ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Program Year 3 Implementation Plan (July 2008 – June 2009)

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	Hospital Nacional 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)

IMPLEMENTATION PLAN for PROGRAM YEAR 3: JULY 2008 – JUNE 2009

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.

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), who works 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.

This annual plan has been prepared taking into account the decisions taken at the Program Management Committee meeting on 31 January 2009. It takes also into account the needs as identified in the Program Design Document (PDD), the Program's 6 monthly progress reports and the Program Review and Evaluation Team's (PRET) report following their mission in December 2007.

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.*

Several long term clinicians (general surgeons, anaesthetists and nurse practitioners) will be based in Dili. They will collaborate closely with the MOH, the Institute for Health Sciences,

the Hospital Nacional 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 long-term advisers will also support clinical service delivery at HNGV.

The Program will support the completion of specialist training for medical graduates who have already commenced specialist training (in general and orthopaedic surgery and ophthalmology) under AETSSP or private sponsorship. Dependent on identification by the MOH more candidates will be supported by ATLASS. to undertake overseas specialist training: in general surgery, anaesthesia and ophthalmic surgery.

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.*

The Program's advisers may also conduct outreach visits to regional and district centres to provide minor and moderate-grade surgery and training, mentoring and professional support for resident medical staff. 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

3. Strategy for Implementation

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

a) by maintaining long term advisers in Timor Leste:
   - ♦ specialist surgeon/s;
   - ♦ a specialist anaesthetist; and
   - ♦ nurses with skills and experience in peri-operative and intensive care nursing.

   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 workers; 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 if considered appropriate.

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 be responsive to the human resource plans of the MOH. In 2008, the new Minister of Health re-focused the emphasis of surgical training towards

improving the basic surgical skills of the doctors in district hospitals. In line with a request from the Minister of Health at the Program Management Committee meeting in January 2008, RACS will play a lead role in this support which is currently in the planning and development phase. Therefore, ATLASS resources and support will be re-focused to support the MOH's objectives, and the coming months can be considered a transition period. However, it is likely that while out-of-country specialist training will continue to be supported for currently identified trainees, other support will be re-directed towards the development of surgical services across the country through other mechanisms.

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 has established the following consultation mechanisms to ensure that the Program's activities are driven by and coordinated with the MOH. There are regular meetings with the General Director and Clinical Director (both newly appointed in March 2008) of HNGV and with the newly created Director of Hospital and Referral Services within the MOH and with the Special Advisor to the MoH. In addition, there is regular contact with the Minister of Health about the direction of the Program. There are also regular technical meetings with the IHS regarding the development of the OT and ICU nurse training courses.

The strategic location of the Program office at HNGV in Dili also enables the team to maintain close communication with health service managers, members of other international medical assistance missions and other development partners. All Long-Term Adviser's have regular contacts and if necessary formal meetings with the department of HNGV in which they are active.

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.

4. Risk Management

Timor Leste continues to present a dynamic and unpredictable environment in which to implement development activities. As events in the last few years demonstrated, internal and external events may potentially affect Program activities in Program Year 3 and pose security risks to international as well as locally engaged team members.

Refer to **Annex A: Risk Matrix for Program Year 3**

The following changes have been made since the Inception Report was submitted to reflect the risk analysis for Program Year 3:

- The risk: 'Program unable to facilitate entry into or continuation of overseas specialist training programs due to language capabilities of trainees being insufficient'. Likilihood has changed from 'Intermediate – High' to 'Low'. This risk is decreasing with the possibility to send trainees to Indonesia under the directions of the new Minister of Health. Previously, this was not possible so trainees were attempting to enter into training programs where English was a requirement. The Minister of Health

is now encouraging training in Indonesia and Dr Ximenes has already commenced at University of Solo and others may commence in Program Year 3.

- The risk: 'Slow development and implementation of information system' has become obsolete as according to the PRET recommendations the relevant output no longer falls under the ATLASS program. Therefore, it has been deleted from the Risk Matrix.
- The risk: 'Unable to locate suitable institutional partners and/or mobilise counterpart funding through Institutional Linkages Initiative'. The Likilihood has changed from 'Low' to 'Intermediate to High' because the experience over program years 1 and 2 has shown that it is very difficult for the Linkage activities to be demand-driven by Timor Institutions. As a result the Guidelines are currently being re-drafted to make the institutional Linkages support the objectives of the ATLASS program more effectively.

