field of work is important and brings important perspective to the work. (S1)
Staff expressed opinion that IEH is not an Indigenous space and is not Indigenous-led. No Indigenous representation on leadership team. (S1)
Establishment of Aboriginal reference group for evaluation has been welcome addition. (S5) (IE1)
Staff expressed need for multiple Indigenous voices to be leading the work of IEH (S1)
Staff expressed desire to make commitment to fill new roles with Indigenous peoples. (S1)

Staff expressed opinion that IEH has not focused on cultural competency as a core skill set. (S1) Recently, IEH developed a cultural competency action plan. IEH staff have found this helpful. (S!)
Staff expressed that how to improve Indigenous leadership is constantly discussed in the organisation. (S5)

Stakeholders reported that IEH is improving
Conferences are example of where IEH has successfully facilitated culturally appropriate implementation and Indigenous leadership. Has also been successful in building relationships between Indigenous and non-Indigenous stakeholders. (S3) Staff expressed opinion that the conferences have been culturally safe, and IEH works in partnerships with Indigenous organisations to ensure the events are Indigenous-led. (S1, S3). IEH would like to hand the conference to an Indigenous organisation. (S3)

Work undertaken by IEH historically has not always been community-led of focussed on being Indigenous-led. (S5) Promoting local adaption of health promotion resources is improving. (S3) Examples include providing materials with space for language on Trachoma materials (S4) and promoting local ownership over the Check Today See Tomorrow resources. (S5).
IEH reports that it has been influential in encouraging mainstream organisations to engage in Indigenous issues. (S2) Example: working with Australian College of Optometry, Vision 2020 Australia, and RANZCO to develop RAPs (S2)

External stakeholders observed that the way IEH approaches Indigenous issues is improving. (E2EH) (E7JF) (IE2)
External stakeholders reported that IEHU are advocates for ensuring thar Indigenous representation is present (E2EH) (IE1)

Indigenous leadership of regional implementation
The role of facilitators of regional implementation of Roadmap is to support ACCHOS. (S3) External Stakeholders share this view (E1EH) Success varies across regions. Some regions have strong Indigenous leadership. (S5)
Regional implementers indicate that they approach ACCHO in first instance in region. (S3) Sometimes through regional implementation is driven by other actors, who are non-Indigenous. Occasionally, IEH is leading secretariat role in regions rather the regional implementation being Indigenous-led. (S3) One of the goals of IEH is to link ACCHOS into primary care. (S2) Some regions are Indigenous-led, sometime, there is only one person in the network(S5) In some regions, IEH has undertaken work to build capacity of ACCHOs to do regional implementation. (E4JF)
Community engagement work is labour intensive, difficult work for a National body to engage with. (S4)
Trachoma team in Alice Springs have been instrumental in building local leadership in Aboriginal communities. Staff are Indigenous, have local knowledge, and are well-known in communities. (S3)
IEH would like regions and communities to be taking leadership over generation of their own resources and materials. (S3)

ARTD survey
65% of respondents agreed that Aboriginal and Torres Strait Islander people were meaningfully involved in regional groups aimed at improving eye health
77% of respondents agreed that regional groups had plans that reflect the local needs and priorities of Aboriginal and Torres Strait Islander People
58% of respondents agree that regional groups had appropriate representation from Aboriginal and Torres Strait Islander people

Aboriginal priorities and IEH priorities

Stakeholders involved in implementation expressed issue with eyes not being seen as priority when compared to other chronic diseases ACCHO affiliates don't always see eyes as priority.
IEH needs to work with the priorities of the Indigenous stakeholders. (IE2) (E1EH) (E5EH) (E2EH) Priorities need to be Indigenous led (E2EH)
Move past comparing Indigenous people to mainstream Australians and striving for excellence. (IE1)
Sometimes IEH leadership show lack of respect to Indigenous individuals (IE1) IEH leadership has advocated against roles that were wanted by Aboriginal communities. (Eye health coordination positions)
IEH are academic experts but ACCHOs are community experts. Their expertise needs to be recognised (IE2.)
Culture wellbeing should be at the heart of everything that is done. (IE2)

Stakeholder perspectives
External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)
Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1)

Evidence table – assessing IEH as an intermediary[xxxiv]

Five components for a robust field
A shared identity that is anchored in the field

History of response to Indigenous eye health

Various strategies and approaches over time has not led to transformative changes in delivery of eye health services for Indigenous communities

- 1975 Introduction of the Visiting Optometrist Scheme (VOS) to improve access to optometry services in rural and remote communities. [xxxv]
- 1970s and 1980s: National Trachoma and Eye Health Program recommended ongoing specialist visits to rural areas
- 1980s: Trachoma and Eye Health Report provided high level recommendations on resources, governance, and funding
- 1980s: National Trachoma and Eye Health Conference implemented a WHO grading system for trachoma
- 1980s: The National Aboriginal Health strategy recommendations included community control and participation and focus on public health integration of primary and specialist programs
- 1990s: 68 community-controlled AHS and 44 clinics set up with Commonwealth support through ATSIC
- 1990s: Indigenous Eye Health Review gave recommendations on models of eye care delivery
- 1990: creation of Regional Eye Health Co-Ordinator positions based in Aboriginal Health Services. In 2008, less than half the original 34 regions had a REHC and many staff work part-time and have insufficient time to fulfill their role. One role not enough to cover gaps in pathway of care.[xxxvi]
- 1997 Major review of Indigenous Eye Health drew attention to continuing issues of unattended refractive error, cataract, diabetic retinopathy, and trachoma. Showed that blindness happened 10 times more frequently among Aboriginal and Torres Strait Islander groups.[xxxvii]
- 1998: National Aboriginal and Torres Strait Islander Eye Health program set up to implement IEH review recommendations by increasing workforce capacity and infrastructure, establishing REHC positions, and providing ophthalmic equipment .[xxxviii]
- 2003: Review of the NATSIEH program recommendations included integrated delivery of eye program into primary care, global funding at ACCHS level, linking with mainstream providers
- 2005: The Australian Health Ministers Conference (AHMC) endorsed the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss – Aboriginal and Torres Strait Islander communities were not specifically identified in the framework.
- 2008: National Indigenous Eye Health Survey defined the size of the problem. The extent of existing eye services and remaining gaps were published in four documents, including Access to Eye Health Services Among Indigenous Australians.

IEH actions that have contributed to a shared identity in the field

IEH staffing supports the delivery of activities that support the IEH goal of a shared identity.
IEH staffing has changed over time, but has maintained a multi-disciplinary team.

The way IEH is staffed[xxxix]

From IEH staff: IEH maintains a culturally diverse, multi-disciplined and multi-skilled staff team. The breadth of skill and experience base allows consideration, planning and action to the complex challenges in Indigenous eye health. The team includes skills and experience in ophthalmology, optometry, nutrition, naturopathy, workforce policy, government relations, photography, community engagement, consultation, service and education, health promotion, politics, project management, health policy and communications.
A clear and demonstrated strength of the team is the capacity to respectfully engage Aboriginal and Torres Strait Islander people and organisations and other stakeholders from across all of Australia and at all levels in the health system.

Roadmap to close the gap for vision
The Roadmap to Close the Gap for Vision was released in 2012 and comprises 42 interlocked recommendations to improve Indigenous eye health over nine domains of specific activity. This identified barriers to accessing care. 42 recommendations. Informed by 10 focus groups with 81 Indigenous community members, 289 staff in field interviews across 21 sites. 86 people provided input through three stakeholder workshops. 38 meetings with 75 people representing 56 stakeholder organisations. Overall aim of the document was to develop a model of eye care for Indigenous Australians for presentation to the Australian Government. The project objectives included the identification of the specific limitations and restrictions of the current funding mechanisms that support visiting eye care services to remote areas, the identification of batters to access for Aboriginal and Torres Strait Islander people to existing eye care services in urban and rural areas and ways to overcome them. The Roadmap identified key components in enhancing the pathway of care for provision of eye services throughout Aboriginal Health Services, identification of economic implications of proposed policy changes.[xl]

Purpose of Roadmap

Program logic developed at time of the Roadmap had following theory:

Changes for Indigenous groups

- Improve awareness of eye health and eye health services
- Change attitudes: see eye health as a priority
- Have increased access to services
- Overcome barriers to services
- Access services
- Follow advice of service system

Changes for eye health pathway

- Improved commitment to eye health for Indigenous Australians
- Improved promotion of services
- Capacity building for individuals
- Services are available, accessible, accommodating, affordable, and culturally sensitive
- Service system is sustainable, monitored, and evaluated
- Service system is efficient and responsive and well staffed
- Improved coordination of services

Staff notes

IEH invested significant time and effort in development of the Roadmap. Significant consultation and review of data and evidence and review of population-level data. Invested significant time in getting buy-in and codesigning solutions. This formative work was done in 2008. (S2) IEH have remained committed to the implementation of the Roadmap over time. (S2)

External stakeholders
External stakeholders recognise the amount of consultation that went into the Roadmap. (E1EH)
External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)
Perception from external stakeholders that the Strong Eyes Strong Communities document is a response to the Roadmap not adapting to the needs of Indigenous communities. (E1EH) (IE2) Strong Eyes Strong Communities fills the gap of working with Indigenous communities (IE2) NACCHOS and ACCHOS should have greater leadership over the Roadmap and the Roadmap should be community-led (E1EH, E2EH)
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
Provided clear, concrete tasks. (E5EH) (E2EH)
Roadmap has contributed to idea that community needs to be involved in the eye health pathway (E5EH)
Stakeholders refer to it to measure progress (E6JF)
Would like to see more flexibility in Roadmap (E7JF)
Challenge for Roadmap to meet complexity of each area. (E8EH)
Roadmap is top down (E9EH)
Establishment of plan (Roadmap) that is evidence-based has been a key role in unifying a sector around Indigenous eye health (S2) (IE1)
Quantifies the size of the gap (IE1)

