Australian Government
AusAID

Activity Completion Report

Provision of A Range of Tertiary Health Services to Pacific Islands Countries – Phase III

Bridging/Transition Phase

Pacific Islands Region

Royal Australasian College of Surgeons

01 June 2011

Table of Contents

List of Acronyms

AMC	Australian Managing Contractor
AusAID	Australian Agency for International Development
CCrISP	Care of the Critically Ill Surgical Patient
DaCT	Development and Coordination Team
DSTC	Definitive Surgical Trauma Care
EMC	Evaluation and Monitoring Committee
EMSB	Emergency Management of Severe Burns
EMST	Early Management of Severe Trauma
ENT	Ear Nose and Throat/Otolaryngology
FSMed	Fiji School of Medicine
GOA	Government of Australia
IPMC	International Project Management Committee
MDG	Millennium Development Goal
MoH	Ministry of Health
NZAID	New Zealand Agency for International Development
PDD	Project Design Document
PIC	Pacific Island Country
PIP	Provision of a Range of Clinical Health Services to Pacific Island Countries
PISA	Pacific Islands Surgeons Association
PNG	Papua New Guinea
PTC	Primary Trauma Care
RACS	Royal Australasian College of Surgeons
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
SSCSIP	Strengthening Specialised Clinical Services in the Pacific
WID	Women in Development

The Royal Australasian College of Surgeons certifies that this ACR has been completed in accordance with AusAID's AusGuideline 185.1 Complete an Activity Completion Report May 2010.

1. Executive Summary

The PIP Transition/Bridging Phase successfully facilitated an effective means of providing continuity of service delivery and capacity building while a new program for strengthening specialist health care in the Pacific was being explored. Australia's contribution towards the development of secondary and tertiary health care in the Pacific was sustained under the PIP Bridging/Transition phase, and improved health outcomes were generated for communities across 11 Pacific Island nations.

Delivery of all projected services and activities was achieved within stated budget and timeframes, with outcomes representing quality of life improvements for patients who received specialist healthcare and strengthened capacity of the regional health workforce to manage secondary and tertiary health demands of their people. Within the confines of four separate 12-month budget and planning cycles, PIP clinical inputs facilitated specialist attention and interventions for thousands of patients who would have otherwise remained untreated during the period of transition. As well as assisting PICs to manage the burden of treatable illnesses and disabilities, PIP activities have been effective in supporting health workforce development, as evidenced by the increasing skills and confidence reported by PIC surgeons, trainees and allied health professionals to diagnose and manage a growing range of conditions; PIP volunteer specialist teams reported that they undertook only complex surgical cases during short-term clinical visits as local clinicians were able to successfully treat the less complex conditions. Key outputs and achievements are summarised below:

- 146 specialist visits delivered to 11 PICs.

- Approximately 14,426 people accessed clinical consultations and almost all of these patients received diagnoses and management and/or treatment options for their medical conditions.

- 3,428 patients received potentially life-altering surgical procedures.

- Instructors' courses established a cohort of Pacific-based trainers qualified to facilitate PTC, EMST and CCrISP workshops to their peers in the Pacific. A number of PTC courses delivered had national trainers as the majority of the teaching faculty.

- The Primary Trauma Care (PTC) course provided in Samoa reportedly contributed to low morbidity and mortality rates at the central hospital recorded after the 2009 tsunami.

- Pacific health workforce development for effectively managing secondary and tertiary health conditions have been recorded as an outcome of capacity development activities. Formal workshop attendance, on-the-job training, mentoring and training attachments for surgeons, trainees and allied health professionals has generated new or improved knowledge and skills in specialist health, and enabled further training opportunities overseas.

The success of PIP activities can be attributed to improved coordination with key stakeholders in Pacific health, namely the MoHs and hospitals of the 11 nations supported under PIP. Regular consultation and the flexibility incorporated into management for the program ensured that inputs were demand driven and closely aligned with PIC health priorities. A key lesson learned was the importance of increased Pacific-based coordination and management of activities, including monitoring and evaluation, to strengthen national ownership of health development and to improve harmonisation of all international medical aid inputs. While more in-country monitoring and evaluation of input, output and outcomes would have been very useful, this was limited by the design and budget restrictions of the PIP Bridging/Transition phase.

PIP has functioned within the context of a significant sector-wide human resources shortage and it is not expected that PICs will become self-sufficient in specialist health care in the foreseeable future. Therefore, sustainability of clinical and training achievements of the Bridging/Transition phase will need to be supported in a context of medium to longer-term donor support. A continued emphasis on the provision of training opportunities as well as strengthening education and professional networks between the Pacific and Australia/New Zealand is recommended for ongoing support of PICs developing their capacities to meet the secondary and tertiary health demands of their populations.

2. Activity Summary

The overarching goal of PIP was *improved health through increased tertiary health services in Pacific Island Countries (PICs)* and the purpose of the project was to overcome the shortage of trained and skilled people in a range of medical specialisations which inhibited the PICs from delivering essential secondary and tertiary health care.

To facilitate a continuity of service delivery and capacity building during the development of a new program design, the PIP Bridging/Transition phase focussed on the implementation of two core components:

2.1 Component 1: Tertiary and Secondary Health Services

Objective: To provide tertiary and secondary health services to selected PICs through a planned program of visits by qualified Australian and New Zealand medical specialists and support staff.

Activity Description: Specialist medical teams travelled to 11 PICs: the Cook Islands, Fiji, the Federated States of Micronesia, the Republic of Kiribati, the Marshall Islands, the Republic of Nauru, Samoa, the Solomon Islands, the Kingdom of Tonga, Tuvalu and the Republic of Vanuatu to deliver a range of essential secondary and tertiary health care, including surgery, to patients with treatable diseases or disabilities who would otherwise be unable to access these services.

Essential medical supplies were procured and equipment were purchased, repaired or replaced to ensure visiting specialist teams and their local counterparts could safely treat patients.

2.2 Component 2: Staff Training

Objective:

To strengthen Pacific health workforce capacity through the provision of formal workshops, academic support, out of country training attachments and training attachments with visiting specialist medical teams.

Activity Description:

Based on identified workforce priorities and in consultation with the local medical staff, various in-country or regional training workshops were delivered across PIP supported countries. Workshop attendees were nominated by their respective MoHs.

In addition, volunteer specialist medical teams were tasked with providing specific clinical instruction and skills transfer to local counterparts during clinical visits. Nominated surgical trainees were included for training attachments during PIP team visits.

Academic support was provided to FSMed and opportunities for attendance at appropriate overseas training course, seminars or conferences were supported through the program.

2.3 Key Dates

Australian Government support for health development in the Pacific was formalised in 1995 through the *Provision of a Range of Tertiary Health Services to Pacific Island Countries*, commonly referred to as the Pacific Islands Project (PIP). PIP has progressed through three design phases (1995-2006) plus a bridging/transition phase, which commenced in September 2007 and concluded on 31 December 2010.

2.4 FUNDING

Source	Approximate Value ($A)	Purpose
GOA through AusAID	**$5,700,821**	**Provision of Specialist Services in PICs**
Volunteer contributions	$5,921,942[1]	Provision of specialist services and training/workshop support
Other donors/funders – Orthopaedics Outreach, Sydney Adventist Hospital Operation Open Heart, Interplast Australia, RANZCO, Suppliers, Airlines, NZAID, self-funded volunteers	$1,027,270	Funding for airfare, accommodation and meal expenses for non-project funded team members; provision of additional medical supplies and consumables
RACS International Travel Grants	$ 20,000	Fund PIC doctors to attend scientific conferences
RACS Foundation for Surgery	$ 9,082	Funds for one month Audiology training program (Solomon Islands)
Project Director	$ 60,000[2]	Guidance and oversight of activity implementation
Evaluation and Monitoring Committee Members and Specialty Coordinators	$ 221,229[3]	Independent review of activities implemented
Total Value of Other Contributions to Project Activities	**$7,259,524**	

The PIP Bridging/Transition phase had been contracted between AusAID and RACS. Financial management arrangements covering the implementation of the PIP III Transition Phase followed the original contract design wherein budget was provided to support the activity implementation under the project aid modality. This form of aid was deemed appropriate throughout the life of the PIP in light of the highly specialised nature of the technical inputs volunteered to the project.

Project fund outflows were initially borne by the RACS and payment of claims for the provision of services were made in arrears in accordance with contract provisions. No funds in advance were made by AusAID and hence no funds needed to be returned at the conclusion of PIP. Given the short term nature of the contracting agreement, this was deemed appropriate and effective as it provided the project the flexibility to respond to emerging needs of PICs within the scope of services contained in the proposal and funding budget. An AusAID financial and system audit of RACS' international programs in November 2010 confirmed the appropriateness of the RACS' management of AusAID funds for this project.

[1] This figure has been calculated using the following estimates: Input of 309 surgeon weeks, 225 weeks of anaesthetist and other doctors' inputs, 403 nurse-weeks and 159 weeks of other health specialists' input. Average weekly fee: Surgeon AUD7,500; Anaesthetist AUD7,500; Nurse AUD 3,500; other Specialist AUD 4,800 average.

[2] The Project Director has donated a minimum of one full day of service per month over the duration of the Bridging/Transition phase or a total of 40 days @ AUD 1,500 per day.

[3] The Evaluation and Monitoring Committee is comprised one nurse, and three specialists, one of whom is the chairperson. It is estimated that members each spend 13.5 hours per annum reviewing reports and attending meetings, and it is estimated that the chairperson spends a total of 30 hours per annum in his role as chairperson. Therefore the estimated value of the contribution of these services is $11,868.75 per annum. The Project has also engaged the voluntary services of 11 Specialty Coordinators. They are each estimated to have contributed at least 30 hours per annum in these roles, and the value of their contribution is estimated to be A$61,875.00 per annum.

2.5 Activity Governance Arrangements, Stakeholder Consultations and Coordination Mechanisms

Through RACS, the PIP program management drew on the expertise of a number of specialists with considerable experience in the provision of health services in developing countries.

The Project Director provided technical guidance and strategic oversight to ensure effective implementation and quality management of PIP activities; these contributions added enormous value to the progress of clinical care and skills training delivered during the Bridging/Transition phase.

Specialty Coordinators were appointed for each major speciality represented under PIP to assist with the suitable identification of specialist volunteers, provide technical advice and monitor activities undertaken and/or issues which arose within their specialty.

The Project Director and Speciality Coordinators were charged with reporting on PIP progress to the annual meetings of the RACS International Project Management Committee (IPMC). The IPMC, which includes representation from the Pacific, PNG and Timor Leste, Project Directors and Specialty Coordinators of all RACS' international development programs, meets annually to oversee project activities, analyse issues and discuss lessons learned across RACS' overseas aid programs. Where possible, the IPMC meetings have been scheduled to coincide with visits to Australia by key PIC stakeholders to encourage face to face Pacific participation and consultation at the meeting. Otherwise they attend by teleconference where possible.

The Evaluation and Monitoring Committee (EMC) is an independent review group (comprising two surgeons, an anaesthetist and a nurse) that meets a minimum of three times per year to assess all PIP visit reports, appraise technical inputs and activity performance as well as, address adverse events and discuss recommendations for improving project implementation. Where possible, Pacific Island health personnel based in Melbourne (Australia) at the time of EMC meetings were invited to attend and participate. EMC inputs were provided on a voluntary basis.

The IPMC and the EMC report to the RACS International Committee which meets three times a year and sets policies and guidelines for the College's international activities. For an overview of the PIP governance structure, please refer to Annex 1. All governance arrangements and inputs are honorary and provided on a *pro bono* basis.

While there were no formal mechanisms established to facilitate stakeholder consultation during the Bridging/Transition phase, the RACS employed a number of strategies to engage key PIC stakeholders in the planning, delivery and assessment of PIP activities. RACS has developed productive working relationships with key MoH and hospital personnel; this long standing association allowed for wide and effective consultation with key PIC stakeholders in the process of establishing clinical and training priorities and in the planning and delivery of all program activities. The schedule of specialist visits and training workshops was entirely demand driven by either MoH or hospital representatives. Regular consultations were undertaken with key in-country stakeholders during debrief sessions, held at the conclusion of each specialist visit. Debrief sessions were attended by MoH representatives, hospital administration and staff, including surgical trainees. Efforts were also made to ensure

relevant AusAID country post representatives were also present. The debrief was an opportunity for all stakeholders to review the clinical and training performance and outcomes of the visit, discuss any issues arising and consider lessons learned and/or strategies for continuous improvements of program activities. Feedback and requests raised by key in-country stakeholders during these debrief sessions were included in team visit reports for circulation.

The PIP project management team capitalised on meetings with relevant PIC stakeholders at every given opportunity; consultations were held at each of the biennial PISA conferences and every RACS Annual Scientific Congress where stakeholders in health from the Pacific attend. RACS participated in stakeholder consultations undertaken in 2008 and 2010, and the Project Director held meetings with FSMed and Program Manager of the SSCSIP during academic support visits, to assist with the new program design process.

The PIP III was a regional program and aid during the transition phase was delivered through contracting arrangements between the Commonwealth and RACS. Refer to Section 2 for information on funding arrangements. No activity funds were channelled through partner government systems and payment of claims for RACS provision of services and procurement were made in arrears.

Funds were not directly pooled with other donors or partner governments, but the RACS collaborated with external organisations to maximise effectiveness of PIP clinical visits and training services. Coordination with organisations including: Interplast Australia and New Zealand, Orthopaedics Outreach, Sydney Adventist Hospital, Foresight, Provision, Optometry Giving Sight, Royal Australian and New Zealand College of Ophthalmology, Royal Australian and New Zealand College of Obstetrics and Gynaecology, Australian Society of Anaesthetists and Australian and New Zealand College of Anaesthetists, Royal Australian & New Zealand College of Radiologists, the Australian Society for Head and Neck Surgery, Counties Manukau, NZ, the Gastroenterological Society of Australia, Royal Australasian College of Physicians, and the NZAID program of health services support to the Pacific, have added value to the resources and services of program activities. Individual PIP volunteers generated funds in support of the program; self-funding additional team members and procurement of additional medical supplies were common examples of valuable volunteer contributions. Significant support was offered by RACS through its scholarships and travel grants foundation programs. The RACS Foundation for Surgery supported ENT development in the Solomon Islands by funding a one month Audiology training program in the Solomon Islands in 2009. The Foundation has also funded the purchase of essential textbooks and online journals access for FSMed surgical and anaesthetic trainees during their training.

3. Activity Description

3.1 Background & Rationale

The *Provision of a Range of Tertiary Health Services to Pacific Island Countries*, commonly referred to as the Pacific Islands Project (PIP), has been managed by the RACS on behalf of AusAID since its inception in 1995, contract extension to Phase II and Phase III in 1998 and 2001 respectively. When Phase III concluded on 31 December 2006, AusAID agreed to fund a bridging/transitional phase through to September 2007. Further contract amendments were made in 2008 and again in 2010 to extend this bridging/transitional phase through to December 31, 2010. The bridging/transition phase aimed to provide continuity of clinical services and training support for PIC medical staff, pending the completion of a new design for future secondary and tertiary health services support in the Pacific.

The activities delivered during the Bridging/Transition phase were developed in line with recommendations of the 2006/7 PIP review. This supported continued provision of high quality clinical services while strengthening integration with PIC health systems through improved capacity building, monitoring and evaluation, and responsiveness to country needs. The 2006/7 review recommended improving the ability of MoHs to plan for, coordinate and monitor the effectiveness of both clinical visits and associated capacity development, to better match country needs for specialised medical services and training, and donor inputs.