5. Sustainability

In the experience of the AETSSP and Program Years 1 and 2 of ATLASS, 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 etc) is likely to be good. ATLASS has a greater focus on training and capacity building, though formal and informal training, in order to promote sustainability.

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, which is why sub-specialty visits from Australian specialists will continue over the life of ATLASS. 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.

6. WORK PLAN for PROGRAM YEAR 2 (JULY 2008 – JUNE 2009)

6.1 Strategy for Program Year 3

In Program Year 3, 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.

In Program Year 3, the Program will continue to provide long-term (at least 12 months periods wherever possible) advisers to HNGV, as this provides many benefits on terms of the capacity building for the Program through formal training and mentoring. The RACS recommends that the ATLASS program continues to be flexible to meet emerging needs in terms of the engagement of long-term advisers to support the human resource plans of the MOH.

In Program Year 3; ATLASS will continue the engagement of all current long-term advisors:

- Dr Eric Vreede will continue as the LTA – Anaesthetist and will continue in the role as team leader. The continuity of his service has many benefits for the Program in terms of relationships with the Ministry of Health and HNGV administration, as well as continuity of training and mentoring of doctor and nurse anaesthetic trainees;
- Dr Emma Lang will continue as the LTA – General Surgeon for the 12 month deployment until February 2009, and the Program will seek out another long-term appointment for the remainder of Program Year 3;
- Mr Daniel McKenzie will continue his deployment in the role of LTA – Intensive Care Unit Nurse, focusing on the Intensive Care Unit at HNGV until the end of Program Year 3; and

- Ms Amanda Jennings will continue her deployment in the role of LTA – Operating Theatre nurse for her 12 month deployment to March 2009 with the possibility for extension depending on funding.

The PRET recommended that the ATLASS program recruit a second experienced surgeon for a period of six to twelve months in 2008 to support the surgical service workload and ensure neither trainee teaching nor service delivery are compromised. Further, the PRET recommended that the ATLASS program commission a study in consultation with MOH and the National hospital to identify the most appropriate model for future specialist surgical and anaesthetic training for Timorese doctors. The ATLASS PMC specifically discussed these recommendations in January 2008 and amended the recommendations to remove the consultative study, but to integrate the provision of this advice into the tasks of the 2nd surgeon. Therefore, throughout Program Year 3, a 2nd surgeon will be engaged based on both service delivery and training/advisory requirements, by assessing the needs throughout the year.

Specifically, in the discussions the Minister of Health requested that RACS, through ATLASS, take a key role in equipping young Timorese doctors with basic surgical skills. As a result in Program Year 3 it is proposed that the 2nd resident surgeon to lead the development and delivery of several three month training programs with an emphasis on Basic Surgical Skills with support from experts based in Australia and the 1st resident surgeon. The aim of this course is to improve basic surgical services throughout the country and to improve surgical referral systems. The 2nd surgeon will be instrumental in developing the syllabus of this course and to oversee its implementation and subsequent supervision of the trainees who have completed the course and returned to their district hospital. The plan currently under development is for a 3 months clinical course to be conducted in HNGV concentrating on a rage of basic surgical skills. Participation in the training would also give the doctors from the districts experience in assessment and stabilisation of more critical patients who will need referral to the major centres of Dili and Bacau. This work follows the engagement of Dr David Hamilton as the 2nd resident surgeon for 6 weeks in Program Year 2 to commence the development of this course. It is envisaged that the first course will commence late in 2008 or early 2009, subject to endorsement by the MOH. As at April 2008, the proposal is subject to approval by the MOH and therefore, the following plans for Program Year 3 are not fully defined at this point in time.

In Program Year 3, the Program will continue to facilitate and support the training of the currently deployed Timorese doctors to achieve recognised qualifications from international training programs in Indonesia, Malaysia, Papua New Guinea, Fiji and Australia. Also, Dr Alito may commence the Orthopaedic Surgical training program (supported by Orthopaedic Outreach) at the Udayana University in Bali or the training program at Solo University in late 2008 and Dr Helder Miranda may commence the General Surgery program at University of Solo depending on the directions of the MOH .

