ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Inception Report
(Incorporating Implementation Plan for Program Year 1)

October 2006 – June 2007

Australia Timor Leste Program of Assistance for Specialist Services (ATLASS)

PREPARED FOR

Australian Agency for International Development

By the Royal Australasian College of Surgeons

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ACRONYMS

Acronym	Definition
ADB	Asian Development Bank
AETSSP	Australia - East Timor Specialised Services Project
AIDS	Acquired Immune Deficiency Syndrome
ATLASS	Australia - Timor Leste program of Assistance in Specialised Services
AusAID	Australian Agency for International Development
BCG	Bacille Calmette-Guérin (tuberculosis vaccine)
BSS	Basic Surgical Skills
CFET	Consolidated Fund for East Timor
CHC	Community Health Centre
DHS	District Health Service
EC	European Community
EMSB	Early Management of Severe Burns
EMST	Early Management of Severe Trauma
ENT	Ear, Nose and Throat (otorhinolaryngology)
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HDI	Human Development Index
HDU	High Dependency (Nursing) Unit
HDR	Human Development Report
HF	High Frequency
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNGV	Hospitál Nacionál Guido Valadares
HRD	Human Resources Development
HSRDP	Health Sector Rehabilitation and Development Project
ICRC	International Committee of the Red Cross
IHS	Institute for Health Sciences
IPRs	Intellectual Property Rights
MDG	Millennium Development Goal
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MMed	Master of Medicine
MOH	Ministry of Health
MOPF	Ministry of Planning and Finance
MSF	Médicins Sans Frontières
MTEF	Medium Term Expenditure Framework
NDP	National Development Plan
NGO	Non-Government Organisation
NHSP	National Health Strategic Plan
NHWP	National Health Workforce Plan
O&G	Obstetrics and Gynaecology

Acronym	Definition
OT	Operating Theatre
PDD	Program Design Document
PMC	Program Management Committee (ATLASS)
PMU	Project Management Unit (HSRDP)
PNG	Papua New Guinea
PRC	People's Republic of China
PRET	Program Review and Evaluation Team
PTC	Primary Trauma Care
RACS	Royal Australasian College of Surgeons
RDTL	Democratic Republic of Timor Leste
SIP	Sector Investment Program
SJOG	Saint John of God (Hospitals)
SRG	Stakeholder Reference Group
SWAp	Sector Wide Approach
TFET	Trust Fund for East Timor
TORs	Terms of Reference
UKM	Universiti Kebangsaan Malaysia
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UPNG	University of Papua New Guinea
VPA	Volunteer Pathologists Australia
WHO	World Health Organization

AUSTRALIA TIMOR LESTE PROGRAM OF ASSISTANCE FOR SPECIALIST SERVICES (ATLASS)

INCEPTION REPORT
(INCORPORATING IMPLEMENTATION PLAN FOR PROGRAM YEAR 1)

OCTOBER 2006 – JUNE 2007

1. INTRODUCTION

The 'Australia Timor Leste program Assistance for Specialist Services' (ATLASS) program was ratified by AusAID on the 23rd of November 2006 with implementation commencing on the 1st of October 2006. This was to ensure a seamless transition from the completion of the Australia East Timor Specialised Services Project which was completed in September 2006.

The evolving governance context in Timor Leste naturally guides the program towards a biphasic structure.

Phase I (Years 1 and 2, and probably Year 3) would be defined by a bilateral program of assistance, managed by a contracted agency and funded by AusAID. Program activities would be viewed in the overall context of Government of RDTL budget planning and based on the operational priorities of the MOH.

Phase II would commence with the adoption of a sector-wide approach to funding and managing the health sector in Timor Leste, at which time program resources would then be managed by the MOH through a dedicated ledger account or AusAID trust fund and the contracted agency would become a direct implementing partner of the MOH. Transition from Phase I to Phase II would be determined by the Governments of Timor Leste and Australia on the advice of the PMC, based on the rate of progress towards a health SWAp.

The Program comprises four components that will support the priority needs for tertiary medical services in East Timor over 4 years and 9 months. The implementing agency is the Royal Australasian College of Surgeons (RACS), which will work closely with the MoH and staff at HNGV and regional centres. RACS will receive support from other organisations including but not limited to Rotary, the Australian Red Cross, St Johns Ambulance of Australia, ProVision Optometry Team (PVOT) and the Overseas Specialist Surgical Association of Australia, Orthopaedic Outreach as well as private donations.

2. PROGRAM DESCRIPTION

2.1 Purpose and Goal

The over-arching goal of the new Program is: **to improve the health status and outcomes of people in Timor Leste with surgically treatable illness, disability or trauma**.

The purpose of the Program is to improve the availability and quality of essential general and specialist surgical services for the people of Timor Leste.

2.2 Description of Components

2.2.1 Component 1 – Long Term Training, Mentoring and Capacity Building

Objective: *To strengthen general surgical, anaesthetic and peri-operative nursing capacity and clinical skills through a combination of in-country mentoring and short courses and out-of-country specialist training.*

Three long term clinicians (a general surgeon, an anaesthetist and a nurse practitioner) will be based in Dili. They will collaborate closely with the MOH, the Institute for Health Sciences, the Hospitál Nacionál Guido Valadares (HNGV) and the regional hospitals to provide in-service training, supervision, mentoring and technical support for East Timorese doctors and

nurses, monitor and guide improvements to the quality of surgical services, and help to strengthen systems and standards of operating theatre and peri-operative nursing and Intensive Care nursing.