Australia has long focused its aid efforts on the Asia-Pacific region to alleviate widespread poverty, promote regional stability and prosperity, and increase economic, social and security links with its neighbours. The rationale for providing ongoing support was simply that PIC populations continued to require access to specialist care for a range of treatable illnesses and disabilities and PIC governments were unable to meet these demands; Australia was well-placed to provide support and improve health outcomes for Pacific populations. The PIP Bridging/Transition phase offered a cost effective means of providing high quality treatment for Pacific patients as all services were provided *pro bono* by volunteers. The objectives and activities of PIP also aligned with AusAID's capacity building focus; each clinical visit enabled skills transfer between visiting specialists and local counterparts, and formal training opportunities provided through the program have helped to strengthen the regional workforce.

3.2 Overall Budget, Duration and Phasing

On 27 April 2007, AusAID ratified an amendment to the PIP contract to incorporate a nine-month Bridging Phase from 1 January to 30 September 2007 with an additional budget of A$836,988. On 31 October 2008, a further amendment to the contract was ratified to incorporate an extended timeframe for delivery of services from April 2008 – December 2009. This amendment allowed the reallocation of the unutilised balance of the original contract (A$261,893) and provided an additional funding budget of A$2,758,912 for the transition phase. This brought the Bridging/Transition phase budget to A$3,857,793 plus GST. On 19 January 2010, Amendment No. 5 to the PIP contract was ratified extending the delivery of clinical services and capacity building initiatives to 31 December 2010. The PIP III Transition Phase budget was increased to A$5,700,821 plus GST.

3. Expenditure/Inputs

Three PIP III contract variations were approved for the Bridging/Transition phase to facilitate adequate time for the development of the new program design (SSCSIP). PIP III Bridging/Transition Phase budget and expenditure details are as follows:

Item	IN AUD		
	Contract Budget Upper Limit	**Expenditure (Actual)**	**Contract Budget (Balance)**
Clinical Visits	3,601,031	3,480,254	120,777
Disposable Supplies	1,113,645	1,103,232	10,413
Essential Equipment	122,169	121,638	531
Training & PIC Medical Staff Travel	581,060	543,970	37,090
Project Management & Reporting Fees	282,916	282,916	-
TOTAL	**5,700,821**	**5,532,010**	**168,811**

The underspending of the clinical visit budget was primarily due to non-utilisation of a grant earmarked to partially fund cardiac surgery visits to Tonga, Vanuatu and the Solomon Islands. The Vanuatu and Solomon Islands planned cardiac surgery visits were deferred because both countries were unable to confirm their funding commitment towards the total cost of the undertaking. A review of the cardiac visits to Tonga made in 2008 and 2009 revealed that the backlog of surgical cases were effectively attended to, hence no urgency to conduct a similar visit in 2010.

Savings from reduced costs and funding support from a number of the PIC MoH in the implementation and delivery of training workshops and other capacity building initiatives contributed to the lower actual training expenditure vis-à-vis budget. For example, several MoHs provided partial funding support in the delivery of the Primary Trauma Care (PTC) course: local participants travel and other workshop expenses.

Key activity inputs included human resources, expertise and equipment. Volunteer human resources and expertise inputs were significant: 669 surgeons and other medical specialists were deployed to the 11 recipient PICs to deliver clinical services during the Bridging/Transition phase and over 65 volunteers provided expertise and training through formal workshops and academic support.

Disposable medical supplies and essential equipment were procured to support the self-sufficiency of clinical teams and the delivery of safe specialist procedures.

There were no expectations of contributions by partner governments or organisations in the PDD or contract variations however, the PIP has encouraged MoHs and hospitals of partner countries to take responsibility for a number of costs and they have done this over the reporting period. Human resources as well as clinical facilities and materials were provided by host hospitals and training institutions during clinical and training visits. Clinical visits could not effectively or safely function without the support, cooperation and contributions of local hospital staff. Contributions and cost-sharing has already been seen in the delivery of training courses and workshops which reflects the growing ownership PICs are taking.

As described in the funding section of this report, RACS has engaged financial, material and human resource contributions from a number of partner organisations specialist colleges and societies. Over the bridging /transition phase, their contribution over and above resources funded by PIP has been valued at over A$1 million.

4. Approach/Strategy Adopted and Key Outputs

The 2006/7 PIP Review recognised the need for a continuity of secondary and tertiary health support in the Pacific; as much as possible, service, workforce and resource constraints required uninterrupted development assistance during the new design process. As such, key PIP activities were funded to maintain quality clinical service provision and a program of training opportunities for PIC health workers in an effort to respond to identified needs expressed by PICs and avoid a lag between the conclusion of PIP III and the implementation of a new designed program .

Based on challengingly short-term funding allocations and planning cycles, a schedule of clinical visits plus training and capacity development activities were developed in close consultation with each MoH. The 2011 Review acknowledged the 'relatively short-term repetitive cycle has inevitably placed constraints on RACS taking a longer-term view on planning and managing its input'[4] – this observation provides a framework for analysing the approaches adopted during the Bridging/Transition phase, particularly in terms of the distribution of funds between service delivery and capacity building components of the project.

4.1 Clinical Activities and Outputs

To generate maximum benefit for PIC populations awaiting specialist treatments, clinical service delivery activities under Component 1 were planned in consultation with PIC MoHs and defined in each renewed contract; contract amendment No.4 confirmed funding for 76 clinical visits to be delivered between April 2008 to December 31 2009 and contract variation No.5 outlined a funding allocation for the deployment of 50 clinical visits between January – December 2010. Both contract amendments made provisions for disposable supplies and essential equipment to facilitate the safe delivery of quality services. Funding was distributed across PICs in relation to the percentage of each county's population, taking into account availability of the skills base of local personnel and the infrastructure in place to support safe clinical activities. 146 specialist visits were delivered during the Bridging/Transition phase, incorporating support for 19 visits in addition to contracted outputs.

Clinical visits of one to two weeks duration were delivered by volunteer medical teams of one to four persons. In response to the scope of medical conditions and disorders which cannot be managed by local clinicians in the Pacific, the RACS facilitated visits over a wide range of specialties, including cardiac surgery, ENT surgery, paediatric surgery, urology, neurosurgery, ophthalmology, plastic & reconstructive surgery, orthopaedic surgery, vascular surgery, maxillofacial surgery as well as cardiology, nephrology, neonatology, paediatric endocrinology, laparoscopy and gastroenterology. Many of these specialties have assisted PICs in managing the burden of conditions related to prevalent non-communicable diseases, such as diabetes and cardiovascular disease. The range of clinical activities undertaken also generated significant benefit in

[4] PIP Phase III Review (2011), p4

improving child health outcomes; 30% of (recorded) operations performed during the Bridging/Transition phase were provided for neonates or paediatric patients. Such outputs contribute to strengthening the Pacific's progress towards achieving the *Millennium Development Goal* (MDG) of improving child health and reducing mortality and morbidity.

The 2011 Review regarded local pre-screening of patients as a 'criteria for success of the new program'[5]; locally managed pre-screening of patients was undertaken by local counterparts where possible. In several instances, the MoH allocated funding for the transport of patients who were identified in remote areas during pre-screening visits; this was a significant step towards demonstrating the ability and willingness of MoHs to plan and budget for clinical visits by international teams. Local pre-screening was an important contribution towards a government-led program of increasing access to services for their remote populations, targeting isolated and poorer communities. Pre-screening fed into key outcomes of the program, as analysed in the 'Outcomes' section of this report.

Patient consultations and procedures performed for an extensive range of treatable illnesses and disabilities were key outputs from specialist visits delivered during the Bridging/Transition phase. For an overview of quantitative outputs of clinical visits, please refer to Annex 2. The immediate benefit generated from these clinical activities was the contribution to managing the secondary and tertiary health needs of Pacific populations. Without this support, the majority of patients seeking specialist healthcare, would not have been able to access or afford appropriate treatment. The benefits associated with PIP clinical visits link directly to AusAID's Pacific Regional Strategy of 'Investing in health helps lay the ground work for skilled and productive populations, and ensures that the poor can expand their range of choices, improve their productivity and participate more fully in society.'[6]

4.2 Training Activities & Outputs

Approximately 11% of the total funding budget was earmarked for the delivery of various capacity building initiatives under Component 2. Key training activities took account of the 2006/7 Review recommendation 'that training activities are strongly aligned with existing national mechanisms for health work force development, support the development of local and regional training institutions, contribute to the development of locally-based courses that are run in-country as much as possible.'[7] The RACS collaborated extensively with MoHs and key health care workers from all 11 PICs to plan appropriate relevant training activities. Internationally recognised formal training courses were provided in-country to surgeons, trainees, anaesthetists, nurses and other allied health workers nominated by their MoH to upskill the regional workforce. A total of 50 training workshops were delivered during the Bridging/Transition phase and were attended by 852 PIC health workers and allied professionals. A complete list of training outputs, including the number and type of workshops delivered during the Bridging/Transition phase, is available in Annex 2. Importantly, several Instructors' workshops were incorporated in the schedule of

[5] PIP Phase III Review (2011), p6

[6] http://www.ausaid.gov.au/keyaid/health.cfm

[7] Recommendation 3: PIP Phase III Review (2007), pvi

training delivered to foster sustainable benefits; 82 health professionals successfully completed instructor courses during the Bridging/Transition phase. A cohort of Pacific-based trainers are now qualified to facilitate PTC workshops to their peers in the Pacific and a number are now accredited instructors for the conduct of EMST and CCrISP courses in the Pacific.

Targeted academic support to FSMed, including pre-examination preparation and external examiners support were supported in consultation with the FSMed. Expertise was provided by PIP volunteers who are leaders in the Australian and New Zealand fellowship of surgery. Pre-examination preparation was made available for all FSMed surgical candidates (from all PICs); with a particular focus on all Masters candidates due to sit their final year exams. Outputs included the successful passing of both Masters candidates in 2009; in 2010, all four diploma candidates passed their examination and gained a Diploma in Surgery (however, only 1 obtained the necessary grade to progress to MMed 2 Programme), all 6 MMed 2 candidates passed the examination and obtained the necessary mark to proceed to MMED 3 program, and all 7 MMed 3 candidates passed and will proceed to the final year MMed program. In addition the PIP-funded external examiner for FSM recommended all three final year candidates be awarded their MMed on satisfactory completion of their thesis. PIP-funded examiner inputs for general surgery, anaesthesia and obstetrics & gynaecology provided evaluations of FSMed examination standards and conduct as well as external assessments of exams and theses. In addition to academic support, the benefits generated through these activities extended towards strengthening educational networks and institutional linkages for the students and faculty of FSMed.

The dollar allocation for training activities (11% of the contracted budget) understates the extent and quality of training activities delivered and the qualitative outputs achieved during the Bridging/Transition phase. The provision of on-the-job training and mentoring provided during clinical visits generated significant benefits in workforce development. Skills transfer and capacity building results were reported where multidisciplinary visiting teams worked directly with PIC counterparts and medical personnel. Informal skills training were provided in the operating theatre, during patient consultations, and on ward rounds; formal tuition sessions were regularly planned in collaboration with local medical staff and implemented during clinical visits. The value and benefit of capacity building initiatives undertaken during clinical visits and the mentoring relationships built upon over the 15 years of PIP is evident through the increasing capacity of PIC health professionals to effectively manage secondary and tertiary presentations. For example, Ni-Van surgeon, Dr Richard Leona, has benefited from on-the-job training with visiting PIP Urology teams under the supervision of Urologist, Dr Richard Grills, to promote his interest in Urology. Dr Grills reported that Dr Leona was able to actively participate in all consultations and every surgical procedure performed on the 2010 visit. Benefits were also extended to other hospital staff; theatre scrub nurse, Leisong Lagoniala, who actively participated in these visits, is now able to assist all types of urological cases with demonstrably more confidence and ability than in previous years.

The success of on-the-job training initiatives was partly due to the high number of PIP volunteers who returned annually or biannually over the three phases of PIP to incrementally foster specialist skills with counterpart surgeons, surgical trainees, anaesthetists and nurses. This has been especially true in the cases of training attachments for PIC surgical trainees and surgeons, which were only made possible through well-established links with the FSMed. Coordination with the FSMed Dean and

other faculty members enabled medical trainees to be released from their studies for short periods to participate in PIP clinical visits. FSMed trainee, Dr Dyxon Hansell (Samoa), was released from his training commitments to join PIP Orthopaedic and Plastic & Reconstructive surgery visits to Apia in 2009 and 2010; Dr Basil Leodoro and Dr Trevor Cullwick (FSMed trainees from Vanuatu) were released for attachments to Urology, Orthopaedic, Plastic & Reconstructive and Paediatric surgery visits to their home country. The following comment from Dr Leodoro's report depicts the benefit of training attachments with PIP visiting teams,

'In summary this was a worthwhile exercise for me as a training registrar. Not only did I learn essential skills and principles from the team and Mr Ian Holten, but I also had the rare opportunity to practise and operate in my own home setting, amongst my own people. It allowed me to appreciate my available resources and to consider what I could do in terms of improving surgical practise in my home country. It also allowed me to establish networks for further training and attachments which can reinforce the experience from this visit. I believe this was a vital learning experience for me and I look forward to more attachments with visiting teams to Vanuatu and elsewhere as I continue my surgical training.'[8]

5. Outcomes

5.1 Expected Outcomes

Expected Outcome	Outcome Achieved	Evidence
Improvement in the quality of life for people who receive surgical services	***Clinical Visits*** Throughout the lifetime of PIP, improvements in the quality of life for many patients treated have been demonstrated. Lives have been saved and physical afflictions have been diminished or eliminated as a direct result of PIP clinical intervention. Key program achievements extended beyond successful medical outcomes; treated patients will now be able to function as independent, active participants of their communities, access education and contribute to their household economies. Where health and physical ability is restored for patients, family members who have acted as full time carers can also enjoy the above benefits. Populations will benefit where patients who are educated and/or skilled individuals are restored to their communities. For example, Ophthalmology teams are able to restore sight to blind children and adults through cataract surgery and other eye operations. Optometrists also work closely with local counterparts to test eyesight and distribute spectacles to those in need to improve their vision.	***Clinical Visits*** There are numerous examples which are demonstrative of the successful outcomes of clinical interventions for program beneficiaries. Please refer to Annex 3.

[8] Dr Basil Leodoro, Plastic & Reconstructive Training Attachment Report (2009)

Expected Outcome	Outcome Achieved	Evidence
	Such outputs can dramatically increase the independence of individuals to manage their day-to-day lives and to be productive members of society. Benefits can also extend to family or community members who do not need to dedicate their time to care for vision impaired individuals. Outputs delivered by clinical teams contribute to improved child health outcomes for example, a number of children were treated by ENT teams for common ear diseases associated with child deafness. Successful outcomes impacts on children's development and access to education. Successful middle to long-term outcomes will contribute to strengthening regional economies and political stability where improved health leads to developing educated, skilled and productive populations. The strain on poorly funded and under-resourced health facilities has also been alleviated where backlogs of patients are seen, diagnosed and treated.	
An increase in health workforce capacity which will lead to more sustainable health services in-country in the long term	***Pre-screening*** Increased levels and quality of pre-screening was undertaken by in-country counterparts during the Bridging/Transition phase. This outcome is a key indicator of workforce and skills development for PICs as well as increased capacity of in-country stakeholders to effectively plan and coordinate visits by international medical teams.	***Pre-screening*** Specialist visit reports recorded improvements in the capacity of local staff to undertake effective pre-screening. Evidence of triage development were reported for: - ENT visits to Vanuatu, Solomon Islands and Fiji; -Orthopaedics visits to the Solomon Islands; -Urology visits for the Solomon Islands and Vanuatu; - Ophthalmology visit for Samoa; - Paediatrics visits for Fiji; - Renal/Vascular visits to Nauru. Patients were selected with more understanding of what can be achieved during the visit'[9] and teams have 'come to expect consistent and effective pre-screening'[10] from local surgeons, trainees and nursing staff with whom they have worked and provided training for over a number of PIP visits. Evidence of outcomes is provided in Annex 3.