Shared Indigenous identity
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)
Staff expressed opinion that it is difficult to identify the ideal people or organisations to take this work and make it Indigenous-led. (S1, S2) Issue of how this work can become Indigenous-led. (S2). NACCHOS and ACCHOS are important players. (S2, S1) ACCHOS have close connections to communities and so are better placed to do long-term intensive community engagement. (S1)
IEH staff expressed opinion that NACHHOS and ACCHOs are more concerned with delivery of primary care rather than specialist services. (S2)
Staff expressed opinion that IEH is not an Indigenous space and is not Indigenous-led. No Indigenous representation on leadership team. (S1)
Staff expressed need for multiple Indigenous voices to be leading the work of IEH (S1)
Staff expressed that how to improve Indigenous leadership is constantly discussed in the organisation. (S5)

External stakeholder notes
External stakeholders also expressed opinion that it would be difficult to find an appropriate Indigenous-led organisation (which current exists) that could take on the responsibilities of the intermediary. (E1EH)
External stakeholders expressed opinion that ACCHOS should be leading regional implementation (E1EH)
Relies on building capacity of Indigenous peoples from a very young age to be able to participate in the kinds of networks and groups that can improve the lives of Indigenous communities (E7JF)

Need to start preparing the next generation. (E1) Need to evolve skills to community (IE1)
There are Indigenous -led vehicles are available to support an intermediary function, but not enough Aboriginal people sitting in the eye health roles. (IE1)
Next step is to support creation of Indigenous -led intermediary. (IE1)
Work undertaken by IEH historically has not always been community-led of focussed on being Indigenous-led. (S5) Promoting local adaption of health promotion resources is improving. (S3) Examples include providing materials with space for language on Trachoma materials (S4) and promoting local ownership over the Check Today See Tomorrow resources. (S5).
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Stakeholders involved in implementation expressed issue with eyes not being seen as priority when compared to other chronic diseases ACCHO affiliates don't always see eyes as priority.
IEH needs to work with the priorities of the Indigenous stakeholders. (IE2) (E1EH) (E5EH) (E2EH) Priorities need to be Indigenous led (E2EH)
Move past comparing Indigenous people to mainstream Australians and striving for excellence. (IE1)
Sometimes IEH leadership show lack of respect to Indigenous individuals (IE1) IEH leadership has advocated against roles that were wanted by Aboriginal communities. (Eye health coordination positions)
IEH are academic experts but ACCHOs are community experts. Their expertise needs to be recognised (IE2.)
Culture wellbeing should be at the heart of everything that is done. (IE2)
External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)
Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1

Collaboration with partners

Endorsed by NACCHO, Optometry Australia, RANZCO, Vision 2020. Collaboration with Australian College of Rural and Remote Medicine, Brien Holden Vision Institute, cbm, Crana Plus, Diabetes Australia, The Fred Hollows Foundation, Royal Australian College of General Practitioners.

- Participate Vision 2020 Australia
- Chair the Optometry Australia Aboriginal and Torres Strait Islander Eye Health Advisory Group
- Chair the OCANZ Indigenous Strategy Taskforce
- Sit on following project committees: National Subsidised Spectacles Scheme, National Eye Care Equipment Inventory, and Strong Eyes, Strong Communities implementation projects

Regional implementation of the Roadmap.
Establish regional collaborative network of stakeholders. IEH provides a template for coordination and integration of health care for other conditions to meet population-based need including: local planning and coordination of visiting specialists. Integration of primary care and secondar specialist care. Identify and support regional project officers to facilitate regional planning and reporting, undertake needs analysis comparing current eye care services with population-based needs. Eye care support workforce needs identifies to set up support staff roles. Need for additional visiting eye care providers identified and funded through RHOF and VOS. Identify patient support roles required to support the patient through the pathway of care. Support chronic disease coordinators to coordinate surgery and management of those with diabetes. Develop regional service directory and referral protocols. Introduce regional health promotion and awareness. Establish regional data collection and monitoring systems. Ensure local accountability and oversight.[xli]

Regional implementation has improved community knowledge in how to access eye health services. Often through sharing information at community events, (S3)
A lot of communities don't yet have the capacity to be able to apply and implement the Roadmap. (E5EH)
Regional implementation creating or influencing collaboration across eye health care networks. (S3)

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)
Conference: staff perceive that it has led to the collaboration of a sector. (S1) Also hold events, forums, roundtables that provide opportunities for collaboration. (S3)
External stakeholders
Conference effective way to get regions to collaborate. (E1EH)
Conference brings people together (E2EH) (E4JF) (E6JF)
Conference has provided opportunities for people to connect. (S1)
Roadmap has contributed to creating unity of purpose and a less siloed sector. (S3)
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
Conferences are example of where IEH has successfully facilitated culturally appropriate implementation and Indigenous leadership. Has also been successful in building relationships between Indigenous and non-Indigenous stakeholders. (S3) Staff expressed opinion that the conferences have been culturally safe, and IEH works in partnerships with Indigenous organisations to ensure the events are Indigenous-led. (S1, S3). IEH would like to hand the conference to an Indigenous organisation. (S3)

Standards of codified practices

Roadmap to close the gap for vision

The Roadmap to Close the Gap for Vision was released in 2012 and comprises 42 interlocked recommendations to improve Indigenous eye health over nine domains of specific activity. This identified barriers to accessing care. 42 recommendations. Informed by 10 focus groups with 81 Indigenous community members, 289 staff in field interviews across 21 sites. 86 people provided input through three stakeholder workshops. 38 meetings with 75 people representing 56 stakeholder organisations.

Overall aim of the document was to develop a model of eye care for Indigenous Australians for presentation to the Australian Government. The project objectives included the identification of the specific limitations and restrictions of the current funding mechanisms that support visiting eye care services to remote areas, the identification of batters to access for Aboriginal and Torres Strait Islander people to existing eye care services in urban and rural areas and ways to overcome them. The Roadmap identified key components in enhancing the pathway of care for provision of eye services throughout Aboriginal Health Services, identification of economic implications of proposed policy changes.[xlii]

Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
IEH invested significant time and effort in development of the Roadmap. Significant consultation and review of data and evidence and review of population-level data. Invested significant time in getting buy-in and codesigning solutions. This formative work was done in 2008. (S2)

IEH have remained committed to the implementation of the Roadmap over time. (S2)

External stakeholders
External stakeholders recognise the amount of consultation that went into the Roadmap. (E1EH)
External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
Provided clear, concrete tasks. (E5EH) (E2EH)
Roadmap has contributed to idea that community needs to be involved in the eye health pathway (E5EH)
Stakeholders refer to it to measure progress (E6JF)
Would like to see more flexibility in Roadmap (E7JF)
Challenge for Roadmap to meet complexity of each area. (E8EH)
Roadmap is top down (E9EH)
Establishment of plan (Roadmap) that is evidence-based has been a key role in unifying a sector around Indigenous eye health (S2) (IE1)
Quantifies the size of the gap (IE1)

Pursue policy goals

Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[xliii]
Collects and disseminates evidence. State and national health outcomes and process indicators adopted and reported. Advocating to establish diabetic eye screening rates as a key performance indicator for Primary Health Networks.[xliv]

Development of resources about eye health

Resources

Annual Roadmap updates

IEH produces annual updates on the implementation of the Roadmap to high progress on regional implementation. Since 2011, IEH has produced nine annual updates (the most recent was published for 2020). These updates illustrate context, track process and health indicators, and track extent of implementation of the recommendations.

Technical publications produced by IEH[xlv]

2009 reports:

- Diabetic retinopathy, accuracy of screening methods
- Outreach eye services in Australia
- National Indigenous Eye Health Survey

2010

- Trachoma Antibiotic Treatments: A Systematic Review
- Access to Eye Health Services Among Indigenous Australians
- Provision of Indigenous Eye Health services

2011

- The Cost to Close the Gap for Vision
- A Critical History of Indigenous Eye Health Policy-Making
- Projected Needs for Eye Care Services for Indigenous Australians

2013

- Software Roundtable Report

2014

- Health promotion roundtable report
- Regional Implementation Roundtable Report

2015

- National Diabetes Eye Care Health Promotion Workshop Report

2016

- Fundholder forum report
- Non Mydriatic Retinal Photography Roundtable Report
- Planning Sustainable and Coordinated Indigenous Eye Health Services Roundtable Report

2018

- Jurisdictional snapshots were published for each state and territory. These snapshots provide information on provision of eye services, and information about primary health care networks.[xlvi]

2020

- Victorian Aboriginal Eye Health Regional Stakeholder Forum Report

Position papers prepared by IEH[xlvii]

- Fundholders and Outreach Funding
- ACCHOs and Good Eye Care Services
- PHNs and Indigenous Eye Care
- National Oversight
- National Leadership
- Role for Jurisdictions
- Mandatory MBS 715
- Cataract Monitoring
- Clinical Practice Software
- Indicators
- Sector Linkage

- Education and Trachoma
- Training, workshops, and events

Development of training resources

Training resources[xlviii]

Self-directed online learning courses

- Remote Area Health Corps: Trachoma Module
- Remote Area Health Corps – Trichiasis
- Remote Area Health Corps – Eye Health and Diabetes
- Trachoma Grading Self-Directed Learning
- Diabetic Retinopathy Screening Card
- Diabetic Retinopathy Grading Course

Convening of roundtables and workshops

Roundtables and workshops convened by IEH[xlix]

- 2013 - Software Roundtable
- 2014 – Health Promotion Roundtable
- 2014 – Regional Implementation Report
- 2015 – National Diabetes Eye Care Health Promotion Workshop
- 2016 – Non Mydriatic Retinal Photography Roundtable
- 2016 – Fundholder Forum
- 2020 – Victorian Aboriginal Eye Health Regional Stakeholder Forum