The surgeon, anaesthetist and nurse will also support clinical service delivery at HNGV and, with East Timorese colleagues, conditions permitting, will conduct up to 12 outreach visits/year to centres outside Dili.

The Program will support the completion of specialist training for three medical graduates who have already commenced specialist training (in general and orthopaedic surgery and ophthalmology) under AETSSP or private sponsorship. Another six medical graduates will be identified by the MOH and supported to undertake overseas specialist training: in general surgery (up to 3), anaesthesia (2) and ophthalmic surgery (1).

East Timorese doctors and nurses will also be supported to undertake in-service training through short courses overseas and in Timor Leste in MOH-identified priority areas.

2.2.2 Component 2 - Short Term Specialist Support and Planning

Objective: *To support surgical and other clinical care through short term specialist visits and attachments, including through outreach to rural and regional communities.*

In addition to outreach visits by the resident specialists, the Program is able to mobilise visiting teams and individuals across a range of specialty areas to support service delivery at HNGV and in the regional hubs: examples are; cardiac surgery, ENT surgery (including audiology screening), ophthalmology (including optometry screening and rehabilitation), orthopaedic surgery, paediatric surgery, plastic and reconstructive surgery and urology. Each visiting team will be entirely self-sufficient for surgical disposables.

To maintain flexibility and responsiveness within the available budget, the exact number, type and duration of specialist and team visits will be determined annually by the MOH in consultation with the Program Management Committee. Should an unforeseen short-fall occur among resident specialists (at HNGV or elsewhere), there is flexibility to reprogram part of the budget for this Component to temporarily support an additional in-country specialist until the staff situation stabilises.

The Program also includes other short term support in bio-medical engineering (pending commencement of the European Community project) and, in synergy with the St John of God hospitals laboratory project and Australian Pathology volunteers, the development of basic histopathology and telepathology capabilities.

A new Program data base will link with the evolving MOH information systems to assist the MOH to effectively forecast, plan and manage specialist and other clinical service delivery in Dili and in the regions; it will also support gender- and age-stratified analysis.

2.2.3 Component 3 – Institutional Linkages Facility

Objective: *To provide targeted support for surgical and other clinical care and support services through strategic linkages with Australian and other international institutions*

To strengthen professional relationships and mobilise support where national budget short-falls exist, a small, highly flexible, demand driven Facility will be established to assist the MOH to harness, develop and strengthen twinning relationships with hospitals, ambulance services, government departments, private foundations and other institutions in Australia and internationally.

The primary focus will be on building human capacity and professional relationships in the most practical and cost-effective way – principally through exchanges of nurses and allied health professionals on well targeted, carefully selected clinical attachments with agreed learning objectives and defined outcomes. The Facility will be resourced so that it could provide for up to 10 such visits each year (with ongoing distance mentoring).

With the agreement of the MOH, Facility resources may be used to identify and mobilise extra-budgetary funding for higher level specialist clinical care or assist areas of the funded MOH program that lack in-country technical expertise (e.g. further development of ambulance services).

2.2.4 Component 4 – Program Management and Monitoring

Objective: *To manage the Program effectively and efficiently, and maintain a program office at HGNV*

To ensure close liaison with MOH counterparts and other international assistance missions and to support resident staff, visiting teams, training activities and the institutional linkages, the Program will maintain an office with two staff at HNGV. One of the resident long term advisers will be appointed as Team Leader.

A Program Management Committee (PMC) will meet twice each year to review progress, discuss and approve projected work plans and expenditure, and adapt to constraints and emerging risks. The PMC will include MOH and AusAID representatives and the in-country and Australia-based Program management team; it may also include trainee representation and district or community stakeholders. PMC meetings will also include a standing agenda item to discuss surgical services development and activity coordination in Timor Leste with delegates from other international medical assistance missions.

The key counterpart for the Program is the MoH.

2.3 Planned Outputs

The intended outputs of the Program according to each component are as follows.

2.3.1 Component 1 – Long Term Training, Mentoring and Capacity Building

- **Output 1.1** – Improved surgical services, training and supervision through long term General Surgeon support
- **Output 1.2** – Improved anaesthesia services, training and supervision through long term Anaesthetic support
- **Output 1.3** – Improved standards of peri-operative nursing and infection control through long term Nurse specialist training, supervision and support
- **Output 1.4** – A core group of East Timorese doctors with recognised specialist qualifications
- **Output 1.5** – Primary care doctors with improved surgical, trauma and burns management skills
- **Output 1.6** – Nurses with improved skills in anaesthesia and peri-operative and procedural nursing

2.2.3 Component 2 - Short Term Specialist Support and Planning

- **Output 2.**1 – Surgical, anaesthetic and peri-operative nursing outreach visits to Regional Hospitals and rural Districts
- **Output 2.2** – Provision of specialist surgical and other services by visiting teams and individual specialists
- **Output 2.3** – Improved information management and other non-clinical support systems