[9] Dr Alex Cato, PIP Urology Clinical Visit Team Leader report, Solomon Islands (2008)

[10] PIP Quarterly Progress Report 31 (Oct-Dec 2009)

Expected Outcome	Outcome Achieved	Evidence
	Informal Training & Mentoring Increased skill levels of local counterparts through on-the-job training and skills transfer during clinical visits contributes to sustainable gains in strengthening specialist health service provision in the Pacific and the ability of some PICs to improve secondary and tertiary health outcomes for their populations. Capacity and confidence of PIC medical personnel has increased as a result of the skills transfer and professional guidance provided by mentors. Strong professional and institutional linkages have been established through mentoring relationships, enabling regular correspondence to facilitate a 'distant consultative service' between visits and overseas training attachments at Australian and NZ hospitals. Mentoring has helped to sustain ongoing professional development for PIC health workers and strengthen workforce capacity, which leads to improved health outcomes for PIC populations. ***Formal Training Courses/Workshops*** There has been a significant increase in local capacity to prepare, manage and deliver educational courses and workshops by PIC medical personnel. This contributes to sustainable workforce development as training can be delivered in-country by national staff. Courses are now being partially delivered in local languages or dialects where possible which ensures that benefits can extend to all PIC medical personnel.	***Informal training & Mentoring*** Evidence has been verified on a number of clinical visits in relation to increasing capacity of staff to correctly identify and diagnose conditions, to scrub for specialist cases and successfully undertake new and increasingly complex procedures. Improved knowledge of specialist equipment, aftercare procedures and best practice protocols for case management have also been recorded by both PIP volunteers and PIC stakeholders. Mentoring has increased skills and generated further opportunities for training. 3 PIC surgeons have been identified and supported for overseas specialist training through the Rowan Nicks Scholarship program as a result of mentoring relationships. They are Dr Dudley Ba'erodo from Solomon Islands in Urology (mentor: Dr Alex Cato), Dr Alan Biribo from Fiji in Neurosurgery (mentor: Dr Nadana Chandran) and Dr Richard Leona from Vanuatu in Urology (mentor: Dr Richard Grills). Anecdotal evidence of outcomes is provided in Annex 3. ***Formal Training Courses/ Workshops*** Over the bridging/transition phase 64% of facilitators of PTC courses delivered in-country were PIC nationals. This is a medium-term outcome of the program in staff development which contributes to the long-term sustainability of initiative Other programs such as the ENT Nurse Training Workshop have seen nurses 'essentially running ENT clinics on their own'.[11] Increased capacity of staff to effectively manage large-scale emergency trauma scenarios has been evidenced in Samoa following the 2009 tsunami. A PTC course was originally requested by the MoH in preparation for the change from left to right hand drive in Samoa. The course was provided to doctors and a wide range of first responders such as paramedics and police officers. Positive outcomes were recorded as

[11] Dr Perry Burstin, PIP ENT Clinical Visit Team Leader report, Vanuatu (2010)

Expected Outcome	Outcome Achieved	Evidence
		a result of this activity; changed behaviour and preparedness of the community when the tsunami struck a few months after the training was delivered. Lower mortality and morbidity can also be attributed to the training. Evidence of outcomes for the 2009 Samoan PTC course and other formal training opportunities is available in Annex 3.

5.2 Unexpected Outcomes

An unplanned positive outcome achieved during the Bridging/Transition period was the consolidation of a robust professional network developed between PIC medical personnel and RACS volunteers. In addition to the cost effectiveness of deploying medical volunteers to the PICs under PIP, RACS has engaged a cohort of dedicated volunteers who have established productive and influential mentoring relationships with their Pacific counterparts. 44% of RACS surgical or specialist volunteers have returned to the Pacific (on either an annual, biannual or biennial basis) to develop the skills of PIC medical personnel incrementally and to provide a continuity of specialist training. Professional guidance provided by volunteers typically extends beyond the one or two week clinical visit; regular email or telephone communication was reportedly maintained between volunteers and PIC medical personnel to plan teaching topics and clinical priorities for future visits, provide ongoing career mentoring, case management support and shared educational resources. For example, PIP Orthopaedic volunteer, Dr Stephen Quain, maintains regular contact with his counterpart, Dr Patrick Housia, in Solomon Islands; 'We have tried to have operative cases and teaching topics prepared in advance as requested by our host team - not always easy to do; and really encourage regular email contact, as a distant consultative service.'[12] The outcome of these communications and relationships has been the positive engagement of key medical personnel, an emphasis on demand driven support, and effective skills transfer to strengthen the Pacific health workforce.

The professional networks established during the Bridging/Transition phase will support a future program in relation to linkages and institutional strengthening, particularly as a number of mentoring relationships have led to RACS supported training attachments for PIC trainees at Australian and New Zealand hospitals. Dr Alan Biribo was awarded a Rowan Nick's scholarship to continue honing the neurosurgical skills he has developed while working with PIP Neurosurgery teams in Fiji. Dr Biribo acknowledged the significance of the training he received from visiting PIP teams; 'I have been attached to the visiting neurosurgery teams at CWMH and have gained a lot in terms of knowledge skills, clinical acumen and even organisational skills. This has progressed to the point that I am now in Canberra training in neurosurgery so this is the extent to which the benefits of PIP visiting teams can be seen.'[13] Other examples where training under PIP has led to skills development and productive professional linkages include a posting to Geelong hospital for Dr Richard Leona (Vanuatu), who

[12] Email communication with Dr Stephen Quain, 11/05/2011

[13] Email communication with Dr Alan Biribo, 12/05/2011

will undertake a Urology attachment with PIP Urology volunteer, Mr Richard Grills, and Dr Dudley Ba'erodo (Solomon Islands) who will take up a training attachment in Melbourne in 2011 through representations made by his mentor PIP volunteer Urologist, Dr Alex Cato. Drs Cato and Ba'erodo have both commented on the successful outcomes of the mentor relationship they cultivated under PIP;

Dr Alex Cato: 'There has been a significant transfer of skills to Dudley Ba'erodo and his competence and confidence have obviously improved. There are a number of urological procedures that he can do unsupervised and his clinical judgment is now very good…He needs a continuous period of training focused on endoscopic procedures…the [RACS] has addressed that by awarding him a Rowan Nicks Fellowship.'[14]

Dr Dudley Ba'erodo: 'The specialist visits have been very beneficial to our patients as well as our surgical doctors…We have our local counterparts working closely with the visiting teams, especially in Urology and Paediatric surgery. There is no doubt that we have gained confidence and learned a lot by working with the visiting teams. For instance, I have been doing TURP[15] when the Urology team come with their resectoscope…As we gain skill and knowledge on dealing with the more common cases, the visiting teams may concentrate on bigger and more challenging cases if possible.'[16]

Another positive outcome was an increase in effective pre-screening undertaken by local staff. Quality pre-screening of patients was recorded for ENT visits to Vanuatu, the Cook Islands and Solomon Islands, Ophthalmology visits to Tonga, Tuvalu and the Solomon Islands, Paediatric visits to Fiji, as well as Plastic & Reconstructive surgery visits to Vanuatu and Renal/Vascular visits to Nauru. Locally driven pre-screening demonstrated improvements in health workforce capacity - staff correctly identified conditions and made appropriate referrals – and generated improved health outcomes for remote populations as screening visits were typically undertaken outside of the main centres. An exceptional example of how pre-screening contributes to workforce development was recorded on the 2010 PIP ENT visit to Vanuatu; the ENT nurses who have conducted pre-screening and participated in annual ENT nurse training over the course of the Bridging/Transition phase, 'essentially conducted the clinics themselves with management plan presentations after each patient'.[17] Increased local ownership of pre-screening visits also signalled improved logistical organisation and coordination in relation to visiting clinical teams – this is significant progress towards a future program that will eventually be managed out of Suva.

6. Expected Long-term Benefits and Sustainability

Within the confines of a short-term program of support, the PIP Bridging/Transition phase facilitated benefits that will contribute to sustainable gains for PIC health workforce development and improved equity of access and health outcomes for over 2.2 million people living in the Pacific. The program's focus on increasing the capacity of medical personnel through a combination of formal training opportunities, peer

[14] Email communication with Dr Alex Cato, 12/05/2011

[15] Transurethral resection of the prostate

[16] Email communication with Dr Dudley Ba'erodo, 11/05/2011

[17] Dr Perry Burstin, PIP ENT Clinical Visit Team Leader report, Vanuatu (2010)

support and on-the-job mentoring have strengthened the regional health workforce which will to lead to improvements in the availability of specialist healthcare in the Pacific. To encourage sustainable outcomes in surgery, PIP worked closely with the MoHs of several PICs to identify future leaders in surgery facilitated targeted skills transfer for identified personnel through training attachments with visiting teams. This strategy has helped to build a regional pool of surgeons and specialist trainees who are developing specialist skills in Paediatric surgery, Urology, ENT surgery, Orthopaedics, Plastic & Reconstructive Surgery and Ophthalmology. While self-sufficiency in these surgical specialties is unlikely for each PIC, the beneficiaries of PIP training attachments will lead to a network of Pacific-based specialists to manage the burden of treatable illnesses and disabilities in the region.

The long-term benefits of training for strengthening workforce capacity and improving the health status of Pacific communities have not been limited to surgery or surgical interventions – doctors, anaesthetists, nurses and other allied health professionals across the Pacific have been formally trained in primary trauma and emergency trauma care, burns management, diabetes management and in identification and management of primary ear disease, to name a few. As trauma is a leading cause of death and disability in many PICs, access to training workshops such as EMST, PTC and EMSB courses will have significant long term benefits in terms of improving health care workers' abilities to effectively and systematically manage trauma patients, as well as improving outcomes for trauma patients. As discussed under Section 4 of this report, to promote sustainability and encourage local ownership of these formal training programs, a number of 'train the trainer' and refresher courses were delivered; identified candidates trained as facilitators and now charged with continuing to deliver these workshops across the Pacific. For the PTC workshops delivered over the Bridging/Transition phase, 64% of course facilitators were PIC nationals, some of whom delivered training modules in their local languages. PIC instructor committees have been established to support the planning and coordination of PTC courses and in the near future, a schedule of workshops will be entirely rolled out by the cohort of Pacific-based instructors trained under PIP. These sustainable strategies will contribute to regional health workforce development.

An overarching risk to achieving sustainable gains in the provision of quality secondary and tertiary healthcare in the Pacific is the possibility of insufficient or declining national health budgets. Poor infrastructure and deficient medical resources are the result of shrinking national health budgets; this ultimately inhibits the quality and safe delivery of surgery and other clinical procedures. To mitigate this risk, hospital infrastructure throughout the Pacific will need upgrading, re-equipping and maintenance. Funding allocations must be considered for managing the recurrent costs of new and improved systems and facilities.

The significant human resources shortage in the public health sector and the 'brain drain' issue will also have serious implications for the development of sustainable health services. The capacity of PICs to provide tertiary health services in a particular specialty is dependent on a small pool of individuals and there is a high mobility trend of well-trained staff, both to administrative roles or to take up medical roles offshore. The risks of investing in training for staff who do not utilise their skills in the public sector remain high. Brain drain may be minimised where PIC governments project their workforce needs and develop clear career pathways and structures for health care workers to pursue. PICs need to support and encourage continuing professional development programs and strengthen linkages with international institutions and professional bodies to counter professional isolation; this has been facilitated through

the continuation of mentoring relationships and training activities generated through PIP and the RACS networks. Improved terms and conditions of employment may help to improve staff retention, however, this strategy links directly with aforementioned MoH budget constraints.

A long standing program such as PIP carries the risk of failing to identify appropriately qualified and experienced teams for continuing service provision and capacity building. Over the life of PIP, the RACS has engaged the expertise and guidance of specialty coordinators in the selection of suitable teams of medical personnel for all clinical visits. The RACS has also had at its disposal, a large pool of specialists who have been attracted to participating in a quality program that is coordinated through a reputable institution with credit in delivery of international development programs. As international service provision will be required in the Pacific over the medium to long term, it will be imperative to maintain active links with long standing PIP volunteers as well as identifying and engaging new specialists for the provision of quality *pro bono* health services to the Pacific.

During previous phases of PIP, service delivery to some PICs has been disrupted by political instability and natural disasters. Whilst this remains a risk for the region, the impact on future programs of support can be managed by incorporating a level of flexibility, for example, designing processes which allows for re-directing planned training or services to other PICs in the region if security concerns arise.

To ensure benefits of the program are realised, ongoing and improved collection and analysis of patient outcomes resulting from clinical visits and skills gained by PIC medical personnel is required. Outcome documentation collection is challenging as there have been limited or no in-country resources to actively undertake patient follow-up or assess the development of medical staff. Supporting MoHs and hospital administration in developing effective monitoring and evaluation systems will be essential for tracking the development of specialist services in the Pacific. Ideally, to support the reliable collection and analysis of outcomes based data, locally based staff would be employed in each country to develop and manage effective monitoring and evaluation systems.

In transitioning to a regional coordination mechanism based in Suva, there is a risk of diminished effectiveness of program and activity management. Effective coordination with PIC MoHs and the new coordinating mechanism, DaCT, will be required. Transparency of visit mobilisation planning and costs is essential so PICs can incorporate direct costs and contributions into their national health budgets. Close liaison with MoHs and/or DaCT will ensure that costs associated with hosting visiting teams, such as staff overtime, patient transportation, additional oxygen and laboratory tests etc., will be adequately covered in future budgets. Maintaining the established dialogue between PIC counterparts, PIP volunteers and PIP project management will ensure that initiatives such as locally managed pre-screening and post-operative aftercare as well as highly valued mentoring relationships continue beyond the life of the project.

7. Relevance

The PIP Bridging/Transition phase has been highly relevant both in terms of continuing Australian assistance for strengthening specialist services in the Pacific and in meeting the tertiary and secondary health demands of PIP populations, which would otherwise have remained unmet until the commencement of a new program. The high number of

patients seeking consultations and requiring surgical interventions by visiting teams demonstrates the relevance and necessity of the activity. The impact of procedures undertaken during the short life of the project will be significant – successful health outcomes for patients treated through the program have economic and social impact on the productivity of PIC communities. The training component also ensured continuous capacity development of the Pacific health workforce. While the impact of some capacity building activities may have been limited by the project's timeframe, anecdotal evidence from PIP beneficiaries reflect the value of the training opportunities provided over the course of the Bridging/Transition phase. In particular, the relevance and impact of the PTC training delivered to Samoan health and emergency response workers (reported above) was revealed in the aftermath of the 2009 tsunami; Samoan surgeon, Dr Loudeen Lam reported that the skills and knowledge gained through PTC training was vital for the nation's disaster response and that the course had "allowed us to prepare our emergency & medical services for the unexpected".[18]

Local Context and Needs

The needs and constraints of providing quality health services in PICs are well documented; training and retention of medical practitioners continue to be a significant challenge, as is providing the full spectrum of secondary and tertiary health services, particularly given infrastructure limitations, the isolated and relatively small populations of several PICs and tight health budgets across the region. The activities delivered during the PIP Bridging/Transition phase remained highly relevant as PICs continued to actively seek support in developing their capacities to deliver specialist health services to their populations.