In Program Year 3, as described above, rather than identifying further trainees, the ATLASS program will work with the MOH to develop and deliver an in-country training program to improve basic surgical skills in the regional hospitals.

In Program Year 3, the program will follow the PRET recommendation that the ATLASS surgeon is no longer required to provide Outreach visits for service purposes. The PRET found that 'the staffing of all 5 referral hospitals by international general and specialist surgeons since the design of the ATLASS program renders the provision of services by ATLASS program staff through service outreach visits no longer necessary. However, visits associated with follow up and/or support to surgical trainees and nurse anaesthetists should continue where necessary. In particular, as described above, the 2nd ATLASS surgeon may undertake assessment and supervisory visits to the regional hospitals to work with the trainees.

Note: the Anaesthetist Adviser to will provide ongoing mentoring and support to the nurse anaesthetists working in district hospitals either through rotations back to HNGV or visits to the districts in conjunction with the 2nd surgeon.

Planning for short-term specialist visits will continue to be done in consultation with the MoH and will be coordinated according to the capacity of HNGV and other regional centres to be serviced. While the scheduling of visits will be dependent upon the collective availability of personnel, many volunteer surgeons, anaesthetists and nurses have confirmed their continuing interest and willingness to travel to East Timor under the auspices of the Program.

In line with the PRET recommendation and following on from preliminary work completed in Program Year 2, the Institutional Linkages guidelines will be revised and the management arrangements will be streamlined. This will result in a more flexible approach to using the funds under the Institutional Linkages Facility to support to the core objectives of the ATLASS Program; particularly around the training of surgical trainees, nurse anaesthetists and ICU and OT nurses. The ATLASS Program Management team will continue to assist in identifying suitable activities and preparing proposals.

6.2 Work Program

The Implementation Schedule is shown **ANNEX B: ATLASS Program Year 3 Implementation Plan** and Cost Schedules are shown in **ANNEX C: ATLASS Program Year 3 Estimates July 2008 - June 2009**

Under each Output some activities will continue from Program Year 2 while some new activities will be implemented in Program Year 3.

COMPONENT 1 – LONG TERM TRAINING, MENTORING AND CAPACITY BUILDING

Output 1.1 – Improved surgical services, training and supervision through long term General Surgeon support

1.1.1 Long-term General Surgeon Adviser providing surgical services (cont.)

Full time general surgical services at HNGV will continue to be provided by Dr Emma Lang until February 2009 when her current contract finishes. Her planned periods of leave will be covered by other RACS surgeons. RACS will identify other suitable general surgeons to find a replacement for Dr Lang when her contact ends.

1.1.2 Long-term General Surgeon Adviser providing on-the-job training (cont.)

The General Surgeon Adviser will continue to mentor national doctors who are currently undertaking surgical training at HNGV throughout the period. While it is anticipated that all current surgical trainees will be out-of-country in their respective specialist training, Dr Helder Miranda will be working at HNGV until a decision is made on whether he will be sent on overseas training. Apprenticeship style training will continue to be provided in theatre, on the ward and in the Emergency Department, with the Program's general surgeon providing supervision and assistance. On the job training will be an essential part of the new basic surgical skills course.

1.1.3 Long-term General Surgeon Adviser giving weekly tutorials (cont.)

The General Surgeon Advisers will continue to conduct weekly tutorials of basic sciences to all Timorese doctors.

1.1.4 Second long-term General Surgeon Adviser to develop and deliver basic surgical training to identified doctors and to address workload issues when necessary

The PRET recommended that the ATLASS program recruit a second experienced surgeon for a period of six to twelve months in 2008 to support the surgical service workload and ensure neither trainee teaching nor service delivery are compromised, as this will continue in Program Year 3. It is estimated that the 2nd surgeon will be engaged for approximately 9 months throughout Program Year 3 but this will be continuously reviewed according to both training and service delivery needs.