2.3.3 Component 3 – Institutional Linkages Facility

- **Output 3.1** – Institutional Linkages Facility established and operational guidelines developed
- **Output 3.2** – Targeted support facilitated and maintained through institutional linkages and twinning arrangements

2.3.4 Component 4 – Program Management and Monitoring

- **Output 4.1 –** Systems for Program management and monitoring established and maintained
- **Output 4.2 –** Program performance monitored continuously and reported periodically
- **Output 4.3 –** Risks to Program implementation monitored continuously, and remedial action taken as necessary

2.4 Strategy for Implementation

The Program aims to improve the availability and quality of surgical services through four over-arching strategies:

a) by maintaining three long term advisers in Timor Leste:
   - ♦ a specialist surgeon,
   - ♦ a specialist anaesthetist, and
   - ♦ a nurse with skills and experience in peri-operative nursing and infection control

   The advisers will be specifically tasked to collaborate closely with the MOH (specifically, the clinical service departments at HNGV and the IHS), to provide in-service training and assist with systems strengthening, quality assurance and other types of capacity building for East Timorese clinical staff and counterparts;

b) by supporting a range of clinical service delivery through the continued short-term deployment of specialist medical teams and individuals (at MOH request).
   The short-term placements will have a focus on extending services to regional hubs as the regional hospitals become operational;

c) by supporting selected East Timorese doctors to undertake and complete specialist training in general and orthopaedic surgery, ophthalmology and anaesthesia, and by training and providing in-service supervision and technical support for East Timorese nurse anaesthetists and other categories of health worker; and

d) by supporting selected East Timorese doctors, nurses and other categories of health worker to undertake a range of in-country and targeted overseas short courses to strengthen their skills and capacity, gaining leverage from institutional linkages with Australian and other international partners.

To facilitate a 'learning by doing' approach to in-country training, all resident medical specialists may participate in the clinical and on-call rosters at HNGV and in clinical outreach activities to regional and district facilities.

The Program's approach to building capacity will place an emphasis on clinical training. The inherent flexibility of the Program will also allow it to respond to emerging capacity or skills gaps and other priorities (by mutual agreement between the MOH and AusAID). This flexibility may include areas that are complementary to and support delivery of surgical, anaesthetic and peri-operative nursing services (e.g. primary trauma care, laboratory capacity and medical equipment maintenance).

Surgical and anaesthetic training will focus on preparing East Timorese doctors to work independently as surgeons and anaesthetists under prevailing conditions in Timor Leste, and to support them to assume a leadership role in clinical mentoring for colleagues returning from overseas medical training – and eventually also those graduating from the new medical school in Dili.

Support for anaesthesia and nursing will be provided through in-country mentoring and courses delivered through the IHS, supplemented where appropriate by short courses in suitable overseas locations.

All training activities will be supported by mutually agreed learning targets and objectives. Overseas short courses and placements will be additionally supported by adequate pre-placement planning and targeted mentoring to assist the integration of new skills and approaches on return to Timor Leste.

In areas where Timor Leste is unlikely to have specialist personnel within the life of the Program (e.g. in laboratory medicine and radiology), innovative approaches to capacity building will be adopted – e.g. distance education, telemedicine, telepathology and remote technical support arrangements with regional, Pacific Rim and other partner institutions where possible and appropriate.

The Program will also help strengthen the MoH's ability to monitor and plan clinical services including the selection of future Australian and other international specialist visits and placements. The Program will engage a volunteer technical specialist through one of the Australian Government's volunteer programs for an initial period of 12 months. The aim is to develop an appropriate information system and generate 'information for management' for the MOH. The volunteer will work closely with MOH counterparts, resident and visiting clinicians and the Program Coordinator to develop data collection forms and a computerised data base (in a format compatible with the evolving MOH HMIS). The information system should be able to integrate data from other clinical areas of the health sector and be absorbed into the evolving MOH HMIS.

The strategic location of the Program office at HNGV in Dili will enable the team to maintain close communication with health service managers, members of other international medical assistance missions and other development partners. Where East Timorese or other partners are able to meet all MOH requirements for training or service delivery, ATLASS resources may be deployed to other areas. Where short-falls arise, Program resources may be used to formulate solutions or to provide core support to the MOH. Where synergies or leverage can be achieved or value added – e.g. through broadening the geographic "reach" of specific specialist services or training activities, or by addressing different aspects of a common technical area such as BME or infection control – activities may be implemented jointly or collaboratively with other organisations.

2.5 Monitoring & Evaluation Strategy

For the purposes of performance assessment and monitoring, the Goal, Purpose and underlying strategies of the ATLASS Program fall into two parallel and inter-connected groups:

a) Direct activities and support for service provision (e.g. the long term advisers performing surgical and anaesthetic procedures, the volunteer technical specialist developing an information system)

b) Building the capacity of the MOH to deliver those same services (i.e. through the benefits accruing from specialist medical training, short training courses, clinical attachments and mentoring).

In the health sector, clinical capacity building is largely the result of a 'learning-by-doing' approach with outcomes that often demonstrate complex, non-linear causal relationships. The flexible, rolling design structure of the ATLASS Program further complicates attempts to apply a simple cause-and-effect approach to performance assessment.