Regional implementation of the Roadmap.
Establish regional collaborative network of stakeholders. IEH provides a template for coordination and integration of health care for other conditions to meet population-based need including: local planning and coordination of visiting specialists. Integration of primary care and secondar specialist care. Identify and support regional project officers to facilitate regional planning and reporting, undertake needs analysis comparing current eye care services with population-based needs. Eye care support workforce needs identifies to set up support staff roles. Need for additional visiting eye care providers identified and funded through RHOF and VOS. Identify patient support roles required to support the patient through the pathway of care. Support chronic disease coordinators to coordinate surgery and management of those with diabetes. Develop regional service directory and referral protocols. Introduce regional health promotion and awareness. Establish regional data collection and monitoring systems. Ensure local accountability and oversight.[l]

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)

Improved awareness of how to improve eye health issues for Indigenous Australians. (E5EH)

A knowledge based built on credible research

Indigenous Eye Health Survey

Indigenous Eye Health Survey was published in 2009. The last national data came from the National Trachoma and Eye Health Program 1976-1980 when blindness rates were 10 times higher than mainstream. The 2009 survey determined the magnitude, distribution, and causes of vision loss in Aboriginal and Torres Strait Islander communities. Blindness rates were six times more than mainstream and low vision three times higher. The main causes of vision loss were cataract, refractive errors, diabetic eye disease and trachoma. 94% of vision loss is preventable or treatable but 35% of Indigenous Adults have never had an eye examination.[li]

The National Indigenous Eye Health Survey showed that although Indigenous children have better vision than mainstream children, Indigenous Australians aged 40 and above have six times the rate of blindness compared to mainstream Australians. 94% of eye loss is preventable. High unmet need for eye care services among Indigenous Australians. Significant shortfall in provision of eye care services in remote Australia. Eye services are underutilised. Indigenous peoples in urban and rural areas have similar rates of vision loss to those in more remote areas, even when eye health services are available. Services need to be better coordinated and organised.[lii]

Roadmap to close the gap for vision

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Staff notes

IEH invested significant time and effort in development of the Roadmap. Significant consultation and review of data and evidence and review of population-level data. Invested significant time in getting buy-in and codesigning solutions. This formative work was done in 2008. (S2)

Conference

Conference: staff perceive that it has led to the collaboration of a sector. (S1) Also hold events, forums, roundtables that provide opportunities for collaboration. (S3)

External stakeholders

External stakeholders commented on the cultural appropriateness of the conference. (E1EH)

Conference effective way to get regions to collaborate. (E1EH)

Conference brings people together (E2EH) (E4JF) (E6JF)

Development of resources about eye health

Resources

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- 2020 – Victorian Aboriginal Eye Health Regional Stakeholder Forum

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)

Leadership and grassroots support that advances the field

'Regions have greater access to resources to improve eye health care pathways.
The changes in funding have led to increased delivery of services at ACCHOS (E4JF)
Some regions have struggled with additional resources: cameras are hard to get to remote areas. GPs need to sign off screenings and are not always available in remote areas. (E6Jf) (E9EH)
Issue with targeted funding, it doesn't allow for adaptation on ground if it is closely tied to body parts, so it may meet national priority but not community priority. (E7JF)

Collaboration with partners

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- Sit on following project committees: National Subsidised Spectacles Scheme, National Eye Care Equipment Inventory, and Strong Eyes, Strong Communities implementation projects

Setting a strategic vision
External stakeholders
External stakeholders recognise the amount of consultation that went into the Roadmap. (E1EH)
External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)
Perception from external stakeholders that the Strong Eyes Strong Communities document is a response to the Roadmap not adapting to the needs of Indigenous communities. (E1EH) (IE2) Strong Eyes Strong Communities fills the gap of working with Indigenous communities (IE2) NACCHOS and ACCHOS should have greater leadership over the Roadmap and the Roadmap should be community-led (E1EH, E2EH)
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
Roadmap has contributed to idea that community needs to be involved in the eye health pathway (E5EH)

Would like to see more flexibility in Roadmap (E7JF)
Challenge for Roadmap to meet complexity of each area. (E8EH)
Roadmap is top down (E9EH)

Regional implementation of the Roadmap.
Establish regional collaborative network of stakeholders. IEH provides a template for coordination and integration of health care for other conditions to meet population-based need including: local planning and coordination of visiting specialists. Integration of primary care and secondar specialist care. Identify and support regional project officers to facilitate regional planning and reporting, undertake needs analysis comparing current eye care services with population-based needs. Eye care support workforce needs identifies to set up support staff roles. Need for additional visiting eye care providers identified and funded through RHOF and VOS. Identify patient support roles required to support the patient through the pathway of care. Support chronic disease coordinators to coordinate surgery and management of those with diabetes. Develop regional service directory and referral protocols. Introduce regional health promotion and awareness. Establish regional data collection and monitoring systems. Ensure local accountability and oversight.[lix]
Mainstream services are demonstrating increased awareness of how to deliver services for Indigenous populations. (S2, S3) Example: improved cultural curriculum in optometry and orthoptics colleges. Example: IEH facilitating development of RAPs with some national eye health actors.
More people working at primary health care level have better knowledge of how to operate cameras as a result of changes in MBS. (S3)
Regional implementation has improved community knowledge in how to access eye health services. Often through sharing information at community events, (S3)
A lot of communities don't yet have the capacity to be able to apply and implement the Roadmap. (E5EH)
Increased understanding of gaps in service delivery (E7JF)
Raising awareness on the state of eye health for Indigenous Australians. (E3EH)
Improved awareness of how to improve eye health issues for Indigenous Australians. (E5EH)
Regional Implementation stakeholders reported that IEH are successful at maintaining interest. (R4) Put spotlight on issues (E8EH)
Very good at sharing information and getting it out. (E1EH)
Stakeholders expressed the regional implementation should be run and owner by communities, even if this means they don't prioritise eye health (E5EH)

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)
Conference: staff perceive that it has led to the collaboration of a sector. (S1) Also hold events, forums, roundtables that provide opportunities for collaboration. (S3)
External stakeholders
External stakeholders commented on the cultural appropriateness of the conference. (E1EH)
Conference effective way to get regions to collaborate. (E1EH)
Conference brings people together (E2EH) (E4JF) (E6JF)

Indigenous ownership
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)Staff expressed opinion that it is difficult to identify the ideal people or organisations to take this work and make it Indigenous-led. (S1, S2) Issue of how this work can become Indigenous-led. (S2). NACCHOS

and ACCHOS are important players. (S2, S1) ACCHOS have close connections to communities and so are better placed to do long-term intensive community engagement. (S1)
IEH staff expressed opinion that NACHHOS and ACCHOs are more concerned with delivery of primary care rather than specialist services. (S2)
External stakeholders also expressed opinion that it would be difficult to find an appropriate Indigenous-led organisation (which current exists) that could take on the responsibilities of the intermediary. (E1EH)
External stakeholders expressed opinion that ACCHOS should be leading regional implementation (E1EH)
Relies on building capacity of Indigenous peoples from a very young age to be able to participate in the kinds of networks and groups that can improve the lives of Indigenous communities (E7JF)
Need to start preparing the next generation. (E1) Need to evolve skills to community (IE1)
There are Indigenous -led vehicles are available, but not enough Aboriginal people sitting in the eye health roles. (IE1)
Next step is to support creation of Indigenous -led intermediary. (IE1)

Sufficient funding and supportive policies

Pursue policy goals

Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[lx]
Collects and disseminates evidence. State and national health outcomes and process indicators adopted and reported. Advocating to establish diabetic eye screening rates as a key performance indicator for Primary Health Networks.[lxi]

Key reforms:[lxii]

- Visiting Optometrist Scheme (VOS)
- Rural Health Outreach Fund (RHOF)
- Sector funding bids through Vision 2020 Australia
- MBS categorisation
- National Eye Health Survey (2009)

Changes in resources
Service reforms at regional level as a result of regional implementation have lead to improved access to eye health care services for the Aboriginal community. Attributed to identifying and addressing gaps in service pathway. (S3)
Changes in funding at national level have lead to improved access to eye checks, camera checks, cataract identification/support,. (S3, S5) (E5EH)

Funding changes that can be attributed to the advocacy efforts of IEH:[lxiii]

2015	Commonwealth funding:

	• $4.6 million for eye health coordination over four years • Funding approved for annual data reporting as part of national oversight over three years • $1.6 million for Trachoma health promotion over two years
2016	Commonwealth funding: • $3.5 million for eye and ear surgery support initiatives over two years • $5.1 million for audit of eye health equipment, provision of equipment to screen for diabetic retinopathy and associated training • $0.3 million for other eye health equipment to NGOs • $33.8 million for Medicare item for retinal screening over four years • $2.52 million for IEH to continue activities to improve Indigenous eye health outcomes over three years
2017	Trachoma health promotion funding: • New cataract surgery initiatives • VOS funding 2017-2020 • Medical Outreach Indigenous Chronic Diseases Program (MOICDP) and Rural Health Outreach Fund (RHOF) 2017-2020 • Retinal camera and equipment rollout
2018	Commonwealth funding • $4 million to boost ophthalmology services through the MOICDP • $2.5 million for additional sites for camera and training rollout • $0.5 million for cataract surgery through Eye and Ear surgical support • $2 million to improve access to subsidised spectacles • $0.9 million for Indigenous Diabetes Eye Screening
2020	Commonwealth funding • $1.5 million to Vision 2020 for the National Subsidised Spectacles Scheme • Eye care outreach funding for VOS, RHOF, and MOICDP secured for 2023-2024

Stakeholders reported that key achievement of IEHU has been in securing funding. (E1EH) (E4JF) (E5EH) Regions have greater access to resources to improve eye health care pathways.