Specifically, in Program Year 3 the 2nd resident surgeon will also take a lead role in developing and delivering a three month basic surgical skills training program with support from Australian experts and the 1st resident surgeon. The aim of this course is to improve basic surgical services throughout the country and to improve surgical referral systems. The 2nd surgeon will be instrumental in developing the syllabus of this course and to oversee its implementation and subsequent supervision of the trainees who have completed the course and returned to their district hospital. It is envisaged that the first course will commence in late 2008 or early in 2009, subject to endorsement by the MOH.

Output 1.2 – Improved anaesthesia services, training and supervision through long term Anaesthetics Adviser support

1.2.1 Long-term Anaesthetic Adviser providing anaesthetic services (cont.)

Dr Eric Vreede will continue to provide full time anaesthesia services at HNGV, the Program anaesthetist since 1 July 2004.

1.2.2 Long-term adviser providing on-the-job mentoring for doctor and nurse anaesthetists (cont.)

Dr Vreede will continue to mentor the five nurse anaesthetists who are working in HNGV. The 15 nurse anaesthetists trained since 2004 and working in the district hospitals will continue to be supported.

As Dr Flavio Brandao will be in overseas anaesthesia training in Fiji, Dr Vreede will not be formally mentoring him over Program Year 3. There is currently no new candidate for anaesthesia training, but depending on directions given by the MOH during Program Year 3 a candidate may be found.

Output 1.3 – Improved standards of peri-operative nursing and infection control through long term Nurse Educator Adviser training, supervision and support

1.3.3 Long term Nurse (ICU) Advisor providing nursing care in the ICU (cont.)

It is anticipated that Mr Daniel McKenzie will continue in the role of the ICU Nurse Advisor for a second year. He will continue to perform daily nursing duties in ICU and the surgical wards in collaboration with Timorese nursing staff. This will include participating in ward rounds, patient handover, drug administration and organ support care.

1.3.4 Long term Nurse (ICU) Advisor on the job mentoring of ICU nurses (cont.)

The ICU Nurse Advisor will continue to support and mentor the Timorese nurses in up to date ICU nursing procedures, departmental organisation, stock keeping and ordering. He will also help identify suitable candidates for training in specific subjects in probably Indonesia or Australia in preparation of the formal IHS training course.

1.3.5 Long term Nurse (ICU) Advisor developing protocols and guidelines for ICU (cont.)

The ICU Nurse Advisor will continue to assist with the formulation and implementation of new protocols and work routines in order to help strengthen systems and standards of Intensive Care nursing.

1.3.6 Long term Nurse (OT) Advisor providing nursing care in the OT (cont)

Ms Amanda Jennings will continue in the role of the OT Nurse Advisor until March 2009 when the extension of her 12 month contract will be reviewed and may be extended. The OT Nurse Advisor will perform daily nursing duties in OT in collaboration with Timorese nursing staff. This will include preparation for surgery, scrubbing, scouting, sterilisation and post-operative recovery.

1.3.7 Long term Nurse (OT) Advisor on the job mentoring of OT nurses (cont)

The OT Nurse Advisor will mentor the Timorese nurses in up to date and appropriate OT nursing procedures; pre-operative preparation, scrubbing and scouting, departmental organisation, stock keeping and ordering.

1.3.8 Long term Nurse (OT) Advisor developing protocols and guidelines for OT (cont)

The OT Nurse Advisor will assist with developing and implementing nursing protocols in OT.

Output 1.4 – A core group of East Timorese doctors with recognised specialist qualifications

1.4.1 Surgical training at UPNG (cont from AETSSP); rotated to HNGV; in 2008 rotation to RDH (Dr Joao Pedro Xavier) (cont.)

It is anticipated that Dr Joao Pedro will continue his attachment to the Royal Darwin Hospital (RDH) throughout 2008 and early 2009 he will return to UPNG to finish his studies and sit the final Masters of Surgery Exam.. 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.

In discussion with his supervisor in Darwin the need for Dr Pedro to undertake a CRISSP course will be explored. Refer to Output 1.5.

1.4.2 Surgical training at UKM (Nilton Tilman) (cont.)

Dr Nilton Tilman will continue his surgical studies at University Kebangsaan Malaysia (UKM) in Program Year 3. He needs to sit and pass the first part before proceeding to the final three years, and if he does not pass at the next attempt in late 2008, the Program will assess whether support should be continued at UKM or if other options should be pursued.