For example (under Output 1.1), the General Surgeon will contribute directly to Objective 1, the Purpose and the Goal of the Program by providing surgical services of a very high standard; this is measurable, and can be confirmed by indicators of clinical outcome (e.g. clinical audit, cause-specific mortality). The Adviser will also provide training, mentoring and supervision for East Timorese doctors, further contributing to that Objective, the Purpose and the Goal.

However, the achievement of the Goal, Purpose and some Outcomes may be influenced by contextual factors outside the Program's control (e.g. the availability and activities of surgeons working for other international assistance missions who may, from time to time, demonstrate an interest in clinical training and supervision or influence the style or results of training provided through the Program). Outcomes will also be subject to risks affecting the learning environment (e.g. political stability in Timor Leste, which will affect recruitment and retention of specialist trainees and their ability to focus on their learning program).

Similar experience from AETSSP showed that 'externalities' of this type add to the complexity of monitoring the performance of the contracted agency and assessing its relative contribution to more complex outcomes.

The Program will therefore use two streams of information to document performance:

Quantitative, Qualitative and Participatory Assessment

The Program will maintain records that match the activities it has undertaken and the inputs delivered with the nature and quality of outputs and outcomes.

Input and activity data will be available from the records of the in-country Program team and the Facility Manager, and through MOH human resources data. The Program will also make increasing use of the information system as a source of monitoring data as that system matures.

The quality of clinical activities will be measured through clinical audits (where possible), while the quality of training will be assessed from participant responses and through follow-up of participants' ability and success in absorbing the content of training courses into their routine work. The possibility of undertaking succesful audits and measures will be largely determined by the resources and situation in the hospital and country and the workload faced by the team members.

Down-stream assessment of the Program's impact on the availability and better targeting of surgical services throughout Timor Leste will be assessed by 'mapping' outreach activities to rural and regional centres, using the MOH's own reporting tools (as they become available) and the Program information system (as it develops). Community consultation and participation in assessment can yield important information about the context in which the Program is operating, especially in regional and rural areas. The ability to perform these assessments over the lifetime of the program will be dependent on the security situation in Timor Leste as this will impact on the ability to travel.

Periodic Contextual Analysis

The Program's performance framework needs to analyse changes taking place in the complex and fluctuating development environment in Timor Leste, which may require adjustments to the Program design and the focus of activities. These factors will inevitably influence the role, function and contribution of the Program in achieving its Purpose and – to a variable extent – Objectives 1 and 2.

The **Program Management Committee** (PMC) will provide a regular forum for review of data collected by the Program and broader assessment of its performance. The inclusion of MOH, DHS, trainee and other stakeholder representation on the PMC will allow it to address priority

and evolving needs and relationships in the health sector, and to assess the performance and relevance of the Program's work plan.

The experienced **Program Review and Evaluation Team** will undertake an annual higher order analysis of the development context, the Program's impact and effectiveness, the value-for-money that it represents, and the performance of the funded organisation. At the beginning of each PRET mission, the Team Leader will brief the team on evolving and contextual issues affecting the health sector and the Program's activities (including changes in other international medical assistance missions and shifts in the donor and fiscal environment in Timor Leste). The PRET will undertake any necessary additional consultations and analysis of documents and Program data, and then advise the PMC and AusAID on any possible adjustments to the overall direction of the Program for the next year. In its mission to Timor Leste in Year 3, the PRET will consult widely with other donors and development partners. It will pay particular attention to progress towards a health SWAP, and will advise AusAID on the readiness of government systems for a graduation of the Program to Phase II.

To assist both the PRET and the PMC, a **Stakeholder Reference Group** comprising a combination of health sector representatives (e.g. trainee, hospital and DHS personnel) and down-stream beneficiaries (e.g. community members) will help to examine available experience and data indicating Program outcomes and impact.

Reporting

The in-country and Australia-based management team will ensure timely documentation of activities (including through the Program's information system; Output 2.3), and reporting in accordance with the standard AusAID reporting format. This will record performance against indicators developed for each annual implementation plan, and assist with monitoring Program outcomes and impact.

The reporting requirements to be met include:

a) a brief Inception Report within 6 weeks of mobilisation, detailing and justifying any adjustments to the Program Design;

b) rolling Annual Implementation and M&E Plans; annual plans may be adjusted every 6 months following discussion at the PMC meeting;

c) Six-Monthly Activity Reports to the PMC, to include the rolling implementation plan or its update;

d) Brief 'exception reports' on any unforeseen problems and/or response to emerging risks;

e) monthly acquittals of expenditure in accordance with the Scope of Services; and

f) a Program Completion Report and, depending of the model adopted for Phase II and decisions around Program extension, a handover plan.

2.5.1 Monitoring & Evaluation Plan for Program Year 1

The activities to be undertaken in the first year of the Program include:

- development of the first year's monitoring and evaluation (M&E) plan (refer to Annex 1: Implementation Schedule)
- development of draft performance indicators (to be endorsed at the PMC in May 2007);
- establishment of TOR for the SRG and identification of members;
- program documentation and reporting; and

- under the guidance of the PMC and AusAID, and in consultation with the PRET, initiation of SRG activities.