National health capacities and priorities vary significantly between the 11 countries supported by PIP; the program's flexibility and responsiveness to individual PIC needs in this context is central to its relevance. This has been demonstrated through the planning and implementation of program activities in direct response to MoH requests for assistance; the repertoire of clinical and training activities expanded during the Bridging/Transition phase in response to new needs arising in specialised fields including Paediatric Endocrinology (Fiji 2009 & 2010); Paediatric Oncology (specialist requested for inclusion on Paediatric visit to Fiji, 2009); Mammography (Cook Islands 2008 &2010); Oral Maxillofacial surgery (Fiji 2009 & 2010); Neonatology (Fiji 2009); Nephrology (Fiji 2009); Oncology scoping (Nauru 2007), as well as, training in severe burns management (Pacific wide). The flexibility of the PIP Bridging/Transition phase was important in effectively responding to the developing capacity of the Colonial War Memorial and Lautoka hospitals; the increasing capacity of local surgeons in Fiji has led to requests for assistance with more complex specialties and sub-specialties.

Partner Government Development Priorities

National health strategic plans across the region are focussed on primary healthcare as a priority for the sector. However, there is a recognised 'parallel need for secondary and tertiary services to address more complex established or non-preventable conditions, support health care workers in the community and meet the community expectation of effective health care.'[19] The relevance of program activities was

[18] Email communication from Dr Loudeen Lam dated 03/10/2009

[19] Strengthening Specialised Clinical Services in the Pacific: Final Program Design Document (May 2010), p.v

demonstrated by ongoing requests for assistance by partner governments to strengthen specialist health services in line with national priorities and the developing capacities of key institutions such as some PICs' public hospital systems and FSMed. To meet the needs of FSMed, academic support implemented during the Bridging/Transition phase, such as external examiner provision, formal preparation for Masters and Diploma exams and curriculum support, have been provided in direct response to requests from the school Dean and faculty members.

AusAID Strategy, Overarching Policy and Cross-Cutting Policy Objectives

Maintaining a level of service provision and training opportunities in specialist healthcare during the Bridging/Transition phase directly aligned with AusAID's Pacific Regional Strategy: 'Investing in health helps lay the ground work for skilled and productive populations, and ensures that the poor can expand their range of choices, improve their productivity and participate more fully in society.'[20] The delivery of quality services and an investment in workforce training to strengthen partner countries' health systems and the health workforces clearly linked with AusAID's regional strategy as well as the *Policy for Australian Development Assistance in Health* (2006) and the *Paris Declaration on Aid Effectiveness*. Ongoing assistance in building the capacity of secondary and tertiary health systems in the Pacific will help to promote national stability, strengthen economic growth in the region and enable poorer communities to participate in and reap the benefits of socio-economic development.

During the reporting period, RACS ensured adequate attention was paid to implementing AusAID's cross-cutting policy objectives across its program activities. Gender was given particular attention within the health context. In terms of access to service delivery, PIP staff and volunteers were guided by the RACS Gender Equality policy and teams were encouraged to query gender imbalances with local authorities if necessary. The PIP also positively discriminated in terms of promoting female access to medical training and professional development opportunities, however, the pool of female candidates for training remained low.

Program activities also supported AusAID's disability inclusiveness objectives as the surgical services delivered under PIP directly reduced and prevented incidences of treatable disability. Ophthalmology, Orthopaedics and ENT visiting teams in particular have successfully treated a significant number of patients with preventable blindness, conditions related to mobility impairment and childhood deafness.

The impact of PIP activities on the fragile Pacific environment has been a serious consideration for the project management team, particularly in terms of medical waste management and the issue of unwanted donations of equipment, which can pose significant disposal issues for host countries. During the Bridging/Transition phase, RACS implemented its policy on In-Kind Donations to International Projects to ensure that donations of medical supplies and equipment are strictly arranged in response to PIC requests and are in accordance with WHO standards.

RACS has developed its own child protection policy to emphasise the organization's zero tolerance approach to child abuse and child pornography and all personnel involved in PIP activities are required to comply with it.

[20] http://www.ausaid.gov.au/keyaid/health.cfm

PIP program activities demonstrably contributed to poverty reduction. Conservative figures estimate that one third of Pacific Islanders live below national poverty lines.[21] Ill health is a key driver of poverty and poor people are also disproportionately affected by the results of ill health. PIP clinical activities targeted poor and disadvantaged communities by increasing access to specialist health care and improving health outcomes for poor patients with treatable disabilities and illnesses.

The program logic and its activities were based on 15 years of sound learning and extensive experience in delivering specialist health aid in the Pacific. A comprehensive analysis of PIP III methodologies, achievements and lessons learned was undertaken during an independent program review in 2006/7. The outcomes of this review helped to inform future tertiary healthcare initiatives in the Pacific; the Bridging/Transitional activity was based on a key recommendation for the Australian government to fund an interim program of support while the new design process was underway. As the managing contractor of PIP since 1995, the RACS was well placed to implement this short-term cycle of contract extensions. RACS' productive working relationships and professional linkages with key stakeholders in the Pacific have facilitated collaborative learning and continuous improvement of PIP activities, ensuring that clinical and training inputs of the Bridging/Transition phase were demand driven and relevant in a context of changing needs and priorities.

8. Appropriateness of Objectives and Design

Objective

The 2011 independent review of the Bridging/Transition phase acknowledged that the program 'must be assessed within the frame of the funding, budgeting and planning cycle in place, which has been relatively short term, has placed constraints on taking a longer-term view on planning and management, but has provided ample time to design the SSCSIP, and gives time for full consideration of transition issues.'[22] As such, the core program objectives of ensuring a continuity of service provision and transfer of clinical skills to local counterparts were realistic and feasible in terms of maintaining responsiveness to PIC MoH requests for support within a short-term framework. The reduced scope of project objectives during the Bridging/Transition period focussed on the principle needs of the region and remained appropriate, flexible and responsive to the Pacific health context.

Activity/Output/Strategy Relationship

The basis of the PIP III design was utilised during the Bridging/Transition phase to ensure success of the contract extensions. Key aspects of the project strategy were comprehensively summarised in the design in relation to realistic expected achievements at the end of the project; the Project Design Document (PDD) accurately forecast that outputs of the program would result in a high number of patients treated and some skills upgrading for local health workers, 'however there will be a continued need for assistance of this kind at the conclusion of the project.'[23]

[21] Australian Agency for International Development. Tracking Development and Governance in the Pacific, (2009). Canberra: AusAID 2009.

[22] PIP Phase III Review (2011), p10

[23] PDD Executive Summary, pIII

Counterpart Capacity and Development

Assessment of counterpart management capacity was not a contractual requirement of PIP and as such was not undertaken during the design or project implementation. However, assessments made at the conclusion of PIP III identified the changing and emergent capacities of some PICs. Close and regular liaison with the MoHs and other key in-country stakeholders throughout the Bridging/Transition phase has also ensured that project activities were appropriate and in accordance with individual PICs' capacity development needs.

Cost/Benefit

In relation to the actual benefits achieved, costs were appropriate and delivered excellent value for money, particularly when considering the cost effectiveness of engaging highly qualified specialist volunteers who provide services *pro bono.* The total program budget allocation for the period 2007-2010 was A$5.7 million, however the conservative estimated dollar value of the program including volunteer contributions, is closer to A$9.7 million. Costs were appropriate in relation to actual benefit of treating large numbers of patients, particularly when considering the costly alternative option of offshore referrals for clinical treatment. During the Bridging/Transition phase, over 14,426 people accessed clinical consultations with PIP volunteer teams – almost all of these patients received diagnoses and treatment options for their conditions - and approximately 3,428 patients received potentially life-altering surgical procedures in Pacific hospitals through the program. The cost of providing surgical interventions only for this number of patients through the alternative system of offshore medical treatment is estimated to be approximately A$48 million.[24]

The appropriateness of costs in relation to actual benefit also extended to education and training aspects of the program. While only 11% of the Bridging/Transition budget was allocated to training, unquantifiable value was added through specialist volunteers who provided hours of mentoring, on-the-job training, formal lectures and academic support *pro bono*. The RACS has also added substantial value to the training component of the program through access to the additional support of scholarship programs as well as other professional networks and resources such as access to online journals.

Costs for essential equipment and consumables were also appropriate in relation to the intended benefit of supporting the safe and effective delivery of clinical activities. Items were not purchased in excess, rather, equipment and medical supplies were procured or replaced as needed. While a dollar value for donations made over the life of the Bridging/Transition phase cannot be estimated, cost effectiveness can also be evidenced by RACS' coordination of regular medical equipment and supply donations made by visiting team members, hospitals and organisations.

[24] A$48 million is based on the provision of surgery to 3,428 patients at a cost of A$14,000 per person. This figure is based on offshore treatment through the NZAID MTS and does not include the cost of medical consultations or other related services, or travel, accommodation and other associated costs for the patient and accompanying person.

Resourcing and Efficiency

Delivery of activities was achieved within stated and agreed timeframes and the overall level of funding, staff and other necessary resources was considered appropriate given the objectives and project aid modality. It has been recognised however that the PIP III contract had no budget provision for in-country coordination and monitoring costs, such as staff and resources, to facilitate effective and efficient systems of planning and tracking of PIP outcomes. This shortcoming, however, reflected the output focus at the time of the PIP III design as well as the constraints of the short term cycles of the Bridging/Transition contracts. The contract also fell short of budgeting for face to face consultation; as analysed throughout the body of this report, this placed some limitations on program implementation as well as monitoring and evaluation. Additional allocations for essential medical equipment and consumables would have maximised the potential of trained specialists to perform an increased range of clinical services. A flexible priority health fund, which was a component of PIP III but omitted from the Bridging/Transition phase, would have enhanced the program's ability to be more responsive to these shortcomings and would have improved overall efficiency and resourcing capacities.

Risk Assessment and Management

A comprehensive risk assessment was included in the PDD (see Annex 5); serious potential risks to project performance and sustainability were identified and a risk management strategy was developed to ensure the Project could continue its service provision as risks were encountered. No unanticipated risks were encountered and there was no significant disruption to service provision during the reporting period. The 2011 PIP review noted, however that the design did not incorporate risks related to outcomes, for example, 'the risk of adverse clinical outcomes during and after treatment, and the response to that situation'.[25] However, in response to the increasing awareness of outcomes considerations, the RACS worked on managing risks related to outcomes as much as possible during implementation of the Bridging/Transition phase, for example, 'Serious Adverse Event Report' and procedures for adequately responding to cases of morbidity or mortality were developed and used. Recommendations on the appropriate management of an adverse event and strategies to reduce similar instances from occurring in the future were communicated to relevant local personnel and visiting team members.

9. Implementation Issues

- *Contextual issues* such as political instability and hospital strikes in the Solomon Islands and Fiji, as well as natural disasters threats in Samoa and Vanuatu, have had limited impact on project implementation. Improved communication with PIC MoHs, in-country AusAID posts and embassies has ensured that appropriate actions were taken in the assessment of such issues. Flexibility ensured that issues of instability only caused minor delays to service or required a logistical reshuffle so as not to disadvantage PIC populations awaiting specialist care. Following a tsunami threat in Vanuatu during a PIP ENT visit, the RACS took action to review and update relevant volunteer briefing manuals and procedures to effectively manage future instances of natural disasters and conflict.

[25] PIP Phase III Review (2011), p9

More pressing contextual issues arising during project implementation related to budget constraints and limited resources to facilitate maximum benefit of clinical visits. PIP clinical teams regularly reported that essential hospital resources, such as microscopes, image intensifiers, anaesthetic monitors and diathermy machines were out of order or not functioning satisfactorily, which reduced local capacity and teams' effectiveness. As hospital infrastructure throughout the Pacific require varying levels of upgrading and re-equipping, the RACS sourced equipment for use by visiting teams where possible and also encouraged advance communication from host countries on the status of essential medical equipment to ensure facilities were adequate for the delivery of planned procedures. In instances where patient care could be compromised due to poor infrastructure, the RACS discussed the possibility of cancelling planned PIP surgical visits with the MoH until issues were resolved. To encourage improved services and appropriate equipment maintenance, all visiting team feedback and recommendations in relation to hospital resources were promptly relayed to key in-country stakeholders, including the AusAID Post.

- Another issue that emerged during the Bridging/Transition phase was the management of patient recovery post-operation. While there are always risks associated with surgery and morbidity or mortality is often beyond the control of clinicians, appropriate steps were taken to ensure only procedures which could be effectively managed by local staff in the post-operative stages were undertaken by PIP teams. Local surgeons and doctors actively participated in the selection of appropriate cases, visiting teams made assessments based on the capacity of the host hospital and competency of local medical personnel to manage infection or other possible complications, and post-operative care instructions were discussed in detail (and provided in writing) with the local team. The project management team and PIP volunteers have emphasized to host hospitals the importance of aftercare and recovery resources, and have encouraged ongoing communication with PIP team members following their departure as required. Governance issues associated with engaging contributions from key in-country stakeholders, particularly in terms of monitoring and evaluation, have remained a key challenge over the life of PIP. While it was accepted that the Evaluation Monitoring Committee provided qualitative monitoring and expertise for evaluating clinical activities since 2002, both 2006/7 and 2011 PIP reviews expressed concern in relation to the appropriateness of an evaluation and monitoring committee that functions 'without the direct involvement of [PIP] countries.'[26] This is a governance constraint that RACS has attempted to manage with funding available for face-to-face consultations or program reviews which involve in-country stakeholders. To increase engagement of relevant PIC stakeholders, the RACS scheduled a debrief meeting at the conclusion of each clinical visit between the visiting team, MoH representatives, AusAID posts and key medical staff. Debrief meetings have been a successful and cost effective means of obtaining immediate feedback on visit outputs and performance from the host country. The Activity Governance Arrangements summary in Section 1 of this report outlines other strategies RACS employed to manage governance issues.

- The challenge of actively engaging MoH representatives and key hospital staff in the planning and management of PIP activities was raised in the 2006/7 PIP review; MoH counterparts interviewed about activity coordination described their involvement as 'passive'. In light of this feedback, RACS increased its efforts to

[26] PIP Phase III Review (2011), p8

meaningfully engage the 11 PIC MoHs in all aspects of program implementation. PIP project management invested in developing productive working relationships with relevant PIC personnel by maintaining close and regular communication in the planning, delivery and follow up stages of activity implementation, with varying success. The need for further improvements in coordination and consultation with relevant in-country stakeholders has been evidenced by instances of duplication or overlap of services, for example, a PIP ENT visit to Nauru coincided with the 3 month posting of a contracted Israeli ENT surgeon, which undermined the effectiveness of the speciality visit. The 2011 PIP Review recognised 'there is an identified need to improve country level planning, and communication so that services are timed appropriately, and supported by availability of staff and resources…there are currently variable capacities in different PIC to currently meet this requirement.'[27] Developing individual PICs capacities in the sound management and harmonisation of external assistance in specialist health services is required; actions taken during PIP implementation to improve functionality between provider and beneficiary has established a strong foundation for future initiatives.

Program Monitoring

As an extension of PIP III, the Bridging/Transition extension phase was based on the log frame developed for the first phase of the Project in 2001. This reflected development thinking at the time of a quantitative, output based approach to activity monitoring. Although this information did not capture the quality of either clinical or training services provided, the monitoring requirements were appropriate for the objectives established during the design stage and were successfully completed by RACS. The outputs of the program are clearly outlined in Annex 2.

The 2006 and 2011 Reviews outlined the need for an outcomes based approach as an outputs based model will not adequately articulate the outcomes to be achieved by each component. Although efforts were taken to implement outcomes based monitoring through the reporting by teams and in-country counterparts, as well as the work of the PIP EMC, the framework for the collection of beneficial, long-term data was unrealistic given the very short- timeframes of each of the contracts. Positive changes to support the outcomes based approach were reflected in the adjustment of the quarterly report format; a summary of each clinical team visit or training activity was captured, as well as information on the number, age and gender of patients or training participants where possible.

The PIP EMC established Key Performance Indicators as one measurement of team visit success. These were based on the team's ability to set, and achieve service delivery and training goals which were decided upon in conjunction with the PIC MoHs and local counterparts. For 2009 visits it was reported that 67% of teams set objectives and 57% of these teams met the objectives. In 2010, 73.25% of teams set objectives and 68.25% of these teams achieved the objectives. Although there was some variance in the quality of the objectives set and the level of involvement of local counterparts, this reflected an improvement in project monitoring.