1.4.3 Surgical training at University of Solo (Dr Joao Ximenes) (cont.)

Dr Joao Ximenes will continue his studies in General Surgery at UNS Solo in Indonesia which he commenced in December 2007. The first two years is a diploma in surgery and Public Health and the final three years as specialist trainee in General Surgery.

1.4.4 Ophthalmology training; Diploma of Ophthalmology (U Sydney); Attachment to RHH; Mentoring by visiting specialists at HNGV (cont) (Dr Marcelino Correia)

Dr Marcelino Correia will finish the International Diploma in Ophthalmology in 2008 and will continue to be mentored by the visit ophthalmology teams. Further clinical attachments are currently being discussed by the East Timor Eye Program (ETEP) who are supervising his training.

The ETEP has also requested the Minister to identify a second ophthalmology trainee, but it is unclear whether there are any interested Timorese doctors

1.4.5 Orthopaedic Surgery training (Dr Alito)

Dr Alito aspires to train in Orthopaedics and is reportedly having a good experience with the Chinese Orthopaedic surgeon. It is planned to try and enrol him in either the Orthopaedic Surgical training program (supported by Orthopaedic Outreach) at the Udayana University in Bali or the training program at Solo University in 2008. In the meantime he will continue to be mentored by the visiting orthopaedic teams.

1.4.6 General Surgery Training (Dr Miranda)

Depending on the development of the basic surgical skills course in Timor and directions given by the MOH, Dr Helder Miranda may commence General Surgical training program at University of Solo at the start of 2009. In the meantime he will continue to be mentored by the ATLASS Advisers.

1.4.7 Anaesthesia training in Fiji (Dr Flavio Brandao)

Dr Flavio Brandao will continue his studies in the Fiji MMed in Anaesthesia throughout Program Year 3.

Output 1.5 – Primary care doctors with improved surgical, trauma and burns management skills

Note: Due to the new directions in basic surgical skills training as described above, activities under this output will be dependent on how this progresses. Some original activities defined in the PDD will become redundant as some courses, such as the Primary Trauma Care course, that may have been undertaken separately (in Timor or Australia) may be incorporated into the new in-country training. Therefore, under this Output, with the exception of Activity 1.5.5 (below) activities will be defined in the coming months as the basic surgical skills course is developed in conjunction with the MOH. Funds from this output should be used for the purpose of developing and delivering this course, including writing and editing the teaching materials, paying for instructors for short-terms inputs etc depending on progress made

1.5.5 Trauma care; CRiSSP course for Dr Joao Pedro

Dr Joao Pedro will complete the CRISSP course during his work in Darwin, subject to approval by his supervisor at Royal Darwin Hospital.

Output 1.6 – Nurses with improved skills in anaesthesia and peri-operative and procedural nursing

1.6.2 Refresher course for previously trained nurse anaesthetists

The clinical attachments (rotating back to HNGV for 2 months each) for the trained nurse anaesthetists will continue to form part of their continuing professional development and quality assessment. One formal refresher course will be conducted in the first half of Year 3.

Note: The third nurse anaesthetist training will complete in June 2008 and the need for a further course in Year 3 or Year 4 is being discussed with the MoH.

1.6.3 The Long term Nurse Advisors will continue the development of formal ICU/OT nurse training in conjunction with the IHS

The advisors will continue to assist with the development formal ICU/OT nurse training in conjunction with the IHS, which will include inputs of technical expertise in curriculum writing through a partnership established through the Institutional Linkages Facility. Refer to Component 3. The certificate courses will form part of a larger framework of a 3 year nurses training that the IHS is currently developing.

1.6.4 Commence delivery of the formal ICU/OT nurse training courses in conjunction with the IHS

In conjunction with the IHS, the advisors will deliver the nurse training courses. Depending on progress made against 1.6.3, it is likely that the ICU course will start in October 2008, to coincide with the commencement of the academic year, and the OT will start in January 2009.