2.5.2 Draft Program Performance Indicators

The Draft Program Performance Indicators are identified in the ATLASS Program Summary Logframe (Refer to Annex 5) and will be endorsed by the PMC in May 2007. They include a mix of quantitative and qualitative indicators and responsibility for the different levels of indicators belongs with various entities including the PRET, the PMC, the SRG and RACS.

The draft higher-level performance indicators for the Program include:

- Improved health outcomes for people with surgically treatable illness, disability or trauma in Timor-Leste:
    - Number and geographical distribution of doctors, nurse anaesthetists and nurses with improved skills and competencies;
    - Quality of clinical outcomes for a defined range of common surgical conditions in Timor Leste.

2.6 Risk Management

Timor Leste presents a dynamic and unpredictable environment in which to implement development activities. As events in 2006 demonstrated, internal and external events may potentially disrupt Program activities and pose security risks to international as well as locally engaged team members.

A Risk Management Plan has been developed as part of the PDD and modified slightly to reflect the current context in Timor Leste (refer to Annex 4). This will need to be reviewed and endorsed by the PMC at its initial meeting in 2007.

The following changes have been made since the Program Design Document:

- 'Identified specialist positions in MOH staff establishment not yet available for returning trainees' – Likelihood changed from 'Low to Intermediate' to 'Low' because we have been assured by the MOH that the trainees' positions in MOH will be maintained while they are away.
- 'MOH and program unable (or slow) to identify suitable candidates for overseas specialist medical and nursing training positions, or early withdrawal of candidates from training' – Likelihood changed from 'Intermediate' to 'Intermediate to High' as there is only a limited number of people who are suitable for these positions, especially due to language difficulties, and, in the current security situation most are unwilling to leave their families while they undertak overseas training.
- 'Large cohort of medical graduates returning from overseas overwhelms MOH supervisory capacity' – Likelihood changed from 'High' to 'Low – Intermediate' because the medical trainees have only recently commenced their studies overseas and will be overseas for most of the Program.
- Political and/or civil and/or military instability – Likelihood changed from 'Low to Intermediate' to 'Intermediate to High' reflecting the events of 2006 and the current situation, especially with elections scheduled for 2007.

2.6.1 Risk Management Plan for Program Year 1

The activities to be undertaken in the first year of the Program include:

- review and endorsement of Risk Management Plan (refer to Annex 4) by PMC;
- development of a Security Plan (refer to Annex 6);
- continuous monitoring of implementation environment and context by Program Team.

2.7 Sustainability

In the experience of the AETSSP, people have been one of the great strengths and, overall, the sustainability of technical skills acquired through ATLASS (e.g. surgical specialists, nurse anaesthetists, basic surgical skills, primary trauma care and EMST) is likely to be good.

However, Timor Leste is unlikely to be self-sufficient in general, orthopaedic or ophthalmic surgery until 2025., The nation is also not likely to be able to provide advanced sub-specialty services in areas like ENT, plastic surgery or laboratory sciences until beyond that time. However, the training inputs of the Program will build a core cadre of local specialists to guide and monitor the development of specialist services into the future, and to mentor the emerging generation of newly qualified medical practitioners from the Cuban and local training schemes.

The Institutional Linkages Facility will be an important contributor to sustainability through its focus on the development of enduring person-to-person and institution-to-institution technical and professional relationships.

3. REVIEW OF PROGRESS FROM THE INCEPTION PHASE

The following achievements refer to work undertaken during the Inception Phase between October and December 2006. Progress during the inception phase was affected by the security situation in Timor Leste and the delay in the signing of the contract. The contract was finally signed signed on 23 November 2006, which meant that the program was operating for 7 weeks without a signed contract. While core activities continued throughout this period, implementation of new activities, including the process for recruiting the long term nurse, specialist visits and the recruitment of a Facility coordinator/manager, had to be delayed.

Timor Leste experienced civil unrest throughout this period, with fluctuating levels of violence directly affecting the operations of the hospital system. The security situation has had implications for staff availability, morale and cooperation, as well as the availability of supplies. Program personnel have observed that staff at the HNGV seem constantly worried, depressed, or angry, and many operating theatre nurses have been particularly unmotivated to work.

The hospital is facing a crisis of IDPs living in the refugee camp within the hospital grounds. The hospital management or the MOH and government are having to deal with this crisis. Many patients are reluctant to come to the hospital even when they have serious injuries as the hospital is considered to be in an unsafe area. Some patients have apparently been threatened by some of the IDPs on the hospital grounds and left without getting treatment.

The rainy season which started in early December will further affect the ability for patients to travel or for the Program specialists to undertake Outreach visits. There are strong concerns of a possible epidemic disease outbreak within the refugee camps. As there were no apparent plans being drawn for epidemics of dengue, malaria or cholera, the Program is assisting hospital management with an emergency preparedness Plan.

3.1 Achievement of Objectives by Component

3.1.1 Component 1 – Long Term Training, Mentoring and Capacity Building

Full time general surgical services at HNGV have been provided by a rotation of surgeons throughout the inception period. These rotations have been effectively managed to ensure that no gaps in service occurred. There has been continuous cover of general surgical services including a 1:3 night and weekend on-call service. The long-term General Surgeon support clearly improves surgical services, training and supervision of East Timorese surgical trainees.