Stakeholders reported using the Roadmap as a resource in their work. (E4JF)
The changes in funding have led to increased delivery of services at ACCHOS (E4JF)
Some regions have struggled with additional resources: cameras are hard to get to remote areas. GPs need to sign off screenings and are not always available in remote areas. (E6Jf) (E9EH)
Issue with targeted funding, it doesn't allow for adaptation on ground if it is closely tied to body parts, so it may meet national priority but not community priority. (E7JF)

Advocating for change
External stakeholders expressed that IEH are strong advocates (E2EH)
Very effective advocates in government (E1EH)
Effective advocates who drive significant investments in funds (E7JF) Raising profile of eye health (E8EH) Put a spotlight on issues. Leverage networks to facilitate advocacy. (E8EH)
Question if they advocate for the Roadmap or for the community. (E9EH) Would like them to listen to community more (E9EH)
Access to lots of different tiers to influence policy (IE1)

IEH leader has been effective in nurturing relationships at the Federal Government level. He has been developing these relationships for many years. (S2) (E2EH) (E3EH) (E6Jf) (E7JF) (E9EH) (IE2)
Discussion around who could replace IEH leader and his influence. (E3EH)

Four characteristics of intermediaries
Focus on achieving population-level change, not simply scaling up an organisation or intervention
Roadmap to close the gap for vision The Roadmap to Close the Gap for Vision was released in 2012 and comprises 42 interlocked recommendations to improve Indigenous eye health over nine domains of specific activity. This identified barriers to accessing care. 42 recommendations. Informed by 10 focus groups with 81 Indigenous community members, 289 staff in field interviews across 21 sites. 86 people provided input through three stakeholder workshops. 38 meetings with 75 people representing 56 stakeholder organisations. Overall aim of the document was to develop a model of eye care for Indigenous Australians for presentation to the Australian Government. The project objectives included the identification of the specific limitations and restrictions of the current funding mechanisms that support visiting eye care services to remote areas, the identification of batters to access for Aboriginal and Torres Strait Islander people to existing eye care services in urban and rural areas and ways to overcome them. The Roadmap identified key components in enhancing the pathway of care for provision of eye services throughout Aboriginal Health Services, identification of economic implications of proposed policy changes.[lxiv] Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH) *Staff notes*

IEH invested significant time and effort in development of the Roadmap. Significant consultation and review of data and evidence and review of population-level data. Invested significant time in getting buy-in and codesigning solutions. This formative work was done in 2008. (S2)
IEH have remained committed to the implementation of the Roadmap over time. (S2)

External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)

Perception from external stakeholders that the Strong Eyes Strong Communities document is a response to the Roadmap not adapting to the needs of Indigenous communities. (E1EH) (IE2) Strong Eyes Strong Communities fills the gap of working with Indigenous communities (IE2) NACCHOS and ACCHOS should have greater leadership over the Roadmap and the Roadmap should be community-led (E1EH, E2EH)
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)
Provided clear, concrete tasks. (E5EH) (E2EH)
Stakeholders refer to it to measure progress (E6JF)
Would like to see more flexibility in Roadmap (E7JF)
Challenge for Roadmap to meet complexity of each area. (E8EH)
Roadmap is top down (E9EH)
Establishment of plan (Roadmap) that is evidence-based has been a key role in unifying a sector around Indigenous eye health (S2) (IE1)
Quantifies the size of the gap (IE1)

Collaboration with national-level partners

Endorsed by NACCHO, Optometry Australia, RANZCO, Vision 2020. Collaboration with Australian College of Rural and Remote Medicine, Brien Holden Vision Institute, cbm, Crana Plus, Diabetes Australia, The Fred Hollows Foundation, Royal Australian College of General Practitioners.

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protocols. Introduce regional health promotion and awareness. Establish regional data collection and monitoring systems. Ensure local accountability and oversight.[lxv]

Concentrate on getting things done, not building consensus

Pursue policy goals

Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[lxvi]

Collects and disseminates evidence. State and national health outcomes and process indicators adopted and reported. Advocating to establish diabetic eye screening rates as a key performance indicator for Primary Health Networks.[lxvii]

Roadmap

IEH have remained committed to the implementation of the Roadmap over time. (S2)

External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)

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Would like to see more flexibility in Roadmap (E7JF)

Challenge for Roadmap to meet complexity of each area. (E8EH)

Roadmap is top down (E9EH)

Advocating for change

IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)

Regional Implementation stakeholders reported that IEH are successful at maintaining interest. (R4) Put spotlight on issues (E8EH)

External stakeholders expressed that IEH are strong advocates (E2EH)

Very effective advocates in government (E1EH)

Effective advocates who drive significant investments in funds (E7JF) Raising profile of eye health (E8EH) Put a spotlight on issues. Leverage networks to facilitate advocacy. (E8EH)

Question if they advocate for the Roadmap or for the community. (E9EH) Would like them to listen to community more (E9EH)

Access to lots of different tiers to influence policy (IE1)

Can be pushy (IE2) Some stakeholders find this frustrating and feel it interferes with collaborative communication. (E3EH)

Very good at sharing information and getting it out. (E1EH)

Indigenous ownership

Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)

External stakeholders also expressed opinion that it would be difficult to find an appropriate Indigenous-led organisation (which current exists) that could take on the responsibilities of the intermediary. (E1EH)

External stakeholders expressed opinion that ACCHOS should be leading regional implementation (E1EH)
There are Indigenous -led vehicles are available, but not enough Aboriginal people sitting in the eye health roles. (IE1)
Next step is to support creation of Indigenous -led intermediary. (IE1)
Staff expressed opinion that IEH is not an Indigenous space and is not Indigenous-led. No Indigenous representation on leadership team. (S1)
Staff expressed need for multiple Indigenous voices to be leading the work of IEH (S1)
External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)
Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1

Indigenous leadership of regional implementation
The role of facilitators of regional implementation of Roadmap is to support ACCHOS. (S3) External Stakeholders share this view (E1EH) Success varies across regions. Some regions have strong Indigenous leadership. (S5)
Regional implementers indicate that they approach ACCHO in first instance in region. (S3) Sometimes through regional implementation is driven by other actors, who are non-Indigenous. Occasionally, IEH is leading secretariat role in regions rather the regional implementation being Indigenous-led. (S3) One of the goals of IEH is to link ACCHOS into primary care. (S2) Some regions are Indigenous-led, sometime, there is only one person in the network(S5) In some regions, IEH has undertaken work to build capacity of ACCHOs to do regional implementation. (E4JF)
Community engagement work is labour intensive, difficult work for a National body to engage with. (S4)
Trachoma team in Alice Springs have been instrumental in building local leadership in Aboriginal communities. Staff are Indigenous, have local knowledge, and are well-known in communities. (S3)
IEH would like regions and communities to be taking leadership over generation of their own resources and materials. (S3)

Aboriginal priorities and IEH priorities
Stakeholders involved in implementation expressed issue with eyes not being seen as priority when compared to other chronic diseases ACCHO affiliates don't always see eyes as priority.
IEH needs to work with the priorities of the Indigenous stakeholders. (IE2) (E1EH) (E5EH) (E2EH) Priorities need to be Indigenous led (E2EH)
Move past comparing Indigenous people to mainstream Australians and striving for excellence. (IE1)
Sometimes IEH leadership show lack of respect to Indigenous individuals (IE1) IEH leader has advocated against roles that were wanted by Aboriginal communities. (Eye health coordination positions)
IEH are academic experts but ACCHOs are community experts. Their expertise needs to be recognised (IE2.)
Culture wellbeing should be at the heart of everything that is done. (IE2)

Are built to win, not to last

Always the intention of IEH that they would close once their four key population-level objectives have been achieved.
Needs to be discussion about where to next.
Next step is to begin a process of promoting self-determination.
Indigenous ownership
Sustainability of the intermediary not at forefront when developing roadmap. (S5).
IEH needs to start having conversations around sustainability and working with regions to consider how to begin the process of thinking about sustainability. (S5)

Staff expressed opinion that it is difficult to identify the ideal people or organisations to take this work and make it Indigenous-led. (S1, S2) Issue of how this work can become Indigenous-led. (S2). NACCHOS and ACCHOS are important players. (S2, S1) ACCHOS have close connections to communities and so are better placed to do long-term intensive community engagement. (S1)
IEH staff expressed opinion that NACHHOS and ACCHOs are more concerned with delivery of primary care rather than specialist services. (S2)
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)

External stakeholder notes
External stakeholders also expressed opinion that it would be difficult to find an appropriate Indigenous-led organisation (which current exists) that could take on the responsibilities of the intermediary. (E1EH)
External stakeholders expressed opinion that ACCHOS should be leading regional implementation (E1EH)
Relies on building capacity of Indigenous peoples from a very young age to be able to participate in the kinds of networks and groups that can improve the lives of Indigenous communities (E7JF)
Need to start preparing the next generation. (E1) Need to evolve skills to community (IE1)
There are Indigenous -led vehicles are available, but not enough Aboriginal people sitting in the eye health roles. (IE1)
Next step is to support creation of Indigenous -led intermediary. (IE1)

Stakeholder perspectives
External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)
Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1

Influence the actions of others, rather than acting directly themselves

Pursue policy goals

Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[lxviii]
Collects and disseminates evidence. State and national health outcomes and process indicators adopted and reported. Advocating to establish diabetic eye screening rates as a key performance indicator for Primary Health Networks.[lxix]

Collaboration with partners

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- Participate Vision 2020 Australia
- Chair the Optometry Australia Aboriginal and Torres Strait Islander Eye Health Advisory Group
- Chair the OCANZ Indigenous Strategy Taskforce
- Sit on following project committees: National Subsidised Spectacles Scheme, National Eye Care Equipment Inventory, and Strong Eyes, Strong Communities implementation projects