[27] PIP Phase III Review (2011), pp5-6

The 2011 review highlighted concerns over the lack of stakeholder involvement in the monitoring and evaluation process; this was hindered by the lack of funding to support PIC medical personnel to join the meetings. When considering the role of the PIP EMC as determined in its Terms of Reference (see Annex 7), much benefit would have been generated through the active engagement of PIC medical personnel. The value of debrief sessions has been discussed earlier in the report. The Program also ensured that all team visit reports are fed back to the relevant MoH. These reports included information on personnel training development, summaries of clinical services delivered, mortality or morbidity (if any) and recommendations from the team on ways of developing services and systems available in-country. Once received by the MoH however, it is not always possible to track the progress of these recommendations

Gender

As noted in Section 7, cross cutting issues related to gender in the development of Pacific healthcare have been monitored over the life of the program. While there were no specific Women in Development (WID) advisory inputs into the project design, it was clearly recognised that women, as members of the health workforce, patients and primary carers, hold a stake in the efficiency and effectiveness of the PIC health system and would be major beneficiaries of any improvements to secondary and tertiary healthcare in the Pacific.

To ensure equity of access to services and opportunities for both sexes, the project integrated practices and strategies to address gender issues arising during implementation. Section 7 provides details of the RACS Gender Equality Policy. A key gender equality issue identified in the design process was the risk of limited female participation in PIP training opportunities. While the selection of local staff for formal training relied heavily on determinations by PIC hospitals and MoHs, and on the interest levels and ambitions of individuals, PIP volunteers were encouraged to identify potential female medical staff for mentoring and further training. This approach found particular success where surgical specialties linked closely with primary health, such as ophthalmology and ENT. The development of ENT services in the Solomon Islands and Vanuatu positively influenced gender outcomes where RACS surgeons identified female nurses to ‘specialise’ in the management of primary ear disease – a mix of formal training, on-the-job training and mentoring have been provided during clinical ENT visits. In the absence of a local ENT surgeon, these women have become leaders in the field and have taken on the responsibility of managing effective pre-screening consultations and have provided training to other hospital staff.

To effectively monitor any gender imbalances in patients seeking or accessing treatment, visiting teams collected patient data disaggregated by sex. The program has consistently recorded an equal representation of both sexes at consultations. Patient selection for interventions/treatment was purely based on clinical need and the capacity to undertake a procedure safely, not on patient gender or sex; this is demonstrated in Annex 8.

The types of tertiary health services offered through the program may result in inconsistencies in terms of gender equity of access to treatment. MoH priorities, such as developing urological services, can serve to address male health issues over female. To counter this issue, the project has worked towards positively influencing health outcomes for women by facilitating activities for female clinical support, such as the delivery of O&G services in Fiji. Such contributions also help to strengthen the Pacific’s progress towards achieving the MDGs in maternal health.

10. Lessons Learned

Project Implementation

- Self-sufficiency in specialist heath in the Pacific is unlikely in the short to medium term and will require an ongoing, long-term donor commitment, both in terms of clinical interventions and workforce capacity development. The Bridging/Transition phase addressed the ongoing need for specialist health services support and up skilling of health workforce in the Pacific

- In contrast to the previous PIP III system of implementing a 5 year plan at the design/proposal stage, flexibility has been an effective feature of the Bridging/Transition phase in terms of responsiveness to the varied needs, emerging priorities and changing capacities of individual PIC's health systems. To encourage activities that are relevant and appropriate, an element of flexibility should be considered in future programs.

- To verify benefits of the program, ongoing and improved monitoring and documentation of clinical visits and training outcomes were required. This was not accomplished as the PIP III contract neglected to budget for in-country management costs, such as staff and resources, to facilitate effective and efficient outcomes-based monitoring and evaluation systems. Collecting and analysing qualitative data on patient outcomes, for example, to measure improvements in the quality of life for people who received surgical treatment during PIP clinical visits, would be a step towards effectively evaluating the medium to long-term impact and achievements of program activities and outputs. Verifiable indicators also need to be developed to measure changes in the skills, competence and confidence of training beneficiaries. Budget allocation and technical support is required to improve the development and implementation of improved M&E systems, and should be considered for all future health programs.

Training & Workforce Strengthening

- A combination of mentoring, on-the-job training/training attachments and peer networking can successfully foster skills acquisition and prevent professional isolation which can lead to 'brain drain'. A particularly successful model has been the delivery of training attachments schemes in aid of up skilling surgical trainees based at FSMed; this had been successfully demonstrated throughout the Bridging/Transition phase. In addition to the practical experience trainees gained with visiting teams, these attachments helped to maintain links between trainees and their home countries, increasing the likelihood of trainees returning to home to contribute to their national medical services at the conclusion of their training.

- The inclusion of local clinicians in the delivery of training activities was an effective way to encourage ownership of skills development and contributes to sustainable outcomes. Where possible, budget and planning should include allocations for the provision of train the trainer or instructor courses, to continue building the cohort of Pacific health workers who have the competence and confidence to deliver on their own training courses in-country. Local ownership in the delivery of training modules stimulated engagement of participants, increased relevance of training (i.e. training modules were increasingly delivered in local languages, contextual examples were included in presentations etc.) and built the capacity of local clinicians to facilitate formal training for the region.

- The Project continued to access additional resources through the RACS' network of highly skilled specialists and scholarship programs, enabling further opportunities for training and support for Pacific medical personnel. The Rowan Nicks Scholarships, the Surgeons International Awards and the International Travel Grants supplemented training provided through PIP with a view to fostering regional leaders in surgery. The opportunities provided, including overseas specialist training attachments in Australia or New Zealand, will foster professional mentoring relationships and strengthen the capacity of the cohort of surgical leaders in the Pacific.

Strengthening Specialist Services & Service Delivery

- Key barriers to accessing specialist services were poverty and the isolation of many PIC communities. Visiting teams reported that remote communities still rely on traditional methods of treatment, such as bone setting instead of seeking orthopaedic care. Improved communication and awareness of the services available through visiting specialist teams and increased coordination with host MoHs and hospitals to facilitate logistical concerns such as patient transport from isolated communities and budget allocations for pre-screening to outlying islands, are steps towards overcoming access barriers

- The in-country management of pre-screening and post-operative care was integral to the effectiveness of PIP clinical visits and successful health outcomes for patients, and will be essential for achieving sustainable outcomes in quality specialist health care in the Pacific; this is discussed in detail under the Outcomes and Implementation Issues sections of this report. Sufficient funding, staff and resources to facilitate pre-screening and post-operative care are important steps towards self-sufficiency and increasing the uptake and types of surgical interventions that can be safely performed in the Pacific.

- Close consultation and improved coordination with PIC MoHs, key hospital personnel and other relevant stakeholders was essential in the planning, delivery and assessment of project activities and increased the likelihood of successful, sustainable outcomes. As health systems evolve in the Pacific, new protocols and regulations for practising medical professionals were regularly introduced over the Bridging/Transition phase; improved communication prior to mobilisation of teams ensured that medical board and registration requirements for different PICs were satisfied – this was especially significant in deploying teams to the Marshall Islands after indemnity issues emerged during PIP III and visits were put on hold. Direct communication between volunteers and their Pacific counterparts also helped to establish visit objectives and ensure that the clinical and training needs and expectations of the activity were clarified in advance. These types of collaborations were integral to the appropriateness and success of project inputs. Equally, debriefing with key stakeholders at the end of each activity was a constructive and cost effective method of obtaining immediate feedback on activity performance as well as an opportunity to discuss lessons learned, any issues arising or recommendations for improved services. However, the ability of the project to actively seek, manage and respond to feedback from countries regarding PIP performance and approaches could be improved. A coordinating mechanism, as proposed through the SSCSIP, will contribute to harmonising all forms of international assistance to the Pacific and will ensure that that aid inputs are aligned with MoH priorities and regional health development strategies.

11. Recommendations

In line with recommendations made by stakeholders under the SSCSIP program, that RACS supports a continuation of specialist service provision through short-term clinical visits by volunteer teams and a greater emphasis on capacity building and workforce strengthening to meet the tertiary health needs of the region. Self-sufficiency in specialist health care is a long-term goal, and is realistically unlikely for smaller Pacific nations. All activities under a new program must be planned for, budgeted and carried out to support and promote national health priorities and to strengthen national ownership of health planning and management. To maximise aid effectiveness in health in the Pacific, the RACS recommends increased Pacific-based coordination of activities and improved harmonisation of all international medical inputs.

Following recommendations made by independent PIP reviews, attention should be given to improving the ability of MoHs to plan for, coordinate and monitor the effectiveness of clinical visits and capacity development activities, to better match country needs for specialised medical services and training with donor inputs. This approach promotes national ownership of the program and will ensure that donor support is consistent with the *Pacific Aid Effectiveness Principles.* Facilitating effective transition of responsibilities to a Pacific coordination mechanism will be essential for building sustainable specialist services in PICs. With over 15 years of experience in the delivery of PIP activities, the RACS is well placed to share its wealth of corporate knowledge and work closely with relevant stakeholders and DaCT as it becomes operational. Transparency and provision of relevant management resources, progress reports and activity implementation plans, as well as, the development of communication and consultation protocols, should be considered and agreed up by key stakeholders to support a Pacific coordination mechanism. The RACS recommends appropriate funding allocations for regular face-to-face consultation with key stakeholders to monitor transition progress and facilitate a demand-driven program of support.

In support of PICs developing their capacity to meet the tertiary demands of their populations, increased emphasis on the provision of training opportunities as well as strengthening education and professional networks between the Pacific and Australia/New Zealand is recommended. Greater attention to mentoring, training attachments and professional development opportunities is critical for strengthening the skills and capacity of the small cohort of surgeons and surgical trainees charged with delivering specialist care in the region. Ongoing support and peer review of Pacific surgeons will help to cultivate quality standards of care in the Pacific and ensure that individual clinicians maintain their expertise and confidence in a context of professional isolation. Wherever possible, additional funding should be allocated for appropriate international training attachments for FSMed trainees and allied health personnel to encourage the delivery of services at international standards. The RACS concurs with the 2011 PIP Review finding that a 'factor in supporting longer-term capacity building is the continued existence of scholarship programs…scholarship provision should be mapped and planned as an overall element with the capacity building/workforce plan at PIC level.'[28] RACS scholarships will be ongoing in the foreseeable future, however, this is not necessarily sustainable and options should be explored for secure funding of international training opportunities for the Pacific workforce.

[28] PIP Phase III Review (2011), pp7-8

The RACS recommends reinstating a priority health needs component for future programs to establish a channel of response to emerging and/or urgent health issues arising. The absence of a priority health fund component during the Bridging/Transition phase limited the program's ability to work with essential complimentary services, such as pathology and emergency medicine, which were identified during implementation as deficient and in urgent need of funding support. Protocols for the endorsement of funding requests would need to be developed in liaison with key stakeholders including DaCT and AusAID.

Improvements to monitoring and evaluation systems will strengthen any future program's capacity to evaluate development outcomes and impact. To monitor and evaluate the medium and long-term outcomes of clinical services and training, there is a need for in-country management of program activities, data collection and analysis. Local management could reliably maintain a regional database of trainees and set suitable competency levels to monitor. This would greatly benefit the Pacific's ability to track the skills development of health care workers and establish training priorities and workforce development plans. A similar database could also be maintained in aid of tracking outcomes for patients who receive treatment by visiting specialists and local clinicians, although this may present some complex issues with patient privacy. Qualitative assessments of patient outcomes, for example, through a beneficiary study on changes to quality of life following surgical interventions, could also be considered M&E improvements will help to effectively track development progress, ensure inputs and activities remain relevant and appropriate, and will provide validation for the continuation of donor services.

12. Handover Arrangements

People involved

Name of Person	Organisation	Role	Contact Details	Position Post-Activity
Prof David Watters	RACS	Project Director	watters.david@gmail.com	Continuing
A/Prof Hamish Ewing	RACS	PIP EMC Chair	lewing@alphalink.com.au	Continuing
Ms Daliah Moss	RACS	Director External Affairs	daliah.moss@surgeons.org	Continuing
Mr Lito De Silva	RACS	Project Manager	lito.desilva@surgeons.org	Continuing
Kate Newall	RACS	PIP Project Officer	kate.newall@surgeons.org	Continuing
Helen Postma	RACS	Medical Equipment Coordinator	helen.postma@surgeons.org	Continuing
Paulini Sesevu	AusAID Post – Suva	Senior Program Manager	Paulini.Sesevu@ausaid.gov.au	Continuing

Documentation Produced

Name of Document	Type of Document	Document Owner	Date Document Produced	Location/s of Document
Quarterly Progress Reports	Reports	AusAID	2007-2010	AusAID, RACS
Deed of Amendment No. 3	Contract Amendment	AusAID	27 April 2007	AusAID, RACS
Deed of Amendment No. 4	Contract Amendment	AusAID	31 October 2008	AusAID, RACS
Deed of Amendment No. 5	Contract Amendment	AusAID	19 January 2010	AusAID, RACS

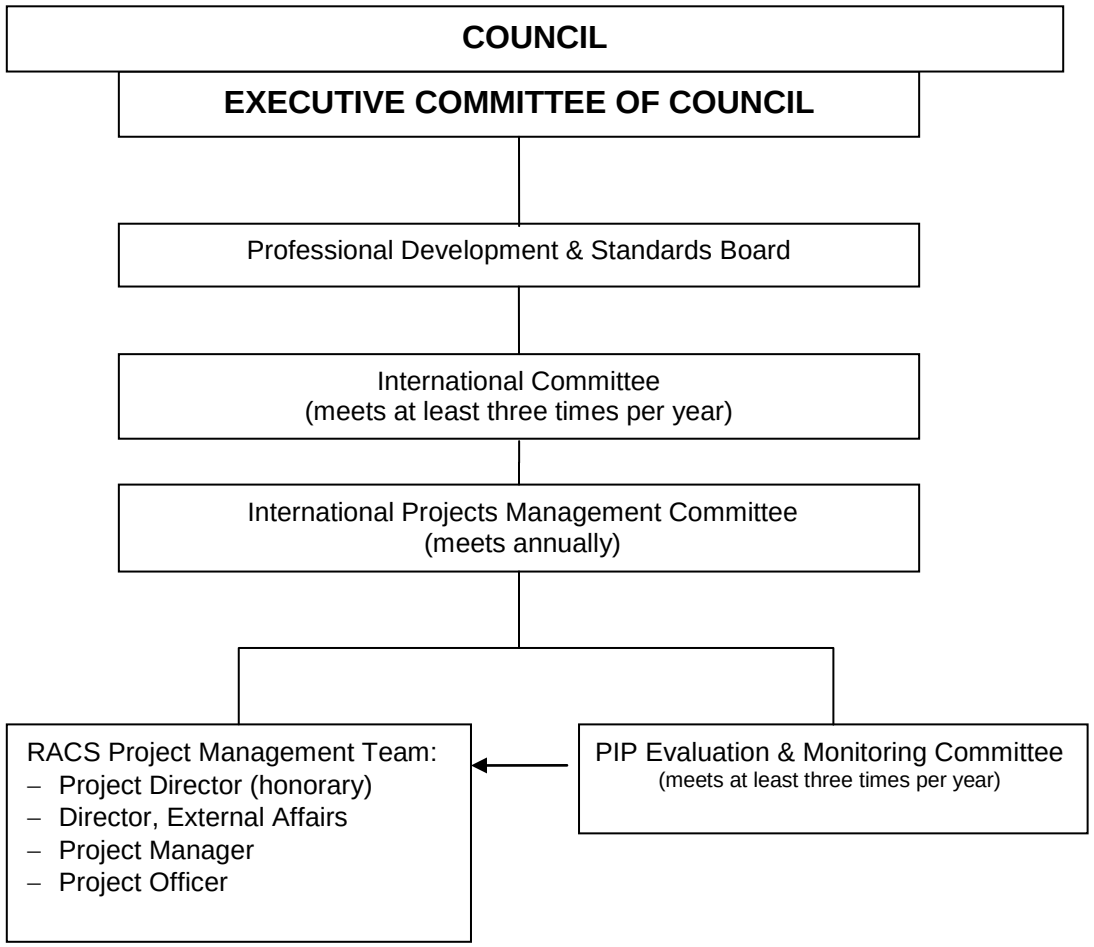
Physical Assets Purchased with Activity Funds

In consultation with AusAID, all physical assets will procured under the program will be handed over to AusAID or its nominee at a mutually acceptable date.