During the inception period Drs Katherine Edyvane (15 September – 30 October), Robert Black (31 October – 1 December), Phil Truskett (4 – 17 December) and David Watters (18 December – 16 January), have been the Program's general surgeons. 91 operations were carried out by the Program's surgeons up to 18 December (plus the 33 plastic and reconstructive surgery procedures during the visit in November 2006).

The General Surgeons have continued to mentor local staff throughout the inception period including; Dr Joao Pedro since returning from PNG in mid-November (where he passed his Part 1 MMeD in Surgery), Dr Joao Ximenes since returning from Malaysia on 1 December, and Dr Helder, a new Timorese surgical trainee, throughout the period. Apprenticeship style training has been provided in theatre, with the Program's general surgeon providing supervision and assistance.

Full time anaesthesia services at HNGV have been provided throughout the inception period by Dr Eric Vreede, the Program anaesthetist since 1 July 2004. There has been continuous cover of anaesthesia services with a 1:3 or 1:2 on-call rota. 146 anaesthetic procedures were provided to 18 December.

The hospital currently has only two anaesthetists, including Dr Vreede, as Dr Eries, the Cuban anaesthetist, is now on holiday and on return, is expected to be in charge of the Cuban team in Timor Leste, and therefore is expected to be no longer available for daytime clinical anaesthesia. There are therefore increased demands on the two available anaesthetists who provide support not just to the surgeons but also to the obstetricians.

Dr Vreede has continued to mentor local doctors in anaesthesia throughout the inception period: Dr Flavio Brandao and Dr Celia Gusmao, as well as the nurse anaesthetists.

There have been delays in recruiting and mobilising the long-term nurse, due to the late signing of the contract. Unfortunately, a good candidate who had been lined up, committed to other employment during this period. The Program plans to advertise the position in January and mobilise the Nurse in February-March 2007.

Dr Joao Pedro returned from PNG in mid-November 2006 having passed his Part 1 MMeD in Surgery from the UPNG. He will continue to be mentored by the Program's surgeons at HNGV until an attachment to the Royal Darwin Hospital (RDH) can be organised. This attachment to the RDH is in response to the strong recommendation from the Professor of Surgery at UPNG that we ensure Dr Joao Pedro's skills continue to be developed and maintained by deploying him for 12 months at a hospital like RDH with its mix of trauma and tropical disease caseload. Dr Nilton Tilman and Dr Joao Ximenes undertook pre-clinical attachment at the University Kebangsaan Malaysia (UKM)in the period 1 October – 24 November; Dr Nilton was selected by the University to commence the first year of the UKM Master of Medicine program, while Dr Joao Ximenes returned to HNGV at the end of November, recommended to start his deployment in June 2006. The Health Minister has now agreed that the Program should find Dr Joao Ximenes an appropriate surgical training program at a Medical School in Indonesia in 2007.

No short courses were planned or implemented in the inception period.

Following training provided by AETSSP, a graduation ceremony for the 15 graduates of the Nurse Anaesthetist training program was held on the 21st December 2006. The aim of the course was to provide theoretical knowledge as well as practical skills. The graduands include the graduates of the first course (who had been previously awarded Certificates, and who sat an examination to qualify for the Diploma). Eleven of the nurses are located in the districts and four are based in Dili.

3.1.2 Component 2 – Short Term Specialist Support and Planning

Outreach visits were not planned during the inception period because here were surgeons in each district hospital during the period.

There was only one clinical specialist visit conducted under the Program during the inception period. given the security situation and the absence of a formal contract , it was difficult to plan and confirm visits.

A plastic and reconstructive surgery team visited Dili from 10 – 16 November. The team examined 77 patients: 12 in Aileu, 18 at Bairo-Pite clinic, and 47 at HNGV. They operated on 33 patients. The visiting team reported that they were saddened by the apparent terror among the staff and population. Many patients could not be convinced to travel to HNGV for surgery (the Aileu and Bairo-Pite clinics were not suitable for safe surgery). The team commended the dedication and motivation of two of the newly qualified Nurse Anaesthetists who worked alongside them. They reported however, that they were disheartened by the lack of support from most of the other Timorese operating theatre nurses who would not assist the visiting team in their work, unlike in previous visits. The team's visit to Bacau had to be cancelled due to the security situation.

Dr Tim Keenan, General and Orthopaedic surgeon visited Baucau Hospital in November (self-funded) to assess the facilities in Baucau hospital and prepare the ground for the orthopaedic team visits planned for 2007.

No activities could be implemented for an improved information management system and other non-clinical support systems in the inception period due to the late signing of the contract.

3.1.3 Component 3 – Institutional Linkages Facility

A meeting had been held between Professor David Scott (Project Director), Mrs Daliah Moss, Team Leader Dr Eric Vreede, and Sr Lorenco Kamnahas (Director of the Institute of Health Sciences) regarding the IHS's priorities for assistance in the new Program. However, no activities could be planned or implemented under this output in the inception period due to the late signing of the contract and the ransacking of the IHS building making it uninhabitable.