IEH see their role is to help and support (E8EH)

Regional implementation
Regional implementation is creating or strengthening collaboration in some regions. Improving understanding in community around how to access services. (S3) Regional implementation has expanded quickly over the past few years. (S3) IEH would prefer to facilitate a system rather than lead a system. Efforts are focused to avoid duplication (S2, S3) Focus is on using tools to support facilitation. (S3)
Sometimes RI facilitators ending up leading more than they would like in regions (S3) Units role is facilitate implementation rather than actually implement. (S2) Community engagement work is labour intensive. (S4)

External stakeholders – regional implementation
Regional implementers have skillset of coming in as an outside and bringing everyone together. (E6JF)
Been effective at bringing in wider group of stakeholders and creating idea that a whole pathway of people need to be involved (E7JF)
Regional implementation tools helpful (E7JF)
Reported that IEH effectively use data to encourage collaboration at regional level. (E4JF)
Regional implementation team fantastic at bringing stakeholders together (E4JF)
Stakeholders expressed the regional implementation should be run and owner by communities, even if this means they don't prioritise eye health (E5EH)
Not always needed in regions but stay connected to gather information about what is happening in regions and facilitate use of this information. (S3)

External stakeholders – general notes on collaboration
External stakeholders reported that IEH staff are well known among the eye health sector. (E2EH)
ES reported that IEH intends to facilitate rather than duplicate (E1EH)
Reported that IEHU work very effectively at the national level (E1EH, E8EH, E6JF) Very effective at engagement with Federal Government (E6JF)
Reported that IEHU are known as effective collaborators (E1EH) (E2EH) (E4JF) (E8EH) (E6JF) Bring relevant stakeholders to relevant discussions (E1EH)
Reported that IEH are effective behind the scenes advocates (E2EH)
Only body working at national, state, regional levels (E2EH) Connects regional to national in a way that other organisations don't
IEH staff have a lot of personal connections (E5EH)
Very generous (E5EH) Very good at engaging services (DOH) See their role as to help and support (E8EH)
Bring people together to facilitate discussions (E8EH)
IEH has strong partnerships at National level with NACCHO, Vision 2020 Australia, RANZCO, Optometry Australia. (S2) Strong relationships at Federal Government level. (S2)
IEH see their role is to help and support (E8EH)

Roadmap
Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)

Conference: staff perceive that it has led to the collaboration of a sector. (S1) Also hold events, forums, roundtables that provide opportunities for collaboration. (S3)
External stakeholders
External stakeholders commented on the cultural appropriateness of the conference. (E1EH)
Conference effective way to get regions to collaborate. (E1EH)
Conference brings people together (E2EH) (E4JF) (E6JF)
IEH facilitate conference with Indigenous partner. Expressed desire to hand leadership over to an Indigenous organisation

Advocating for change
IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)
Regional Implementation stakeholders reported that IEH are successful at maintaining interest. (R4) Put spotlight on issues (E8EH)
External stakeholders expressed that IEH are strong advocates (E2EH)
Very effective advocates in government (E1EH)
Effective advocates who drive significant investments in funds (E7JF) Raising profile of eye health (E8EH) Put a spotlight on issues. Leverage networks to facilitate advocacy. (E8EH)
Question if they advocate for the Roadmap or for the community. (E9EH) Would like them to listen to community more (E9EH)
Access to lots of different tiers to influence policy (IE1)
Can be pushy (IE2) Some stakeholders find this frustrating and feel it interferes with collaborative communication. (E3EH)
Very good at sharing information and getting it out. (E1EH)

Indigenous ownership
IEH staff expressed opinion that NACHHOS and ACCHOs are more concerned with delivery of primary care rather than specialist services. (S2)
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)

External stakeholder notes
Next step is to support creation of Indigenous -led intermediary. (IE1)
Staff expressed need for multiple Indigenous voices to be leading the work of IEH (S1)
Conferences are example of where IEH has successfully facilitated culturally appropriate implementation and Indigenous leadership. Has also been successful in building relationships between Indigenous and non-Indigenous stakeholders. (S3) Staff expressed opinion that the conferences have been culturally safe, and IEH works in partnerships with Indigenous organisations to ensure the events are Indigenous-led. (S1, S3). IEH would like to hand the conference to an Indigenous organisation. (S3)

Work undertaken by IEH historically has not always been community-led of focussed on being Indigenous-led. (S5) Promoting local adaption of health promotion resources is improving. (S3) Examples include providing materials with space for language on Trachoma materials (S4) and promoting local ownership over the Check Today See Tomorrow resources. (S5).
IEH reports that it has been influential in encouraging mainstream organisations to engage in Indigenous issues. (S2) Example: working with Australian College of Optometry, Vision 2020 Australia, and RANZCO to develop RAPs (S2)

Indigenous leadership of regional implementation

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Regional implementers indicate that they approach ACCHO in first instance in region. (S3) Sometimes through regional implementation is driven by other actors, who are non-Indigenous. Occasionally, IEH is leading secretariat role in regions rather the regional implementation being Indigenous-led. (S3) One of the goals of IEH is to link ACCHOS into primary care. (S2) Some regions are Indigenous-led, sometime, there is only one person in the network(S5) In some regions, IEH has undertaken work to build capacity of ACCHOs to do regional implementation. (E4JF)

Trachoma team in Alice Springs have been instrumental in building local leadership in Aboriginal communities. Staff are Indigenous, have local knowledge, and are well-known in communities. (S3)

IEH would like regions and communities to be taking leadership over generation of their own resources and materials. (S3)

External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)

Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1

What intermediaries think about

They think about how their field, fractured though it may be, can contribute to population-level change

Roadmap to close the gap for vision

The Roadmap to Close the Gap for Vision was released in 2012 and comprises 42 interlocked recommendations to improve Indigenous eye health over nine domains of specific activity. This identified barriers to accessing care. 42 recommendations. Informed by 10 focus groups with 81 Indigenous community members, 289 staff in field interviews across 21 sites. 86 people provided input through three stakeholder workshops. 38 meetings with 75 people representing 56 stakeholder organisations.

Overall aim of the document was to develop a model of eye care for Indigenous Australians for presentation to the Australian Government. The project objectives included the identification of the specific limitations and restrictions of the current funding mechanisms that support visiting eye care services to remote areas, the identification of batters to access for Aboriginal and Torres Strait Islander people to existing eye care services in urban and rural areas and ways to overcome them. The Roadmap identified key components in enhancing the pathway of care for provision of eye services throughout Aboriginal Health Services, identification of economic implications of proposed policy changes.[lxx]

Purpose of Roadmap

Program logic developed at time of the Roadmap had following theory:

Changes for Indigenous groups

- Improve awareness of eye health and eye health services
- Change attitudes: see eye health as a priority
- Have increased access to services
- Overcome barriers to services
- Access services
- Follow advice of service system

Changes for eye health pathway

- Improved commitment to eye health for Indigenous Australians
- Improved promotion of services
- Capacity building for individuals
- Services are available, accessible, accommodating, affordable, and culturally sensitive
- Service system is sustainable, monitored, and evaluated
- Service system is efficient and responsive and well staffed
- Improved coordination of services

Four key 2020 goals of Roadmap[lxxi]

- Elimination of Trachoma
- Cataract: sight restoration for 4000 Indigenous Australians with cataract each year
- Diabetic retinopathy: blindness prevention in 23,000 Indigenous Australians with diabetic retinopathy each year
- Refractive error: sight enablement for 42500 Indigenous Australians each year by giving them glasses

Roadmap is a comprehensive and coordinated plan that has people working together – created less silos. Spans spectrum of eye health all the way from the patient to surgical care to policy. (E2EH)

Regional implementation of the Roadmap.

Establish regional collaborative network of stakeholders. IEH provides a template for coordination and integration of health care for other conditions to meet population-based need including: local planning and coordination of visiting specialists. Integration of primary care and secondar specialist care. Identify and support regional project officers to facilitate regional planning and reporting, undertake needs analysis comparing current eye care services with population-based needs. Eye care support workforce needs identifies to set up support staff roles. Need for additional visiting eye care providers identified and funded through RHOF and VOS. Identify patient support roles required to support the patient through the pathway of care. Support chronic disease coordinators to coordinate surgery and management of those with diabetes. Develop regional service directory and referral protocols. Introduce regional health promotion and awareness. Establish regional data collection and monitoring systems. Ensure local accountability and oversight.[lxxii]

Regional implementers indicate that they approach ACCHO in first instance in region. (S3) Sometimes through regional implementation is driven by other actors, who are non-Indigenous. Occasionally, IEH is leading secretariat role in regions rather the regional implementation being Indigenous-led. (S3) One of the goals of IEH is to link ACCHOS into primary care. (S2) Some regions are Indigenous-led, sometime, there is only one person in the network(S5) In some regions, IEH has undertaken work to build capacity of ACCHOs to do regional implementation. (E4JF)

Community engagement work is labour intensive, difficult work for a National body to engage with. (S4)

Not always needed in regions but stay connected to gather information about what is happening in regions and facilitate use of this information. (S3)

Reported that IEH effectively use data to encourage collaboration at regional level. (E4JF)

Regional Implementers able to use access to regions to monitor provision of eye heath services for Indigenous people in regions (S2, S3) Feed information at regional level into state-wide and/or national advocacy. (S3) (DOH)