Contractual Obligations/Terms and Status at End of Activity

Name of Contract	Contract Number	Contractual Obligations/terms	Status at the End of Activity
Provision of a Range of Tertiary Health Services to Pacific Island Countries – Phase III Bridging/Transition Phase	CON 10478 Amendment No. 3, 4 and 5	Provision of tertiary health services to Pacific Island countries (2007-2010)	Completed

Annex 1: RACS International Projects Management Structure



Annex 2: Outputs Summary of PIP Clinical and Training Activities

CLINICAL OUTPUTS SUMMARY

CONSULTATIONS			OPERATIONS			Visits Total	146
Male	4517		Male	1589		Weeks Total	215
Female	4784		Female	1198		Volunteers Total	669
Sex Not Recorded	5060		Sex Not Recorded	706			
Total	14426		Total	3428			

Table A: Clinical Outputs

No of Visits	Program	Country	Dates	No. of Persons	No. of Weeks	Consultations				Operations			
						M	F	?	T	M	F	?	T
1	ENT	Cook Is.	03 - 08 Sept 2007	1	2	-	-	96	96	13	9	-	22
2	ENT	Cook Is.	31 Aug – 07 Sept 2008	1	1	-	-	58	58	-	-	8	8
3	ENT	Cook Is.	15 - 19 Nov 2010	2	1	-	-	97	97	-	-	18	18
4	Mammography	Cook Is.	21 Jul – 05 Aug 2008	3	2	-	326	-	326	-	-	-	-
5	Mammography	Cook Is.	26 Jul - 06 Aug 2010	3	2	-	344	-	344	-	-	-	-
6	Orthopaedics	Cook Is.	18 - 26 Jun 2007	1	1	-	-	199	199	25	6	-	31
7	Orthopaedics	Cook Is.	18 - 29 May 2009	1	1	-	-	128	128	-	-	26	26
8	Orthopaedics	Cook Is.	11 - 22 Oct 2010	1	1	-	-	175	175	-	-	15	15
9	Psychiatry	Cook Is.	07 – 18 Oct 2008	1	1	-	-	-	-	-	-	-	-
10	Psychiatry	Cook Is.	01 - 17 Jul 2009	1	2	-	-	-	-	-	-	-	-
11	Urology	Cook Is.	29 Jun – 05 Jul 2008	1	1	-	-	29	29	-	-	8	8
12	Urology	Cook Is.	03 - 09 Jul 2009	1	1	26	7	-	33	8	2	-	10
13	Urology	Cook Is.	24 Jun - 02 Jul 2010	1	1	48	25	-	73	-	-	6	6
14	Cardiac Surgery	Fiji	12 - 26 May 2007	49	1	-	-	159	159	13	22	-	35
15	Cardiac Surgery	Fiji	10 - 30 May 2008	49	2	73	100	-	173	-	-	-	-
16	Cardiac Surgery	Fiji	15 - 30 May 2009	57	1	-	-	162	162	-	-	46	46
17	Cardiac Surgery	Fiji	15 - 30 May 2010	58	2	-	-	195	195	24	29	-	53
18	Endocrinology	Fiji	15 - 19 Mar 2010	1	1	15	21		36	-	-	-	-
19	ENT	Fiji	09 - 15 Nov 2009	2	1	-	-	71	71	11	7	-	18
20	ENT	Fiji	18 - 24 Apr 2010	2	1	33	18	-	51	25	15	-	40
21	Maxillofacial	Fiji	30 May - 06 Jun 2010	3	1	17	17	-	34	7	3	-	10
22	Nephrology	Fiji	13 - 19 Jul 2009	1	1	14	14	4	32	-	-	-	-
23	Nephrology	Fiji	27 Sept - 02 Oct 2010	1	1	20	16	-	36	-	-	-	-
24	Neurosurgery	Fiji	22 Apr – 02 May 2008	4	1	-	-	92	92	5	5	3	13
25	Neurosurgery	Fiji	03 - 14 Nov 2008	2	2	-	-	100	100	-	-	18	18
26	Neurosurgery	Fiji	18 - 29 Oct 2010	2	2	-	-	71	71	-	-	11	11
27	Paediatrics	Fiji	21 - 26 Aug 2007	4	2	68	19	2	89	26	6	1	33
28	Paediatrics	Fiji	19 - 27 Nov 2008	4	1	-	-	-	-	-	-	-	-
29	Paediatrics	Fiji	22 - 29 Mar 2010	3	1	13	9	8	30	11	5	2	18
30	Paediatrics	Fiji	08 - 12 Nov 2010	4	1	-	-	-	-	-	-	-	-
31	Plastics	Fiji	11 - 22 Aug 2008	5	2	14	15	-	29	14	15	-	29
32	Plastics	Fiji	18 Sept - 03 Oct 2009	4	2	32	51	2	85	12	16	-	28
33	Plastics	Fiji	25 - 31 Oct 2009	6	1	29	17	-	46	26	7	-	33
34	Plastics	Fiji	14 - 27 Nov 2010	4	2	-	-	101	101	-	-	53	53
35	Endocrinology	Fiji	09 – 13 Feb 2009	1	1	-	-	28	28	-	-	-	-
36	ENT	Fiji	10 - 17 Feb 2009	2	1	12	5	-	17	12	4	-	16
37	Maxillofacial	Fiji	29 Mar – 04 Apr 2009	3	1	11	13	-	24	5	5	-	10
38	Maxillofacial	Fiji	30 May - 06 Jun 2010	3	1	17	17	-	34	7	3	-	10
39	Neonatology	Fiji	24 – 30 May 2009	2	1	-	-	-	-	-	-	-	-
40	Paediatrics	Fiji	22 – 30 Mar 2009	4	1	6	11	1	18	5	8	1	14
41	Paediatrics	Fiji	13 - 17 Sept 2009	3	1	16	7	-	23	7	5	-	12
42	ENT	Kiribati	03 - 14 Sept 2007	4	2	264	260	-	524	15	7	-	22
43	ENT	Kirlbati	03 – 11 Sept 2009	4	2	-	-	-	-	-	-	-	-
44	Opthalmology	Kiribati	30 Dec 2008 - 07 Jan 2009	4	1	-	-	317	317	53	56	-	109
45	Opthalmology	Kiribati	16 - 26 Mar 2010	5	1	198	232	-	430	69	54	-	123
46	Orthopaedics	Kiribati	08 - 22 May 2007	4	2	-	-	96	96	13	9	2	24
47	Orthopaedics	Kirlbati	25 Jun - 09 Jul 2009	4	2	126	70	1	197	8	7	-	15
48	Orthopaedics	Kiribati	14 - 30 Nov 2010	4	2	-	-	-	-	-	-	-	-
49	Plastics	Kiribati	19 Nov – 03 Dec 2008	4	2	-	-	75	75	-	-	57	57
50	Plastics	Kiribati	28 Jun - 09 Jul 2010	4	2	42	37	-	79	24	22	-	46
51	ENT	Marshall Is	27 Sept – 09 Oct 2009	3	2	-	-	-	-	-	-		-
52	Orthopaedics	Marshall Is	02 - 12 Aug 2010	3	2	28	50	-	78	8	6	-	14
53	Paediatrics	Marshall Is	11 – 20 Dec 2009	2	2	-	-	-	-	-	-	-	-
54	Urology	Marshall Is	26 Nov - 03 Dec 2010	3	1	25	9	-	34	3	1	-	4
55	ENT	Micronesia	10 – 21 Dec 2009	4	2	78	74	-	152	12	8	-	20
56	Laparoscopy	Micronesia	09 - 21 Jun 2009	3	2	-	-	10	10	1	3	1	5
57	Opthalmology	Micronesia	27 Dec 2009 – 10 Jan 2010	3	2	-	-	-	-	-	-	-	-
58	Orthopaedics	Micronesia	09 - 23 Sept 2007	5	2	73	53	-	126	15	7	-	22
59	Orthopaedics	Micronesia	19 – 29 Oct 2009	6	2	105	108	-	213	30	13	-	43
60	Urology	Micronesia	14 - 26 Nov 2010	3	2	74	23	-	97	13	1	-	14

61	Cardiology	Nauru	09 - 17 Jul 2007	2	1	47	60	2	109	-	-	-	-
62	Cardiology	Nauru	28 Sept – 05 Oct 2008	2	1	-	-	123	123	-	-	-	-
63	Cardiology	Nauru	26 Oct – 04 Nov 2009	2	1	43	56	-	99	-	-	-	-
64	ENT	Nauru	25 Jun - 02 Jul 2007	3	2	84	50	-	134	4	-	-	4
65	ENT	Nauru	20 - 30 Nov 2009	3	1	21	29	-	50	1	6	-	7
66	Gastroenterology	Nauru	13 - 21 Jul 2009	2	1	28	1	-	29	3	2	1	6
67	Vascular	Nauru	10 – 17 Mar 2009	4	1	15	11	-	26	5	2	-	7
68	Vascular	Nauru	06 - 14 Sept 2009	3	1	47	55	-	102	6	2	-	8
69	Vascular	Nauru	15 - 24 May 2010	2	2	11	3	-	14	8	1	-	9
70	Vascular	Nauru	05 - 11 Oct 2010	2	1	7	3	-	10	11	2	-	13
71	Nephrology	Nauru	06 - 14 Sept 2009	1	1	29	29	-	58	-	-	-	-
72	Nephrology	Nauru	15 - 24 May 2010	1	2	46	45	-	91	-	-	-	-
73	Nephrology	Nauru	05 - 11 Oct 2010	1	1		-	-	65	65	-	-	-
74	Nephrology	Nauru	10 – 17 Mar 2009	1	1	8	8	-	16	-	-	-	-
75	Oncology - Scoping	Nauru	20 - 29 Jun 2007	1	1	-	-	-	-	-	-	-	-
76	ENT	Samoa	14 - 27 Jun 2009	4	2	103	91	1	195	35	27	-	62
77	ENT	Samoa	25 Jul - 05 Aug 2010	4	2	148	132	-	280	28	21	-	49
78	General Surgery	Samoa	12 - 22 Sept 2007	1	2	3	2	-	5	5	1	-	6
79	General Surgery	Samoa	09 - 22 Jul 2009	1	2	8	24	5	37	5	11	-	16
80	Opthalmology	Samoa	31 May - 4 June 2010	5	1	35	47	-	82	39	47	-	86
81	Orthopaedics	Samoa	10 - 20 Sept 2008	6	1	-	-	117	117	-	-	32	32
82	Orthopaedics	Samoa	06 - 16 May 2009	2	1	-	-	79	79	-	-	28	28
83	Orthopaedics	Samoa	29 Sept - 09 Oct 2010	6	2	116	64	-	180	25	13	-	38
84	Plastics	Samoa	04 - 18 Aug 2007	3	1	27	19	2	48	8	6	1	15
85	Plastics	Samoa	10 - 24 Aug 2008	4	2	-	-	-	-	-	-	55	55
86	Plastics	Samoa	28 Jun -11 Jul 2009	3	2	38	38	-	76	17	19	-	36
87	Plastics	Samoa	15 - 25 Aug 2010	5	2	57	68	-	125	23	26	-	49
88	ENT	Solomon Is.	03 - 17 Jul 2007	3	2	117	95	-	212	37	23	-	60
89	ENT	Solomon Is.	28 Jun – 13 Jul 2008	5	2	115	144	1	260	35	35	-	70
90	ENT	Solomon Is.	14 - 27 Jun 2009	3	2	64	57	2	123	19	17	-	36
91	ENT	Solomon Is.	19 - 25 Jul 2010	4	1	105	113	-	218	21	32	22	75
92	Neurosurgery	Solomon Is.	03 - 07 Aug 2010	1	1	6	4	-	10	1	1	-	2
93	Opthalmology	Solomon Is.	31 May – 28 Jun 2008	7	3	-	-	-	-	110	80	10	200
94	Opthalmology	Solomon Is.	19 - 30 Jul 2009	3	2	-	-	150	150	38	42	-	80
95	Orthopaedics	Solomon Is.	02 – 11 Nov 2008	3	2	9	6	3	18	10	3	-	13
96	Orthopaedics	Solomon Is.	19 – 26 May 2009	2	1	-	-	30	30	11	5	-	16
97	Orthopaedics	Solomon Is.	11 - 19 Nov 2009	3	1	-	-	57	57	-	-	23	23
98	Orthopaedics	Solomon Is.	17 - 24 Jun 2010	3	1	-	-	100	100	11	9	-	20
99	Paediatrics	Solomon Is.	07 - 14 Dec 2008	3	1	-	-	-	-	-	-	-	-
100	Paediatrics	Solomon Is.	20 – 27 Nov 2009	4	1	-	-	30	30	10	2	3	15
101	Paediatrics	Solomon Is.	13 - 19 Nov 2010	4	1	-	-	-	-	-	-	-	-
102	Plastics	Solomon Is.	25 Apr - 07 May 2009	4	2	52	47	-	99	39	30	-	69
103	Plastics	Solomon Is.	08 - 22 Apr 2010	6	2	40	35	-	75	39	30	-	69
104	Radiology	Solomon Is.	14 - 19 Nov 2010	1	1	11	8	4	23	-	-	-	-
105	Urology	Solomon Is.	10 – 17 Aug 2008	3	1	-	-	32	32	-	-	16	16
106	Urology	Solomon Is.	21 - 25 Sept 2009	3	1	24	6	-	30	3	11	-	14
107	Urology	Solomon Is.	28 Jun - 05 Jul 2010	4	1	45	8	-	53	14	3	-	17
108	Cardiac Surgery	Tonga	06 – 25 Oct 2008	30	3	-	-	102	102	7	7	-	14
109	ENT	Tonga	13 - 24 Jul 2009	3	2	37	54	-	91	9	8	-	17
110	ENT	Tonga	09 - 19 August 2010	3	2	65	31	-	96	13	6	-	19
111	Ophthalmology	Tonga	04 - 16 Oct 2010	3	2	-	-	640	640	-	-	134	134
112	Opthalmology	Tonga	21 - 30 Aug 2007	3	2	-	-	500	500	53	54	2	109
113	Opthalmology	Tonga	11 - 22 Aug 2009	3	2	-	-	150	150	32	56	-	88
114	Orthopaedics	Tonga	09 - 15 Nov 2009	2	1	-	-	60	60	21	7	-	28
115	Plastics	Tonga	11 – 21 May 2009	4	2	-	-	57	57	-	-	35	35
116	Plastics	Tonga	11 - 25 Sept 2010	6	2	-	-	112	112	-	-	64	64
117	Scoping - Cardiac	Tonga	14 – 17 Apr 2008	1	1	-	-	-	-	-	-	-	-
118	Urology	Tonga	23 Mar – 02 Apr 2009	3	2	17	6	-	23	10	2	-	12
119	Urology	Tonga	14 - 21 Jun 2010	4	1	25	7	-	32	11	3	-	14
120	Cardiology	Tuvalu	02 - 09 Jul 2009	2	1	73	88	-	161	-	-	-	-
121	Cardiology	Tuvalu	19 - 27 Aug 2010	2	1	44	46	-	90	-	-	-	-
122	Diabetes	Tuvalu	01 - 12 Jun 2009	2	1	2	5	-	7	-	-	-	-
123	Diabetes	Tuvalu	24 May - 02 Jun 2010	2	1	11	16	-	27	-	-	-	-
124	ENT	Tuvalu	22 - 29 Sept 2007	4	2	153	144	-	297	10	9	-	19
125	ENT	Tuvalu	10 – 20 Mar 2009	4	1	91	89	-	180	6	1	-	7
126	ENT	Tuvalu	01 - 07 Sept 2010	4	1	69	79	2	150	6	6	-	12
127	Ophthalmology	Tuvalu	08 - 17 Nov 2010	4	1	-	-	-	-	-	-	-	-
128	Opthalmology	Tuvalu	08 - 18 Aug 2007	4	2	129	148	-	277	8	16	-	24
129	Opthalmology	Tuvalu	13 - 22 Aug 2008	4	2	-	-	100	100	14	13	-	27
130	Opthalmology	Tuvalu	28 Sept – 06 Oct 2009	3	1	-	-	300	300	-	-	2	2