COMPONENT 2 – SHORT TERM SPECIALIST SUPPORT AND PLANNING

Output 2.1 – Regular surgical, anaesthetic and peri-operative nursing outreach visits to Regional Hospitals and rural Districts

2.1.1 Regular review of the need for surgical outreach to the district hospitals and restart if needed.

While the situation will be regularly reviewed the Program does not anticipate that it will undertake outreach visits. The PRET found that 'the staffing of all 5 referral hospitals by international general and specialist surgeons since the design of the ATLASS program renders the provision of services by ATLASS program staff through outreach visits no longer necessary.' However, visits associated with follow up and/or support to surgical trainees may continue where necessary. In particular, as described above, the 2nd ATLASS surgeon may undertake assessment and supervisory visits to the regional hospitals to work with the trainees.

2.1.2 Mentoring of the nurse anaesthetists working in district hospitals

The Anaesthetist Adviser will provide ongoing mentoring and support to the nurse anaesthetists working in district hospitals. If possible and necessary regular rotations back into HNGV for those working in hospitals where the work load is low will continue. For others the Anaesthetic Advisor may visit them on site especially in conjunction with the surgical supervision visits.

Output 2.2 – Provision of specialist surgical and other services by visiting teams and individual specialists

2.2.1 Specialist visits implemented according to schedule defined by PMC.

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 the remainder 2008 was agreed at the PMC on January 29 and includes the following visits:

Specialist Visits Schedule July – December 2008

Dates	Specialty	Location
July 5 - 11	Plastics	Bacau

July 9 - 13	Ophthalmology	Bacau
July 14 - 18	Paediatric cardiac surgery	Dili
August 4 - 8	Ophthalmology *(funded by St John's Ambulance of Australia)*	Oecussi
August 4 - 8	Orthopaedic *(funded by orthopaedic outreach)*	Maliana
September 15 - 19	Ophthalmology	Suai
September 22 - 26	Ophthalmology	Maubisse
October 13 - 17	Ophthalmology	Maliana
October 13 -17	Plastics	TBC
November 17 -21	Orthopaedic *(funded by orthopaedic outreach)*	Bacau

The visits for the second half of year 3 will be agreed during the PMC in September 2008 and exact dates will be determined in consultations with the MOH and Hospital Directors. However, it is anticipated that the visits will be similar to January – June 2008 and estimating has been done on this basis.

Output 2.3 – Improved information management and other non-clinical support systems

Note: this Output will not be progressed. Based on the PRET recommendation that this function does not clearly fit within the scope of ATLASS and should be undertaken by the MOH with the wider development of the Health Information System for Timor, the PMC has agreed not to fill the vacant position of the Hospital Data Analyst. At the PMC in January 2008, the Minister endorsed this recommendation to not fill the Hospital Data Analyst position under the ATLASS program and said that the MOH will separately look into this.

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*

Output 3.2 – Targeted support facilitated and maintained through institutional linkages and twinning arrangements

In line with the PRET recommendation and following on from preliminary work completed in Program Year 2, the Institutional Linkages guidelines will be revised and the management arrangements will be streamlined. This will result in a more flexible approach to using the funds under the Institutional Linkages Facility to support to the core objectives of the ATLASS Program; particularly around the training of surgical trainees, nurse anaesthetists and ICU and OT nurses. For instance, support for the establishment of the training centre may provide through this Component of the program. The ATLASS Program Management team will continue to assist in identifying suitable activities and preparing proposals in addition to those listed below.

It is anticipated that the following activities will be pursued in Program Year 3, as well as other yet to be defined subject to the revision of the institutional linkages guidelines:

3.2.1 Histo-pathology visits to HNGV (cont)

With a few improvements, the anatomical pathology laboratory will be capable of producing work to a high standard such as that which is produced in Australian laboratories. Continuing advisory visits by Suzanne Ward have been recommended. Therefore Ms Ward will make at least one follow-up visit in late 2008 to reinforce the techniques.

3.2.4 Continued BME support visits

Depending on developments through the EU funded BME support program, there may be a continued need for BME support visits, which may be funded through the Institutional Linkages facility through the partnership with Cabrini Hospital.