Use data and evidence to influence (S3) IEH uses knowledge and sharing of knowledge between groups as a way of facilitating collaboration. (S5)
Use the annual Roadmap update as an engagement tool with regions. (S3)
Reported that IEHU use data to inform improvements (E1EH) (E3EH). Get out there and do things.
Reported that regions use IEH resources and they are effective and very practical (E2EH) Materials are presented in accessible way, makes them more accessible. (E2EH) Very solution-focused (E3EH) Very approachable (E6JF)
Working effectively in community requires strong understanding of community and linkages. (S1)
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Gathering and disseminating information
External stakeholders reported that key achievements or IEHU have been about research. (E1EH) (E4JF)
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Groups depend on IEH for information (e.g. Federal to regional and regional to Federal) (DOH)
Regional Implementation tools and resources really effective. (E7JF) Calculator is a practical tool. (E6JF) Communities can use it to advocate for resources (E6JF)
Have been effective in trachoma space getting key messages and resources out. (E6JF)
IEH see their role is to help and support (E8EH) Very good at research translation. (IE2)

Advocating for change
IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)
Regional Implementation stakeholders reported that IEH are successful at maintaining interest. (R4) Put spotlight on issues (E8EH)
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Question if they advocate for the Roadmap or for the community. (E9EH) Would like them to listen to community more (E9EH)
Access to lots of different tiers to influence policy (IE1)
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Very good at sharing information and getting it out. (E1EH)

Indigenous ownership
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)

Next step is to support creation of Indigenous -led intermediary. (IE1)

Staff at IEH want to strengthen Indigenous representation

Being Indigenous in this field of work is important and brings important perspective to the work. (S1)
Staff expressed opinion that IEH is not an Indigenous space and is not Indigenous-led. No Indigenous representation on leadership team. (S1)
Establishment of Aboriginal reference group for evaluation has been welcome addition. (S5) (IE1)
Staff expressed need for multiple Indigenous voices to be leading the work of IEH (S1)
Staff expressed desire to make commitment to fill new roles with Indigenous peoples. (S1)
Staff expressed opinion that IEH has not focused on cultural competency as a core skill set. (S1) Recently, IEH developed a cultural competency action plan. IEH staff have found this helpful. (S!)
Staff expressed that how to improve Indigenous leadership is constantly discussed in the organisation. (S5)

Think about creating a Roadmap for change

Roadmap to close the gap for vision

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Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[lxxiv]
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Staff notes

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Think about how to marshal efforts. This type of leadership is a paradoxical mix of personal humility and professional will

Regional implementation of the Roadmap.
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Impact of IEH leader
has been influential in not framing IEH through a traditional research structure. (S2)
pushes barriers and it can interrupt relationships with stakeholders, particularly in the Ophthalmology sector (S2, S3, R4, E2EH, E3EH)
has been effective in nurturing relationships at the Federal Government level. He has been developing these relationships for many years. (S2) (E2EH) (E3EH) (E6Jf) (E7JF) (E9EH) (IE2)
Some external stakeholders reported that this forthrightness is effective at creating change (E2EH)
Discussion around who could replace IEH leadership and his influence. (E3EH)

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IEH are academic experts but ACCHOs are community experts. Their expertise needs to be recognised (IE2.)
Culture wellbeing should be at the heart of everything that is done. (IE2)

What intermediaries do
Help the field meet its evolving needs by filling key capability gaps across a range of disciplines. Span traditional organisational boundaries. Conduct research, build public awareness, assess the fields strengths and weaknesses, advance policy, contribute to technical support to direct-service providers. Collect, analyse and share data.

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Groups depend on IEH for information (e.g. Federal to regional and regional to Federal) (DOH)
Regional Implementation tools and resources really effective. (E7JF) Calculator is a practical tool. (E6JF) Communities can use it to advocate for resources (E6JF)
Have been effective in trachoma space getting key messages and resources out. (E6JF)
IEH see their role is to help and support (E8EH) Very good at research translation. (IE2)

Resources

Annual Roadmap updates

IEH produces annual updates on the implementation of the Roadmap to high progress on regional implementation. Since 2011, IEH has produced nine annual updates (the most recent was published for 2020). These updates illustrate context, track process and health indicators, and track extent of implementation of the recommendations.

Technical publications produced by IEH[lxxx]

2009 reports:

- Diabetic retinopathy, accuracy of screening methods
- Outreach eye services in Australia
- National Indigenous Eye Health Survey

2010

- Trachoma Antibiotic Treatments: A Systematic Review

- Access to Eye Health Services Among Indigenous Australians
- Provision of Indigenous Eye Health services

2011

- The Cost to Close the Gap for Vision
- A Critical History of Indigenous Eye Health Policy-Making
- Projected Needs for Eye Care Services for Indigenous Australians

2013

- Software Roundtable Report

2014

- Health promotion roundtable report
- Regional Implementation Roundtable Report

2015

- National Diabetes Eye Care Health Promotion Workshop Report

2016

- Fundholder forum report
- Non Mydriatic Retinal Photography Roundtable Report
- Planning Sustainable and Coordinated Indigenous Eye Health Services Roundtable Report

2018

- Jurisdictional snapshots were published for each state and territory. These snapshots provide information on provision of eye services, and information about primary health care networks.[lxxxi]

2020

- Victorian Aboriginal Eye Health Regional Stakeholder Forum Report

Position papers prepared by IEH[lxxxii]

- Fundholders and Outreach Funding
- ACCHOs and Good Eye Care Services
- PHNs and Indigenous Eye Care
- National Oversight
- National Leadership
- Role for Jurisdictions
- Mandatory MBS 715
- Cataract Monitoring
- Clinical Practice Software
- Indicators
- Sector Linkage
- Education and Trachoma
- Training, workshops, and events

Development of training resources

Training resources[lxxxiii]

Self-directed online learning courses

- Remote Area Health Corps: Trachoma Module
- Remote Area Health Corps – Trichiasis
- Remote Area Health Corps – Eye Health and Diabetes
- Trachoma Grading Self-Directed Learning
- Diabetic Retinopathy Screening Card
- Diabetic Retinopathy Grading Course

Convening of roundtables and workshops

Roundtables and workshops convened by IEH[lxxxiv]

- 2013 - Software Roundtable
- 2014 – Health Promotion Roundtable
- 2014 – Regional Implementation Report
- 2015 – National Diabetes Eye Care Health Promotion Workshop
- 2016 – Non Mydriatic Retinal Photography Roundtable
- 2016 – Fundholder Forum
- 2020 – Victorian Aboriginal Eye Health Regional Stakeholder Forum

Close the Gap for Vision Conference
Started in 2017. Four conferences to date. Last one in April 2021. (S1)

Advocating for change
IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)
Regional Implementation stakeholders reported that IEH are successful at maintaining interest. (R4) Put spotlight on issues (E8EH)
External stakeholders expressed that IEH are strong advocates (E2EH)
Very effective advocates in government (E1EH)
Effective advocates who drive significant investments in funds (E7JF) Raising profile of eye health (E8EH) Put a spotlight on issues. Leverage networks to facilitate advocacy. (E8EH)
Question if they advocate for the Roadmap or for the community. (E9EH) Would like them to listen to community more (E9EH)
Access to lots of different tiers to influence policy (IE1)
Can be pushy (IE2) Some stakeholders find this frustrating and feel it interferes with collaborative communication. (E3EH)
Very good at sharing information and getting it out. (E1EH)

Indigenous ownership
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)
Next step is to support creation of Indigenous -led intermediary. (IE1))
External stakeholders observed that the way IEH approaches Indigenous issues is improving. (E2EH) (E7JF) (IE2)
External stakeholders reported that IEHU are advocates for ensuring thar Indigenous representation is present (E2EH) (IE1)
Aboriginal priorities and IEH priorities

Stakeholders involved in implementation expressed issue with eyes not being seen as priority when compared to other chronic diseases ACCHO affiliates don't always see eyes as priority.
IEH needs to work with the priorities of the Indigenous stakeholders. (IE2) (E1EH) (E5EH) (E2EH) Priorities need to be Indigenous led (E2EH)
Move past comparing Indigenous people to mainstream Australians and striving for excellence. (IE1)
Sometimes IEH leadership show lack of respect to Indigenous individuals (IE1) IEH leader has advocated against roles that were wanted by Aboriginal communities. (Eye health coordination positions)
IEH are academic experts but ACCHOs are community experts. Their expertise needs to be recognised (IE2.)
Culture wellbeing should be at the heart of everything that is done. (IE2)

Stakeholder perspectives
External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)
Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1

Appeal to multiple funders. Secure multiple funding sources. Earn credibility and win enough trust to influence the fields other actors. Steers funding streams without controlling them

History of funding for IEH [lxxxv]

2008
- Harvard Mitchel
- Ian Potter
- Cybec
- CBM

2013
- 16.4 million from federal Government for Trachoma
- Gandal Foundation
- Q Elizabeth Diamond Jubilee Funds
- Anne Miller

2014
- DOH grant for Roadmap 2014-2016

2015
- DOH grant for trachoma 2015-2017

2016
- DOH grant for Trachoma 2016-2019

2017
- DOH grant for Trachoma 2017-2021
- Paul Ramsay Funding 2017 – 2021
- Minderoo Funding 2017 - 2021

2019
- DOH Grant for Trachoma 2019-2023

EFFECTIVENESS

Freedom and flexibility
Staff notes
IEH has had access to independent funding, philanthropic private funding. University has been very flexible. Has allowed IEH to be flexible, innovative, and adaptive. (S2)
IEH team has breadth and experience. Means team is flexible and open, multi skilled and can make multiple contributions. (S2)

External stakeholders
External stakeholders also commented on IEHUs unique position of independence and agility (E2EH)
Being part of a university gives them credibility and influence (E8EH)

Roadmap is effective because it is funded. (E1EH)

Impact of IEH leader
has been influential in not framing IEH through a traditional research structure. (S2)
pushes barriers and it can interrupt relationships with stakeholders, particularly in the Ophthalmology sector (S2, S3, R4, E2EH, E3EH)
has been effective in nurturing relationships at the Federal Government level. He has been developing these relationships for many years. (S2) (E2EH) (E3EH) (E6Jf) (E7JF) (E9EH) (IE2)
Some external stakeholders reported that this forthrightness is effective at creating change (E2EH)
Discussion around who could replace IEH leader and his influence. (E3EH)

Advocating for change
IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)
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Can be pushy (IE2) Some stakeholders find this frustrating and feel it interferes with collaborative communication. (E3EH)
Very good at sharing information and getting it out. (E1EH)

Consult with many, but make decisions within a small group. Seek input from many but limit decision making to a comparative few.