3.1.4 Component 4 – Program Management and Monitoring

The Program Management team in Australia has continued to maintain close contact with Program personnel in-country. Tanya Edmonds replaced Elizabeth McNess as Program Manager during the Inception Phase, Lito DeSilva acted as Interim Program Manager in the period between the two appointments and Daniel Vorbach provided continuous support to the program and visiting specialists as the Timor Leste Program Officer (half-time) .

The in-country personnel remained unchanged from AETSSP. They continue to build on the strong relationships that have been established with the HNGV administration and MOH. The Team Leader, Dr Eric Vreede, continues to provide support and advice to in-country Program personnel with the guidance of the Program Director. In-country liaison and administrative support has been provided by the Local Coordinator, Mr Sarmento Faus Correia, supported by a number of local interpreters.

Specialty Coordinators in Australia have assisted the Program Director with the identification of suitable personnel for deployment and for monitoring of specialist team activities. The coordinators have responded to issues arising within their specialty and provided technical advice where necessary.

3.2 Proposed Variations to Program Design

General variation may include the rescheduling of some visits between quarters and financial years, which may impact upon the expenditure within years but should not affect the total contract budget. This rescheduling will be the result of: a) external factors such as the security situation in Timor Leste, b) requests by East Timorese counterpart medical staff, hospital administrators and the MoH to alter the timing of visits and/or c) the availability of volunteers to undertake visits.

The program needs to provide a living allowance for Dr Joao Pedro to undertake a twelve month clinical attachment as part of his on-going surgical training in Darwin. Dr Joao Pedro has successfully completed his Master of Medicine Part I examinations from the UPNG. In consideration of the security situation in Timor Leste where patients are apparently afraid to go to the hospitals, and while there are additional expatriate doctors in country, the Professor of Surgery at UPNG, the Program Director, as well as the Program's LTA surgeons have all recommended that Dr Joao undertake a 12 month teaching attachment at a well-run surgical department which has a high trauma caseload and the appropriate mix of tropical disease (similar to Timor Leste) before he returns to UPNG for a final 12 months to complete his MMeD Part II in 2009. All have recommended that this be undertaken as soon as possible to ensure that the skills and knowledge he obtained through his recent studies at UPNG are maintained. The RDH is highly suitable training attachment. RACS has deployed many PNG surgical trainees in similar circumstances to the RDH successfully in the past.

In response to discussions with the MOH and the HNGV, the long-term nurse practitioner will be an ICU (Intensive Care Unit) nurse in the first instance. The PDD indicated that the nurse will be an OT (Operating theatre) nurse who at a later stage could be changed into an ICU nurse. However, the need for an ICU nurse has become acute with the purchase by the hospital of mechanical ventilators. At the last PMC it was discussed and agreed to have an ICU nurse first followed by an OT nurse, if and when required.

4. WORK PLAN for PROGRAM YEAR 1 (OCTOBER 2006 – JUNE 2007)

4.1 Strategy for Program Year 1

In Program Year 1, the Program will continue to monitor and respond to the security situation, given its impact on the functioning of the hospital as well as its impact on the visiting specialist teams.

The RACS Program Director/Speciality Coordinator for General Surgery identifies suitable personnel for deployment in the position of LTA surgeon; and for Program Year 1 the positions of general surgeon and anaesthetist have been filled on a long-term basis which provides benefits to the Program. In program year 1, the long-term Nurse will be recruited and mobilised in 2007. The long-term specialists will continue to provide mentoring and training to local staff and perform outreach visits from March subject to the security situation and other factors including the availability of specialists at HGNV.

Planning for short-term specialist visits will continue to be done in consultation with the MoH and HNGV administration. The scheduling of visits will be dependent upon the collective availability of personnel and many volunteer surgeons, anaesthetists and nurses have confirmed their continuing interest and willingness to travel to East Timor under the auspices of the Program. Their availability must also be coordinated with the capacity of HNGV and other regional centres to be serviced. This may result in variations from the scheduled timing of visits in the Contract.

In Program Year 1, the Program will continue to support the training of identified Timorese doctors to achieve recognised qualifications. However, further assessment and planning will need to be done for appropriate short courses and nurse anaesthetist training. Recruitment will be undertaken for the volunteer technical specialist (health planner/database manager) and the institutional linkages facilities manager in order to commence planning for these outputs.

4.2 Schedule of Activities and Resources

The Implementation Schedule is shown in Annex 1, and Cost Schedules are shown in Annexes 2 and 3 for Program Year 1.

Summary of Activities by Component

4.2.1 Component 1: Long-term Training, Mentoring and Capacity Building

For Program Year 1, the role of long-term adviser (General Surgery) from January 2007 will be filled by Dr Katherine Edyvane for a period of 12 months. Dr Edyvane had filled the role of long-term adviser, surgery in September and October 2006 and established good working relationships with the medical staff in-country. This arrangement will promote continuity of training and mentoring, and existing good working relationship can be consolidated. During Dr Edyvane's planned leave, the program will organise for a replacement surgeon who is experienced with Timor Leste and familiar with the Program to be mobilised.