3.2.5 OT & ICU Nursing curriculum development

It is envisaged that qualified curriculum writers will work with IHS Staff, RACS Specialist Nurses and HNGV staff to develop a curriculum and syllabus for ICU / OT post basic course. IHS will coordinate 3-4 stakeholder workshops over the period of curriculum development to ensure input is obtained from all relevant bodies. The consultant will participate in the workshops and provide feedback on the process of the curriculum development to ensure the final curriculum is approved by all relevant stakeholders including the IHS. Technical input for the curriculum will be provided by RACS Specialist nurses (ICU / OT) based at Dili Hospital. Refer to Output 1.6.

While it is planned that this activity will commence in Program Year 2, it may continue into Program Year 3 depending on the plans of the HIS and the progress of the curriculum development. The curriculum writers may also assist in the delivery of the course.

3.2.6 Ventilator Training

The ICU Advisor is currently training ICU nurses in the use of ventilators. However, it will not be possible for ICU staff to acquire sufficient experience in the use of mechanical ventilators in the initial stages of deployment because it will not be used that often. Once the system is up and running experience can be gained in HNGV. Therefore, it is envisaged that 3 – 5 selected ICU nurses will be send overseas for approximately 1 month to become competent with the techniques. There will be clear expected outcomes and competencies.

It is envisaged that 1 nurse may go to Darwin or Geelong and the others to a hospital in Indonesia (because of the language). This hospital has yet to be selected through our contacts with the President of the Indonesian Nurse Federation who is also assisting the IHS with curriculum development and with whom the LTA ICU nurse has had extensive discussions.

COMPONENT 4 – PROGRAM MANAGEMENT AND MONITORING

Output 4.1 – Systems for Program management and monitoring established and maintained

The Program management arrangements will continue as per Program Year 2. At the time of writing, the local program officer has resigned but it is envisaged that a new local program officer will be engaged by the commencement of Program Year 3. In the meantime, this gap will be filled by Ms Natalie Stephens, ATLASS Program Officer, who is undertaking a 3-6 month VIDA assignment in Dili, and once a new Program Officer is recruited Natalie will mentor them in their new role. Natalie's role of ATLASS Program Officer at RACS in Melbourne is being back-filled by Ms Karen Moss.

Before the commencement of Program Year 3, the data collection systems and the systems for the collection and reporting of data against the Purpose and Component Objectives will be finalised. Reporting templates to capture program outcomes and report against the Monitoring & Evaluation Framework including team visits reports, trainee reports and workshop evaluations. The templates developed in Program Year 2 will continue to be used for reporting and refined as needed.

It was agreed at the PMC in January 2008 that PMC meetings will now be held in September and March, to allow for complete reporting following the 6 monthly periods; January – June and July – December. The next Program management Committee meeting will be held in September 2008, following the submission of the 6 monthly progress report for the January – June 2008 period.

Output 4.2 – Program performance monitored continuously, and reported periodically

The ATLASS M&E framework was endorsed by the PMC on 18 July 2007, and subsequently modified in response to PRET recommendations, endorsed at the PMC on 31 January 2008.

Using the framework and new reporting templates the program performance will continue to be continuously monitored and reported on a 6 monthly basis to AusAID and the MOH. The new reporting mechanisms focus more on gathering information to allow the Program management team to effectively report on achievements of the Program, rather than simply outputs. Remedial steps will be undertaken were necessary and changes will be reflected by adjustments to the annual implementation plan or its update on a 6 monthly basis.

In Program Year 3, it is planned that a commissioned study on beneficiary assessments of the health outcomes of people treated under ATLASS will commence.

Output 4.3 – Risks to Program implementation monitored continuously, and remedial action taken as necessary

The Program Management team will continue to analyse and monitor the risks to the Program and makes periodic assessments of the risks; including the security situation in Timor Leste. The Team Leader issues regular security updates to the Program Management team and upcoming volunteers. When the risk is considered too great, Program activities will be postponed. Refer to Annex A: Risk Management Matrix.

Costs

Total expenditure for the period of this Annual Plan is estimated to be approximately $1.82 million. Please note: the 2nd surgeon and 2nd nurses' costs have been estimated against Output 1.1 and Output 1.3 respectively as it is expected that the contract amendment to facilitate this change in scope to Component 1 of the Program will be in place by the commencement of Program Year 3.

Refer to the ANNEX C Program Year 2 Cost Schedule.

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 its effective delivery.