Pursue policy goals

Pursues policy goals: implementation of a nationally consistent subsidised spectacle scheme. Prioritisation of cataract surgery for Indigenous Australians. Establishment of bulk billing agreements for services funded by RHOF and VOS. Funding of ophthalmology and optometry training visits. Security of funding for elimination of trachoma and adequate capped funding for implementation of Roadmap.[lxxxvi]
Collects and disseminates evidence. State and national health outcomes and process indicators adopted and reported. Advocating to establish diabetic eye screening rates as a key performance indicator for Primary Health Networks.[lxxxvii]

Impact of IEH leader
has been influential in not framing IEH through a traditional research structure. (S2)
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Some external stakeholders reported that this forthrightness is effective at creating change (E2EH)
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Collaboration with partners

Endorsed by NACCHO, Optometry Australia, RANZCO, Vision 2020. Collaboration with Australian College of Rural and Remote Medicine, Brien Holden Vision Institute, cbm, Crana Plus, Diabetes Australia, The Fred Hollows Foundation, Royal Australian College of General Practitioners.

- Participate Vision 2020 Australia
- Chair the Optometry Australia Aboriginal and Torres Strait Islander Eye Health Advisory Group
- Chair the OCANZ Indigenous Strategy Taskforce
- Sit on following project committees: National Subsidised Spectacles Scheme, National Eye Care Equipment Inventory, and Strong Eyes, Strong Communities implementation projects

Setting a strategic vision

Staff notes
IEH invested significant time and effort in development of the Roadmap. Significant consultation and review of data and evidence and review of population-level data. Invested significant time in getting buy-in and codesigning solutions. This formative work was done in 2008. (S2)
IEH have remained committed to the implementation of the Roadmap over time. (S2)
External stakeholders recognise the amount of consultation that went into the Roadmap. (E1EH)
External stakeholders expressed the view that IEHU has been unwavering in its commitment to the Roadmap at the expense of listening to the views of Indigenous peoples. (E1EH) Other stakeholders felt that the Roadmap provides direction rather than tells communities what to do (E2EH) (E1EH) (E9EH)
Perception from external stakeholders that the Strong Eyes Strong Communities document is a response to the Roadmap not adapting to the needs of Indigenous communities. (E1EH) (IE2) Strong Eyes Strong Communities fills the gap of working with Indigenous communities (IE2) NACCHOS and ACCHOS should have greater leadership over the Roadmap and the Roadmap should be community-led (E1EH, E2EH)
Provided clear, concrete tasks. (E5EH) (E2EH)
Would like to see more flexibility in Roadmap (E7JF)
Challenge for Roadmap to meet complexity of each area. (E8EH)
Roadmap is top down (E9EH)
Need to listen to field more (E9EH)

Advocating for change
IEH continually identifies and advocates for change. Examples: coordination of funds, improve health promotion, community-level activity, raising money, facilitating collaboration. (S5)
External stakeholders expressed that IEH are strong advocates (E2EH) Very effective advocates in government (E1EH)
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Can be pushy (IE2) Some stakeholders find this frustrating and feel it interferes with collaborative communication. (E3EH)
Very good at sharing information and getting it out. (E1EH)

Indigenous ownership
Sustainability of the intermediary not at forefront when developing Roadmap. (S5).
IEH needs to start having conversations around sustainability and working with regions to consider how to begin the process of thinking about sustainability. (S5)
Staff expressed opinion that it is difficult to identify the ideal people or organisations to take this work and make it Indigenous-led. (S1, S2) Issue of how this work can become Indigenous-led. (S2). NACCHOS and ACCHOS are important players. (S2, S1) ACCHOS have close connections to communities and so are better placed to do long-term intensive community engagement. (S1)
IEH staff expressed opinion that NACHHOS and ACCHOs are more concerned with delivery of primary care rather than specialist services. (S2)
Sector needs Indigenous-led ownership over future of Intermediary activities. (S1)

External stakeholder notes

External stakeholders also expressed opinion that it would be difficult to find an appropriate Indigenous-led organisation (which current exists) that could take on the responsibilities of the intermediary. (E1EH)
External stakeholders expressed opinion that ACCHOS should be leading regional implementation (E1EH)
Relies on building capacity of Indigenous peoples from a very young age to be able to participate in the kinds of networks and groups that can improve the lives of Indigenous communities (E7JF)
Need to start preparing the next generation. (E1) Need to evolve skills to community (IE1)
There are Indigenous -led vehicles are available, but not enough Aboriginal people sitting in the eye health roles. (IE1)
Next step is to support creation of Indigenous -led intermediary. (IE1)

Staff at IEH want to strengthen Indigenous representation
Being Indigenous in this field of work is important and brings important perspective to the work. (S1)
Staff expressed opinion that IEH is not an Indigenous space and is not Indigenous-led. No Indigenous representation on leadership team. (S1)
Establishment of Aboriginal reference group for evaluation has been welcome addition. (S5) (IE1)
Staff expressed need for multiple Indigenous voices to be leading the work of IEH (S1)
Staff expressed desire to make commitment to fill new roles with Indigenous peoples. (S1)
Staff expressed opinion that IEH has not focused on cultural competency as a core skill set. (S1) Recently, IEH developed a cultural competency action plan. IEH staff have found this helpful. (S!)
Staff expressed that how to improve Indigenous leadership is constantly discussed in the organisation. (S5)

Indigenous issues
Work undertaken by IEH historically has not always been community-led of focussed on being Indigenous-led. (S5) Promoting local adaption of health promotion resources is improving. (S3) Examples include providing materials with space for language on Trachoma materials (S4) and promoting local ownership over the Check Today See Tomorrow resources. (S5).
IEH reports that it has been influential in encouraging mainstream organisations to engage in Indigenous issues. (S2) Example: working with Australian College of Optometry, Vision 2020 Australia, and RANZCO to develop RAPs (S2)
External stakeholders observed that the way IEH approaches Indigenous issues is improving. (E2EH) (E7JF) (IE2)
External stakeholders reported that IEHU are advocates for ensuring thar Indigenous representation is present (E2EH) (IE1)

Aboriginal priorities and IEH priorities

Stakeholders involved in implementation expressed issue with eyes not being seen as priority when compared to other chronic diseases ACCHO affiliates don't always see eyes as priority.
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Stakeholder perspectives

External stakeholders discussed shifts to prioritising self-determination over past decade. (E2EH) (E5EH (E2EH)
Stakeholder expectations are changing. Expecting initiatives to be Indigenous-led (E5EH) (E7JF) (E9EH) (IE1

7.2 Appendix two: full list of key and sub evaluation questions

1. Impact. Which individuals, agencies and groups have experienced change as a result of their interaction with IEH, and what kinds of changes have they experienced?

    a. What have stakeholders (including individuals, agencies or groups) learnt about what is happening at the local/state/federal level because of IEH?
    b. What have stakeholders (including individuals, agencies or groups) learnt about improving eye health care for Indigenous people?
    c. What kinds of new networks have stakeholder groups been connected to?
    d. Has IEH contributed to increased commitment to Close the Gap for Vision among stakeholders?
    e. How have stakeholders used the knowledge and connections provided by IEH to contribute to closing the gap for vision?
    f. How have stakeholders made changes to systems and ways of working as a result of their interaction with IEH?
    g. What contribution has IEH made in creating a shared agenda for stakeholders?
    h. Has IEH been successful in identifying and leveraging Indigenous stakeholders who can lead and take ownership over eye health issues into the future
2. Effectiveness. What does IEH do that contributes to change? What are the qualities and attributes that have contributed to IEH effectiveness? Is there anything different that IEH could have done to be more effective in its work?

    a. How effectively does IEH engage with relevant and appropriate stakeholders (including individuals, agencies or groups)?
    b. How effective have IEH's efforts to connect stakeholders between local, state, and federal levels been?
    c. How effective is the information (and technical inputs) that IEH disseminates to stakeholders?
    d. How effective have IEH's advocacy activities been?
    e. How has the presence of influential champions and leaders contributed to the effectiveness of IEH activities (especially advocacy activities)?
    f. Has taking a regional team approach to supporting implementation of the Roadmap been effective?
    g. What are the benefits and drawbacks of having an approach that focuses on change at the national, jurisdictional and regional levels?
    h. How effectively has IEH been in identifying Indigenous stakeholders who can take ownership of IEH activities and promotion of eye health?
    i. How effective has IEH been at blending Indigenous cultural knowledge with knowledge about eye health and collaboration building?
3. The way forward for IEH and building Indigenous leadership into the future?

    a. What is the impact of this work being led by a non-Indigenous organisation?
    b. What changes have occurred over the past decade in regard to opinions on the need for work to be Indigenous-led, and how has IEH adapted to these changes?
    c. Have Indigenous organisations, peoples, and communities been sufficiently engaged and consulted over the life of The Roadmap?
    d. How much influence have Indigenous communities had over the strategic direction of IEH?
    e. How does IEH create trusting relationships in its work, and how effective are these approaches?
4. Sustainability. If IEH were to cease work what would be the enduring impact of its work?

a. What activities has IEH undertaken to ensure sustainability of its work?
b. What has been the impact of policy implementation on ensuring sustainability
c. What has been the impact of workforce capacity building on ensuring sustainability?
d. What has been the impact of advocacy around funding commitments on ensuring sustainability?
e. What impact has Indigenous leadership had on ensuring sustainability?