131	Diabetes	Vanuatu	16 - 27 Jul 2007	2	2	28	31	-	59	-	-	-	-
132	Diabetes	Vanuatu	03 - 15 Aug 2009	2	2	5	5	-	10	-	-	-	-
133	ENT	Vanuatu	13 - 26 Aug 2007	4	2	118	153	6	277	28	25	-	53
134	ENT	Vanuatu	03 - 16 Nov 2008	4	2	127	128	2	257	24	28	2	54
135	ENT	Vanuatu	01 - 10 Oct 2009	4	1	87	92	12	191	22	21	-	43
136	ENT	Vanuatu	15 - 21 Aug 2010	5	1	116	117	2	235	16	15	-	31
137	Orthopaedics	Vanuatu	02 - 16 Aug 2008	4	2	21	5	-	26	21	5	-	26
138	Orthopaedics	Vanuatu	05 - 11 Jun 2010	1	1	86	75	-	161	1	-	-	1
139	Orthopaedics	Vanuatu	12 - 23 Jul 2010	4	2	19	10	-	29	17	7	-	24
140	Screening - Ortho	Vanuatu	12 – 21 Jun 2008	1	1	120	72	-	192	-	1	-	1
141	Paediatrics	Vanuatu	07 - 15 Aug 2010	3	1	7	4	-	11	6	2	-	8
142	Plastics	Vanuatu	30 Jul – 09 Aug 2009	4	2	14	16	-	30	10	12	-	22
143	Plastics	Vanuatu	17 - 24 Oct 2010	4	1	16	19	-	35	14	13	-	27
144	Urology	Vanuatu	20 – 26 Apr 2009	3	1	30	13	-	43	12	2	-	14
145	Urology	Vanuatu	22 Apr - 02 May 2010	4	1	21	5	-	26	12	4	-	16
146	Emergency Medicine Scoping	Vanuatu	20 Nov - 05 Dec 2010	4	2	-	-	-	-	-	-	-	-
			TOTALS:	**669**	**215**	**4,517**	**4,784**	**5,060**	**14,426**	**1,589**	**1,198**	**706**	**3,428**

TRAINING OUTPUTS SUMMARY

TYPE OF TRAINING	No.	PARTICIPANTS
PIP TRAINING PROGRAMS/WORKSHOPS	43	840 PIC participants
OTHER TRAINING PROGRAMS/WORKSHOPS	7	PIP sent 12 PIC participants
PROF. DEVT/CONFERENCES	6	PIP sent 14 PIC participants
O/S TRAINING ATTACHMENT	1	Samoan ECN (1)
CLINICAL VISIT ATTACHMENT (TO PIP TEAM)	11	Overseas-based PIC surgeons/trainees attached to PIP clinical team

NOTE: ON-THE-JOB TRAINING DATA NOT INCLUDED

Table B: Summary of PIP Bridging/Transition Phase Training Activities

COUNTRY	No.	PARTICIPANTS											
		FIJI	SOLOMON	VANUATU	TUVALU	KIRIBATI	COOK IS.	TONGA	SAMOA	MARSHAL	FSM	NAURU	OTHER	TOTAL
EMST & CCrISP - FIJI														
CCrISP 2007 (FIJI)	1	16	-	1	-	1	-	1	-	-	-	-	-	**19**
EMST 2009 (Fiji)	2	14	1	4	1	2	1	4	2	-	-	-	3	**32**
CCrISP 2009 (FIJI)	1	4	1	1	-	1	1	1	2	-	-	-	1	**12**
EMST 2010 (Fiji)	2	23	1	-	1	2	-	1	4	-	-	-	-	**32**
CCrISP 2010 (FIJI)	1	6	-	-	1	1	-	1	3	-	-	-	-	**12**
EMST & CCrISP - PNG														**-**
EMST 2009 - PNG		-	1	-	-	-	-	-	-	-	-	-	-	**1**
CCrISP 2009 - PNG		-	1	-	-	-	-	-	-	-	-	-	-	**1**
EMST 2010 - PNG		-	2	-	-	-	-	-	-	-	-	-	-	**2**
CCrISP 2010 - PNG		-	2	-	-	-	-	-	-	-	-	-	-	**2**
EMST INSTRUCTORS COURSE														**-**
2010	2	2	-	1	-	-	-	-	1	-	-	-	-	**4**
PRIMARY TRAUMA CARE														**-**
2007 (PNG)		-	1	-	-	-	-	-	-	-	-	-	-	**1**
2008 Provider (Tonga)	2	-	-	-	-	-	-	48	-	-	-	-	-	**48**
2008 Instructor (Tonga)	1	-	-	-	-	-	-	8	-	-	-	-	-	**8**
2008 Provider (Solomon Islands)	2	-	63	-	-	-	-	-	-	-	-	-	-	**63**
2008 Instructor (Solomon Is.)	1	-	11	-	-	-	-	-	-	-	-	-	-	**11**
2009 Provider (FIJI)	1	25	-	-	-	-	-	-	-	-	-	-	-	**25**
2009 Instructors Refresher (FIJI)	1	4	2	2	-	1	1	2	3	-	-	-	3	**18**
2009 Provider (Tonga)	1	-	-	-	-	-	-	22	-	-	-	-	-	**22**
2009 Provider (Samoa)	1	-	-	-	-	-	-	-	27	-	-	-	-	**27**
2009 Instructors (Samoa)	1	-	-	-	-	-	-	-	9	-	-	-	-	**9**
2009 Provider (Vanuatu)	2	-	-	45	-	-	-	-	-	-	-	-	-	**45**
2009 Instructors (Vanuatu)	1	-	-	10	-	-	-	-	-	-	-	-	-	**10**
2010 Provider (Kiribati)	2	-	-	-	-	40	-	-	-	-	-	-	-	**40**
2010 Instructors (Kiribati)	1	-	-	-	-	7	-	-	-	-	-	-	-	**7**
2010 Provider (Samoa)	2	-	-	-	-	-	-	-	74	-	-	-	-	**74**
2010 Provider (Cook Is.)	1	-	-	-	-	-	19	-	-	-	-	-	-	**19**
2011 Instructors (Cook Is.)	1	-	-	-	-	-	16	-	-	-	-	-	-	**16**
2010 Provider (Vanuatu)	1	-	-	20	-	-	-	-	-	-	-	-	-	**20**
2010 Provider (Micronesia)	2	-	-	-	-	-	-	-	-	-	53	-	-	**53**
2010 Insructor (Micronesia)	1	-	-	-	-	-	-	-	-	-	7	-	-	**7**

ANAESTHETIST REFRESHER														**-**
2007 (SAMOA)	1	7	1	3	1	-	1	2	4	1	-	-	-	**20**
2008 (FIJI)	1	18	1	2	1	-	1	1	2	-	-	1	1	**28**
2009 (VANUATU)	1	9	2	5	1	-	1	2	2	-	-	-	2	**24**
2010 (FIJI)	1	9	2	2	1	1	-	1	2	-	-	-	2	**20**
ENT Nurse Training														**-**
ENT Nurse Training (2007)	1	-	2	13	-	1	1	-	1	-	-	-	-	**18**
ENT Nurse Training (2008)	1	-	1	11	-	-	-	-	-	-	-	-	-	**12**
ENT Nurse Training (2009)	1	-	-	6	-	-	-	-	-	-	-	-	-	**6**
ENT Nurse Training (2010)	1	-	2	10	-	-	-	-	-	-	-	-	-	**12**
EMSB														**-**
EMSB 2009 (FIJI)	1	50	-	2	2	1	2	9	5	-	-	-	-	**71**
EMSB 2010 (PNG)		-	1	-	-	-	-	-	-	-	-	-	-	**1**
TRAINING ATTACHMENTS/CONFERENCES														**-**
ASC - 2007, Christchurch		-	-	-	-	-	-	1	-	-	-	-	-	**1**
ASC - 2009, Brisbane		1	1	-	-	1	-	1	-	-	-	-	-	**4**
ASC - 2010, Perth		1	-	-	-	-	1	1	-	-	1	-	-	**4**
PISA - 2008, Fiji		-	-	-	-	-	-	-	-	-	1	-	-	**1**
PISA - 2010, Vanuatu		1	-	-	-	-	-	-	-	-	2	-	-	**3**
RSA - 2010, Cairns		-	-	-	-	-	-	-	-	-	-	1	-	**1**
Clinical Visit - 2008		-	1	-	-	1	-	-	1	-	-	-	-	**3**
Clinical Visit - 2009		-	-	2	-	-	-	-	1	-	-	-	-	**3**
Clinical Visit - 2010		-	-	2	-	-	1	1	1	-	-	-	-	**5**
Eye Care - 2010, Hobart		-	-	-	-	-	-	-	1	-	-	-	-	**1**
Total Per Country	**43**	**190**	**100**	**142**	**9**	**60**	**46**	**107**	**145**	**1**	**64**	**2**	**12**	**878**

Annex 3: Evidence of Outcomes

COMPONENT 1
CLINICAL SERVICES

PIP teams have provided lifesaving operations on multiple occasions and have contributed to the management of treatable disability and non-communicable diseases. Examples of evidence provided below:

ENT Surgery

- In the Solomon Islands, a 2 year old boy was provided with a mastoidectomy that 'would have been ultimately fatal for this child without operation.'[1]

- 'The impact on quality of life [following major operations such as mastoidectomies, myringoplasties and adenoidectomies] will be related to control of disease and avoidance of potentially life-threatening complications (from cholesteatoma), reduction in chronic infections, management of thyroid disease (cure of a potential cancer or benign nodule) and improvement in chronic sinus disease.'[2]

- Surgeries performed in the Federated States of Micronesia, where 55% of patients treated were under 18 years of age and 40% of patients were of a productive working age, will prevent further ear damage and/or hearing complications for patients, thus enabling access to wider education and employment opportunities.[3]

Paediatrics

- A Paediatric surgery visit to Vanuatu in 2010 facilitated life changing surgery for boys with peno-scrotal hypospadias; the surgical repairs performed for these patients will enable normal sexual function and fertility.[4]

Oral & Maxillofacial Surgery

- Surgery delivered in Fiji in 2009 and 2010 will not only restore normal function of the jaws in terms of eating and speech but restore aesthetics, self-esteem and confidence after patients have been living with the debilitating tumours for many years.'[5]

Ophthalmology

- 'The major surgeries performed were cataract and pterygium and the results on the patients' quality of life with cataract surgery, are impressive. Cataract surgery is known to be one of the most effective interventions in medicine and

[1] Mr Malcolm Baxter, PIP ENT Visit Team Leader Report, Solomon Islands (2010)
[2] Mr Dayan Chandrasekara, PIP ENT Visit Team Leader Report, Tuvalu (2010)
[3] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 31 (Oct-Dec 2009)
[4] Professor Spencer Beasley, PIP Paediatric Surgery Visit Team Leader Report, Vanuatu (2009)
[5] Mr Sunia Vudiniabola, PIP OMF Visit Team Leader Report, Fiji (2010)

given the fact that most of the disease was advanced with patients virtually or totally blind, this would be no different in Samoa…One of the patients was a local general practitioner who was having problems carrying out minor surgery and he underwent phacoemulsification with insertion of a flexible intraocular lens with a very good result. He had been referred to New Zealand for surgery and we were pleased to be able to carry out his treatment in-country.'[6]

Urology

- 'Open stone operations (two procedures performed) [will have a] major impact on both these patients lives. Both of these patients were experiencing considerable ongoing pain which had been ongoing for several months. One patient was likely to have had their kidney salvaged which otherwise would have been lost due to ongoing obstruction.'[7]

Orthopaedics

- Outcomes from a visit to the Marshall Islands in 2010 included elective knee arthrodesis for a patient unable to stand or walk. Increased mobility was achieved as a direct result of the surgery provided; the patient was able to stand with limited walking capability. On the same visit, procedures involving diabetic patients included 2 below the knee amputations which were reportedly timely and lifesaving.[8]

COMPONENT 2
PRE-SCREENING

Evidence of increasing capacity and confidence of local staff to undertake effective pre-screening provided below:

ENT Surgery

- Vanuatu: In 2008, the visiting team reported a good level of pre-visit screening which enabled the team to see a large volume of patients with appropriate ENT conditions.[9] The following year, Dr Burstin reported excellent pre-visit triage by Andorine Aki at Vila Central Hospital (VCH) and commented that the team has 'come to expect consistent and effective pre-screening'[10] of ENT patients from Andorine and her team. In 2010, the visiting team reported the local ENT nurses conducted an excellent preliminary screening and noted that 'confidence and expertise is increasing.'[11] Dr Burstin maintains that funding to support Andorine to conduct future pre-visit screening is essential.

Vascular Surgery

[6] Dr Nitin Verma, PIP Ophthalmology Visit Team Leader Report, Samoa (2010)
[7] Mr Richard Grills, PIP Urology Visit Team Leader Report, Vanuatu (2010)
[8] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 34 (July-Sept 2010)
[9] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 26 (Oct-Dec 2008)
[10] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 31 (Oct-Dec 2009)
[11] Mr Perry Burstin, PIP ENT Visit Team Leader Report, Vanuatu (2010)

- Nauru: The capacity of staff in the haemodialysis unit at the Republic of Nauru Hospital to provide quality pre-screening of patients with diabetic renal failure has 'improved in leaps and bounds' over the past 3-4 years. This has helped to maximise the benefit of the biennial one week Renal/Vascular visits to Nauru. Local nurses are now skilled in classifying patients in relation to who can or cannot benefit from PIP team visits and are able to identify diabetic patients who are at risk of renal failure. Processes have been established for stratifying patients in preparation for visits; surgical volunteer, Mr Alan Saunder, observed that pre-visit organisation of patients 'was once random and is now regimented.'[12]

Orthopaedics

- Samoa: In 2008, the team noted a higher level of pre-screening conducted by the local medical staff. Dr Tala presented a large number of selected patients for knee reconstructions and talipes (club foot) corrections.[13] In 2009, pre-screening was described as 'excellent'[14] as local staff vetted and preselected a number of appropriate patients for review by the team.