Dr Edyvane will continue to assist with the establishment of a pathology service at HNGV in consultation with Volunteer Pathologists Australia and local laboratory personnel including Mr Ruben David who is running the St John of God pathology project at HNGV. Other improvements in the provision of surgical services at HNGV will continue to be explored in discussion with the MoH and HNGV administration. This will include the ongoing monitoring of equipment maintenance and medical supplies.

Dr Eric Vreede continues in the position of LTA anaesthetist and has delivered full time anaesthetic services in East Timor since June 2004. This benefits the Program through the improved consolidation of existing relationships with key stakeholders in East Timor, improved continuity in service delivery and the training and up-skilling of local staff.

Dr Vreede is also the Program's Team Leader and has a key role at HNGV as the appointed Advisor to the Clinical Director and Head of the Department of Anaesthesia and Intensive Care. He has been proactive is establishing an Emergency Epidemic Preparedness Plan for the hospital with the onset of the rainy season and the situation with IDPs living within the hospital grounds.

Both positions will continue to provide mentoring to build the practicals skills and confidence of the East Timorese medical, nursing and administrative staff through the provision of on-the-job training, demonstrations and workshops.

The program will continue funding Dr Nilton Tilman's surgical training at UKM in Malaysia. He commenced a four yearl surgical training program on 1 December 2006, after completing the required pre-clinical attachment. The plan is to send Dr Joao Pedro Xavier on a clinical attachment to Royal Darwin Hospital in early 2007, and Dr Joao Ximenes to an appropriate surgical training program at a Medical School in Indonesia in 2007.

The third nurse-anaesthetist course is on the plan for discussion with all parties in January 2007. The course may commence later in 2007 to coincide with the desire of the Institute of Health Sciences to have a set academic year. However, the course will be planned so that graduation from the course will coincide with new district hospitals becoming functional.

Short courses will be planned in early 2007 depending on availability and further assessment of priority trainee needs. The program plans to fund a Primary Trauma Care course to be run in Dili for doctors and nurses and sending one or two trainees to Melbourne to undertake a Basic surgical Skills course in Program Year 1.

4.2.2 Component 2 – Short Term Specialist Support and Planning

The schedule of visits is continually updated and regularly forwarded to the MoH, AusAID Post and other relevant organisations and institutions. The schedule for visits for 2007 has been submitted to the MOH for approval. It includes the following visits for Program Year 1:

Specialist Visits Schedule January to June 2007

January 22-27	Ophthalmology, Dili
February 12 – 17	Orthopaedic, Dili
March 12 – 17	Paediatric surgery, Dili
April 16 – 21	Plastics, Bacau and Oecussi
May 7 – 12	Orthopaedic, Baucau
June 4 – 15	Ophthalmology and optometry, Baucau

The need for general surgical and anaesthetic outreach visits will be reviewed and discussed with the MOH, but it is envisaged that they may re-commence in March, following the rainy season, and depending on the security situation and the ability for the anaesthetist to leave the hospital for a few days at a time. The security situation may restrict the ability of the long-term surgeon and anaesthetist to conduct any outreach visits as was the case in May under AETSSP when a visit was cancelled due to the security situation. Further, the shortage of specialists in Dili, especially the availability of a third anaesthetist has hampered the possibility of outreach visits. It is clear that until the issue of the lack of anaesthetists is resolved, outreach visits will not be possible.

A volunteer technical specialist (health planner/data-base manager) will be recruited in program year 1, with the aim to mobilise by September 2007. The detailed position description will be developed in January-February 2007 in consultation with the MOH and a proposal will be submitted to the volunteer sending agencies (likely to be VIDA) by March 2007. RACS may use internal networks to advertise the position and if this is unsuccessful will ask the volunteer sending agency to advertise the position.

The Program includes other short term support in bio-medical engineering (pending commencement of the European Community project) in Program year 1.

4.2.3 Component 3 – Institutional Linkages Facility

The Program plans to recruit a part-time Institutional Linkages Manager from January 2007, and to commence planning activities under the Facility for all years of the program.

4.2.4 Component 4 – Program Management and Monitoring

All members of the Program Management Team will continue to perform their duties in Program Year 1. An additional Program Coordinator based in-country will be recruited in early 2007 to report to the Team leader as per the position description in the Program Design Document. A part-time Institutional Linkages Facility Manager will also be recruited.

The first PMC is tentatively scheduled for May 2007.

4.3 Confirmation of Recipient Government Inputs

The East Timor Ministry of Health (MoH) is expected to maintain salary payments to health workers and to provide funds in their budget for the operation of HNGV and relevant regional hospitals. While there is no direct financial link with the Program, this funding is essential to the delivery of the Program.

5. COSTS

The financial limitation for the Program is $A8,149,666, plus GST if any, up to a maximum of A$814,967. Total expenditure for the period of this Annual Plan is estimated to be $1,009,585.

Anticipated expenditure for the period 1 October 2006 - 30 June 2007 (excluding GST) by component is as follows:

Component	Personnel & Management Costs	Training & Equipment Costs
1. Long term training, Mentoring and Capacity Building	376,795	106,500
2. Short term Specialist Support and Planning	197,550	180,140
3. Institutional Linkages Facility	24,000	50,000
4. Program Management & Monitoring	42,725	31,375
Total	**641,070**	**368,515**