7.3 Appendix three: interview schedule

There are two types of interview tools being used for this evaluation, which will be administered at the discretion of the interviewer and can also be at the discretion of the interviewee. The first tool is a standard semi-structured interview schedule. The second tool is a story collection template.

Interview tool one: story collection tool

We are wanting you to tell us a story about a time that IEH has been particularly effective in its activities. The story has a beginning, a middle, and an end. The beginning of the story describes what things were like before, the middle describes the actions that IEH took, and the end describes what changes have happened.

To help give you some prompts for your story, we have included a story template below.

- You don't have to follow the story template, if you already have a great story, feel free to share it with us
- You don't have to tell us the story in the order of beginning, middle, and end, you can change the order you tell us the story in if that works better for you
- The dot points below are just a guide to prompt thinking, you don't have to respond to each dot point
- You can choose to write your story, or just tell us

Beginning – what things were like before Prompts (to be tailored per interview subject) • How Indigenous peoples access eye health services • How well different service systems interacted • How well mainstream and Indigenous organisations and peoples interacted • Resources available to service systems • What kinds of resources did communities and organisations have access to
Middle – what IEH did Prompts • Was there a time where IEH developed some type of product (could be a strategy, a research report, or a digital tool) and this product had some kind of positive impact on people working in the field of Indigenous Eye health? What were the positive changes and how did IEH contribute to these changes? • Was there a time where IEH held some type of event (could be a conference, a presentation, a workshop) and you felt it made some kind of positive impact? What was the impact and how did IEH contribute to these changes? • In your opinion, what are the strongest relationships that IEH has established and maintained? Why are these relationships important and how do they help IEH meet their goals?
Prompts • Changes to policy, programs, funding models, workforce

- The way that different service systems interact
- The ways in which Indigenous and mainstream peoples and organisations interact
- The resources available for people working in the eye health system
- Changes in the ways that Indigenous peoples access eye health services
- Changes in the ways that services were delivered to Indigenous peoples

Interview tool two: semi-structured interview tool

These questions are designed to be modular. That is, people can respond to the questions that they feel they can respond to, and leave out the ones they don't feel that they can respond to.

The interviewer will have a list of the Key Evaluation Questions that they will use as prompts during the interview. The approach here in the interview is to ask more general questions about what is emerging from the interviews and to understand what is important to interviews, before asking more detailed questions about that respond closely to what the Key Evaluation Questions ask.

INTRODUCTION

- Tell me a little about yourself, and your role
- What is your relationship to the eye health care pathway and service system?
- What is your relationship to IEH? \

MOST SIGNIFICANT CHANGES

- In your opinion, what have been the Most Significant Changes that have occurred to Indigenous access to eye health and eye care as a result of the actions of the IEH from the University of Melbourne?
  [List changes]
  [Interview to repeat changes back to the interviewee]

- For each change you mentioned, I would like you to tell me:
  - What IEH did to create the change
  - Which other actors were involved
  - What might have happened if IEH was not around to create this change

COLLABORATION

Have you observed activities that IEH has done to promote collaboration of people and services? This could include informal efforts to connect people, or more formal efforts such as facilitating regional groups or networks, holding roundtables, etc.

[If yes, proceed to next questions. If no, proceed to next block]

- What was IEH doing to promote collaboration and integration?
- Who was involved?
- What were the challenges involved in creating these collaborations and networks?

- How were Indigenous peoples and communities involved?
- Who benefited from these collaborations?
- What impact have they had or are these collaborations likely to have on providing eye health services to Indigenous communities?

FACILITATION OF KNOWLEDGE ABOUT EYE HEALTH CARE AND EYE HEALTH SYSTEMS

Have you had any direct interaction with formal and informal dissemination of technical information about eye health care conducted by IEH? This includes things like health promotion resources, training, capacity building, and the calculator.

[If yes, proceed to next questions. If no, proceed to next block]

- What was the nature of the technical information, and who was the target audience?
- What is the impact for eye health care of this information being shared?
- Was the technical information shared the right type of information? Is there other technical information that should be made available? Was the quality of information adequate/good?
- Have you seen changes in the ways that health services provide eye health services as a result of the technical information provided by IEH?
- If IEH did not provide this information, who else would be able to provide this information?
- What activities has IEH done in regards to blending Indigenous cultural knowledge with knowledge about eye health?

ADVOCACY

Have you been involved in any advocacy activities implemented by IEH? This includes roundtables, development and/or dissemination of public papers, formal or informal advocacy with people of influence.

[If yes, proceed to next questions. If no, proceed to next block]

- What was the nature of the advocacy? What was it intending to do?
- In your opinion, was the advocacy activity successful, did it meet its intended aims?
- Who was involved in the advocacy activities?
- Were the right stakeholders involved? Who else should have been involved?
- What has this advocacy done to improve access to eye health care services for Indigenous peoples?
- What has IEH done in regards to supporting Indigenous leaders who want to advocate for improved eye health?

LEADERSHIP

Have you had any engagement with the leadership of the IEH?

[If yes, proceed to next questions. If no, proceed to next block]

- How does having people of stature and influence both help and hinder the goals and objectives of IEH?

- In your opinion, what has been the contribution of IEH's position in a prominent academic institution towards the goals (the goals being to close the gap for vision and improve eye health for Indigenous peoples)
- What do you think might happen if IEH was moved outside of an academic institution?

COMMUNITY ENGAGEMENT

Have you been involved in IEH's efforts to engage the eye health sector in the work of the IEH?

[If yes, proceed to next questions. If no, proceed to next block]

- What has IEH been doing to ensure Indigenous peoples and communities are engaged in the work of the IEH?
- Are Indigenous peoples and communities sufficiently engaged in IEH? If no, what more needs to be done?
- Are Indigenous peoples and organisations being given opportunities to lead interventions to improve eye health and to set the goals and objectives?
- In your opinion, what are the benefits and drawbacks of having a non-First-Nations organisation lead this work to improve eye health for Indigenous peoples?

CULTURAL SAFETY

- Do the staff of IEH conduct themselves in a culturally safe way?
- Are the activities of the IEH conducted in a culturally safe way?
- What could be done to promote cultural safety?

BUILDING INDIGENOUS LEADERSHIP

It is the goal of IEH to strengthen Indigenous leadership in the eye health care sector.

- Which Indigenous actors and/or Indigenous-led organsations do you think might be particularly well suited to providing leadership in the eye health care space?
- What factors need to be considered when building Indigenous leadership to strengthen eye health systems?
- In your opinion, what are the benefits and drawbacks of moving the work of IEH from the University of Melbourne to an Indigenous-led organisation or network?
- Are there ways that IEH can support a transition to enhanced community leadership and control?

Endnotes for evidence tables

[i] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/about/minum-barreng
[ii] Roadmap to Close the Gap for Vision
[iii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[iv] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0011/2260865/value-of-indigenous-sight-sep2015.pdf
[v] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0011/2260865/value-of-indigenous-sight-sep2015.pdf
[vi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[vii] Roadmap to Close the Gap for Vision
[viii] Roadmap to Close the Gap for Vision
[ix] Roadmap to Close the Gap for Vision
[x] Roadmap to Close the Gap for Vision
[xi] Correspondence received from IEH staff in July 2021
[xii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/about/minum-barreng
[xiii] Roadmap to close the gap for vision.
[xiv] Roadmap to close the gap for vision
[xv] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xvi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xvii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/asking-the-question
[xviii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/toolkit
[xix] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/diabetes
[xx] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xxi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xxii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[xxiii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/jurisdictional-snapshots
[xxiv] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/position-papers
[xxv] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/training-e-news/training
[xxvi] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[xxvii] Communication from IEH staff, received in May 2020
[xxviii]
https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2442858/NintiOne_EvaluationNationalTrachomaHealthPromotionProgramme.pdf

[xxx] Correspondence received by IEH staff in May 2021
[xxxi] This information was provided by IEH in 2020 and included in the evaluation plan
[xxxii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xxxiii]
https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2442858/NintiOne_EvaluationNationalTrachomaHealthPromotionProgramme.pdf
[xxxiv] Taz Hussein, Matt Plummer and Bill Breen. *How Field Catalysts Galvanize Social Change*. Stanford Social Innovation Review, Winter 2018
[xxxv] Roadmap to Close the Gap for Vision
[xxxvi] Roadmap to Close the Gap for Vision
[xxxvii] Roadmap to Close the Gap for Vision
[xxxviii] Roadmap to Close the Gap for Vision
[xxxix] Correspondence received from IEH in July 2021
[xl] Roadmap to close the gap for vision.
[xli] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xlii] Roadmap to close the gap for vision.
[xliii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xliv] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[xlv] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[xlvi] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/jurisdictional-snapshots
[xlvii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/position-papers
[xlviii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/training-e-news/training
[xlix] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[l] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[li] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/about/minum-barreng
[lii] Roadmap to Close the Gap for Vision
[liii] Roadmap to close the gap for vision.
[liv] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[lv] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/jurisdictional-snapshots
[lvi] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/position-papers

[lvii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/training-e-news/training
[lviii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[lix] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lx] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxii] This information was provided by IEH in 2020 and included in the evaluation plan

[lxiv] Roadmap to close the gap for vision.
[lxv] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxvi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxvii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxviii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxix] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxx] Roadmap to close the gap for vision.
[lxxi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxiii] Roadmap to close the gap for vision.
[lxxiv] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxv] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxvi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxvii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxviii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxix] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxx] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[lxxxi] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/jurisdictional-snapshots
[lxxxii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/position-papers
[lxxxiii] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/training-e-news/training
[lxxxiv] https://mspgh.unimelb.edu.au/centres-institutes/centre-for-health-equity/research-group/ieh/roadmap/technical-reports
[lxxxv] Communication from IEH staff, received in May 2020
[lxxxvi] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf
[lxxxvii] https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0006/2308443/Mckinsey-report-2017.pdf