Urology

- Solomon Islands: In 2009, Dr Cato reported that preoperative assessments by local staff were better than on previous visits, evidenced by a decrease in unnecessary clinical consultations. For the 2010 visit, Dr Cato reported that excellent pre-screening was conducted by local staff; all 53 patients presented to the team were appropriate for further review.[15]

Ophthalmology

- Samoa: 'The team reported that the eye clinic at TTMH was well organised and the level of patient selection/pre-screening conducted by the local eye care nurses was excellent and appropriate. Many of the patients presenting for treatment had advanced disease and some of them were completely blind from cataracts and pterygia.'[16]

INFORMAL TRAINING & MENTORING

Anecdotal evidence from PIC health professionals has confirmed that on-the-job training and capacity building activities provided during PIP clinical activities was 'very important for continuity of learning and for preparations for subsequent visits.'[17] New skills were learned and skill levels were improved as a result of working with the visiting teams. Dr Dudley Ba'erodo (Solomon Islands) has summarised the benefit

[12] Telephone interview with Mr Alan Saunder, 18.05.2011
[13] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 25 (July-Sept 2008)
[14] Mr Wayne Viglione, Orthopaedics Visit Team Leader Report, Samoa (2009)
[15] Mr Alex Cato, PIP Urology Visit Team Leader Report, Solomon Islands (2009 & 2010)
[16] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 33 (April-June 2010)
[17] Email communication with Dr Basil Leodoro, 13.05.2011

and outcomes of this type of training; 'The specialist visits have been very beneficial to our patients as well as our surgical doctors...We have our local counterparts working closely with the visiting teams, especially in Urology and Paediatric surgery. There is no doubt that we have gained confidence and learned a lot by working with the visiting teams. For instance, I have been doing TURP when the Urology team come with their resectoscope. I would like to also add here that as we gain skill and knowledge on dealing with the more common cases, the visiting teams may concentrate on bigger and more challenging cases if possible.'[18]

A number of volunteers and PIC health workers have also provided assessments on the outcomes of informal training and mentoring provided during PIP clinical visits:

Ophthalmology

- 'Each consultation and surgical procedure was an opportunity for building the capacity of eye care practitioners and services in the Solomon Islands. The team has established productive working relationships with Dr Adu and his registrars – as a result, the provision of on-the-job training and mentoring has been particularly effective. Drs Adu, Posala, Pikacha and Hue often assumed the role of lead surgeon in theatre, under the supervision of Mr Painter.'[19]

Urology

- 'Other parts of the National Referral Hospital have benefited [from on-the-job training] in particular the nursing staff. The operating theatre nurses now demonstrate a good understanding of urological equipment and its use as well as common urological procedures. There are at least 2 nurses (Rosie and Densi) who can mentor others.'[20]

- 'One of the local surgeons, Richard Leona gravitated towards our Urology team during our first visit, attended every ward round, reviewed all of our patients pre- and post-operatively and attended every theatre session, he was really keen to become involved. At the end of our first visit he declared that he would like the opportunity to spend more time developing urology skills and was the recipient of a Rowan Nicks scholarship that would enable him to do so in Australia…Richard will be spending 12 months with us in Geelong on the Urology Unit and it is anticipated by the end of this time he will develop the necessary endoscopic skills that would enable him to perform a good deal of the surgery that we are currently doing on annual visits to Port Vila.'[21]

- 'Nursing staff and medical staff, some of whom at the start of our first visit were a little nervous, almost took up where we left off last visit. I was

[18] Email communication with Dr Dudley Ba'erodo, 11.05.2011

[19] Mr Geoffrey Painter PIP Ophthalmology Visit Team Leader Report, Solomon Islands (2009)

[20] Email communication with Mr Alex Cato 12.05.11

[21] Email communication with Mr Richard Grills, 16.05.2011

surprised at the level of skill that had been retained and their enthusiasm to go the "next step" given they already had some background knowledge.'[22]

- 'Ni-Van Scrub Nurse, Leisong Lagoniala, demonstrates ability to scrub for all types of urological cases with considerably more confidence than in previous years. She has been encouraged to develop presentations for other theatre nurses regarding urological surgery.'[23]

Orthopaedics

- Dr Stephen Quain and his team have made a number of repeat visits to the Solomon Islands to facilitate a continuity of education and training for Dr Hou'asia. The capacity building focus for each visit has been the provision of skills transfer for Dr Patrick Hou'asia and his orthopaedic team. Ward rounds and consultations in fractures clinics provided opportunities for mentoring and discussion of case management. In 2009, it was reported that Dr Hou'asia, Dr Kabwere or Dr Munamua assisted in every surgical case. The team noted improvements in Dr Hou'asia's arthroscopic skills during that visit as he undertook the first shoulder arthroscopy to be performed in Honiara.[24] Dr Housia has identified a number of skills he has developed as a result of working with the PIP orthopaedic teams including 'how to approach and manage congenital talipes, arthroscopic procedures and techniques, for instance ACL reconstructions and decompression laminectomies for spinal stenosis.'[25] Dr Housia has commented that the tutorials and audits organised during these visits were also 'very rewarding for us.'[26]

ENT Surgery

- 'The skills gained and improved [through on-the-job training] has equipped me with my career especially when teaching skills and supervising ENT procedures to new ENT nurses and students in venturing to providing improved and quality ENT services to the people of our country.'[27]

- 'On the job training provided by the visiting teams was very beneficial and valuable for my professional development...I really value those trainings. Those training is like a lamp to me to guide my practice in my country…I have learn a lot of new skills as a result of working with the visiting teams:
    - I had the ability to detect early complications of chronic otitis media and also able to manage accordingly.
    - Ability to do proper ENT examination.
    - Ability to provide proper management of ENT conditions.

[22] Email communication with Mr Richard Grills, 16.05.2011
[23] Mr Richard Grills, PIP Urology Visit Team Leader Report, Vanuatu (2010)
[24] Royal Australasian College of Surgeons. PIP Quarterly Progress Report 31 (Oct-Dec 2009)
[25] Email communication with Dr Patrick Housia, 20.05.2011
[26] Email communication with Dr Patrick Housia, 20.05.2011
[27] Email communication with Sr Mary Loduha, 18.05.2011

- Skills to remove different types of foreign bodies in the ear, nose and throat.
- Ability to do audiometry test and interprate the audiodram. We do not have an audiologist in the country.
- Taking good ear impression.
- Ability to prioritise patients severity of ENT condition needing operation when the specialists are in the country.'[28]

Neurosurgery

- 'I have been attached to the visiting neurosurgery teams at CWMH and have gained a lot in terms of knowledge skills, clinical accumen and even organisational skills. This has progressed to the point that I am now in Canberra training in neurosurgery, so this is the extent to which the benefits of PIP visiting teams can be seen.'[29]

Plastic & Reconstructive Surgery

- 'Good academic discussions [with Mr Ian Holten] on conditions that are uncommon or don't get operated upon in my [hospital] settings, for example in the clinics and screening of patients. The options for surgery would be discussed taking into account my local setting and my resources available e.g. options for flaps on the face, joints.'[30]

Paediatrics

- 'Improvement with surgical technique intra-op because I would be assisting with or doing the operation under the guidance of a specialist who would discuss my techniques and thus improve my surgical skills directly and not in-retrospect. [For example] Sacorcoccygeal Tumor with Prof Spencer Beasley.'[31]

- On mentoring Dr Jitoko Cama: In the 2009 PIP Paediatrics visit to Fiji 'all patients had been assessed and organised by Dr Cama and he was the primary surgeon in all cases.'[32] On a follow up visit later that same year, Dr Cama 'was the lead surgeon in all but one of the operations' and it was reported that 'Jitoko Cama is doing an excellent job.'[33]

FORMAL TRAINING COURSES/WORKSHOPS

Anecdotal evidence from PIC health professionals and observations from PIP volunteers on outcomes related to participation in PIP formal training courses:

PTC Course

[28] Email communication with Sr Andorin Aki, 20.05.2011
[29] Email communication with Dr Alan Biribo, 12.05.2011
[30] Email communication with Dr Basil Leodoro, 13.05.2011
[31] Email communication with Dr Basil Leodoro, 13.05.2011
[32] Mr Alex Auldist, PIP Paediatric Surgery Visit Team Leader Report, Fiji (2009)
[33] Professor Spencer Beasley, PIP Paediatric Surgery Visit Team Leader Report, Fiji (2009)

In the aftermath of the tsunami which hit Samoa on 29 September 2009, Dr Loudeen Lam (one of PTC local instructors) provided feedback to RACS on the outcomes of participating in PTC:

- 'We fought hard trying to make PTC happen here (Samoa) after the Swine flu global alert...the historical road switch was an obvious excuse we used to push for training to happen but in fact...it allowed us to prepare our emergency & medical services for the unexpected.... PTC instructors took PTC to another level during our Samoa trainings by extending our invitations to the non-medics....we even carried out a mass demonstration...(bus accidents scenario)....PTC (in reality) happened here September 29th until now.....As emotional as it is....I feel that we were somehow preparing for this. So far those who presented to hospital...since the incident:
  Mortality = zero (0)
  Morbidity = 130 and still rising
  We are working extremely hard to reduce and improve our morbidity.'[34]

EMST & CCrISP

Feedback from 2009 Fiji EMST & CCrISP course attendee, A&E Junior Registrar TTM Hospital Samoa, Dr Mikaele. Ah Kuoi:

- 'The systematic approach taught by the courses is an easier and self-explanatory method of managing cases especially in a situation of panicking and confusion. These were very comparative to our everyday practice and were delivered in a live manner so that students can attain it for the long run. I also learned new skills and even the correct ways of carrying out procedures. Now with the Tsunami experience that we had, there will be no questions on these courses relevancies to our local practice…I strongly recommend similar types of courses for our local doctors who face these kinds of situations in everyday life of their practices.'[35]

ENT Nurse Training

PIC ENT Specialty Coordinator and volunteer observations of workforce development and improved service delivery:

- 'One of the participants of that course was Mary Loduha from Solomon Islands who went back to Honiara and established the nurse led ENT clinic there. Mary has certainly been a huge success in that role to the point where she is regarded as the Ear expert in Solomons… she treats purulent ears, carries out medical ENT treatment and does basic audiometry. Her work in triaging patients for the surgical teams has become invaluable. Another nurse Obigada Newton has joined her in the last three years and has attended the Vanuatu training course on two or three occasions. He is very keen and works

[34] Email communication from Dr Loudeen Lam to Dr Wayne Morriss, 3.10.2009

[35] Dr Mikaele Ah Kuoi, Fiji EMST and CCrISP Course Attendance Report, (September 2009)

very long hours with the teams and has an excellent knowledge. He is keen to undertake formal training in Audiometry.'[36]

- Nurses in Vanuatu are 'essentially running ENT clinics own their own.'[37]

[36] Email communication with Mr Malcolm Baxter, 15.05.2011

[37] Mr Perry Burstin, PIP ENT Visit & Nurse Training Team Leader Report, Vanuatu (2010)

Annex 4: Logical Framework Matrix

LOGICAL FRAMEWORK MATRIX

Code	Narrative Summary	Verifiable Indicators	Means of Verification	Assumptions
Goal	Improved health through increased tertiary health services in Pacific Island Countries.	Skills upgrading and training in a range of specialist medical services for PIC health professionals; Access for PIC nationals to a range of tertiary health care; Improved standards of secondary and tertiary health care delivery; Ongoing links between PIC health professionals and Australian counterparts; Improved standards of health.	Patient and hospital records; Australian medical team reports; PIC Health Department records.	Patients identified for treatment; Adequate facilities and equipment to perform a range of clinical services; Training programs meet the needs of PIC; PIC Health Department employs locally trained staff; PIC health workers assist visiting teams and attend training seminars.
Objective **Component 1: Clinical Services**	To provide tertiary health care services to selected Pacific Island Countries through a planned program of visits by qualified Australian and New Zealand medical specialists and support staff.	Number of visits by medical teams; Number of countries visited; Number of specialisations covered; Number of patients treated.	PIC Health Department records; Australian medical team reports; Project records.	Patients identified for treatment; Adequate hospital facilities and equipment available for use by visiting teams; Australian medical teams identified and mobilised.
Component 2: Training	To provide on-the-job training to local medical staff to enable them to become more self-reliant in the provision of services in selected areas of tertiary health care.	Level of skill in delivering a range of tertiary health services; Increased number of patients treated by national medical staff.	PIC Health Department records; Australian medical team reports; Records of participation in courses offered. Training materials provided.	Training contributes to improved skill base in PICs; PIC health workers are granted permission to work with visitors & the necessary release from duties to attend training programs.
Component 3: Priority Health Needs Fund	To respond effectively to emerging priority health needs as identified by the RACS, agreed by AusAID and endorsed by PIC health officials.	Identified needs responded to in an appropriate manner.	Project records.	PICs health officials submit or endorse appropriate requests for funding.
Component 4: Diabetes Training	To increase the local capacity of Pacific Islands to deal with the increasing burden of diabetes and related Non-Communicable Diseases	Improved skills of local medical and non-medical staff to deliver clinical skills related to diabetes prevention and management.	PIC Health Department records; Australian medical team reports; Records of participation in courses offered.	Training contributes to improved skill base in PICs; PIC health workers are granted permission to work with visitors & the necessary release from duties to attend training programs.
Component 5: Project Management	To efficiently and effectively manage the project within the budget and time frame agreed.	Project objectives and targets are achieved in accordance with TOR, work plans and budget.	Training materials provided. Annual work plans & budget; Project Completion Report.	MOU will be signed; AusAID budget will be approved.
Component 1 Objective	**Clinical Services** To provide tertiary health care services to selected Pacific Island Countries through a planned program of visits by qualified Australian and New Zealand medical specialists and support staff.			
Output 1.1	Delivery of clinical services by cardiac surgery teams.	Number of operations performed; Number of patients treated.	Reports of visiting teams; 3-monthly & Annual Reports; Minutes of PMC meetings; Minutes of EMC meetings.	Specialist teams identified and mobilised; Sufficient number of patients requiring specialist treatment.
Activities **1.1.X**	Clinical services provided by Adventist cardiac surgery teams in Fiji and the Solomon Islands.	Number of people successfully treated; Local staff with skills to care for patients treated by visiting teams.	Reports of visiting teams; Reports of PIC health officials; Hospital and patient records.	Operating theatres available for use by the visiting teams; Health personnel in PIC available to work with the visiting teams.
Output 1.2	Delivery of clinical services and training in ENT	As for 1.1	As for 1.1	As for 1.1
Activities **1.2.X**	Clinical services provided by ENT teams in the Cook Islands, Fiji, Kiribati, the Marshall Islands, the Federated States of Micronesia, Samoa, the Solomon Islands, Tonga, Tuvalu and Vanuatu.			

Code	Narrative Summary	Verifiable Indicators	Means of Verification	Assumptions
Output 1.3	Delivery of clinical services in neurosurgery	As for 1.1	As for 1.1	As for 1.1
Activities				
1.3.X	Clinical services provided by a neurosurgery team in Fiji.			
Output 1.4	Delivery of clinical services in ophthalmology.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.4.X	Clinical services provided by ophthalmology team to Kiribati, the Solomon Islands, Tonga, Tuvalu and Vanuatu.			
Output 1.5	Delivery of clinical services in orthopaedic surgery.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.5.X	Clinical services provided by orthopaedic teams to the Cook Islands, Kiribati, Samoa and Vanuatu.			
Output 1.6	Delivery of clinical services in paediatric surgery.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.6.X	Clinical services provided by paediatric surgeons to Fiji and the Solomon Islands.			
Output 1.7	Delivery of clinical services in plastic & reconstructive surgery.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.7.X	Clinical services provided by Interplast teams to the Cook Islands, Fiji, Kiribati, the Marshall Islands, Micronesia, Samoa, the Solomon Islands, Tonga and Vanuatu.			
Output 1.8	Delivery of services in psychiatry.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.8.X	Clinical services provided by a psychiatrist to Samoa.			
Output 1.9	Delivery of services in radiology.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.9.X	Clinical services provided by radiologist to Samoa and the Solomon Islands.			
Output 1.10	Delivery of services in urology.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.10.X	Clinical services provided by urology team to the Solomon Islands.			
Output 1.11	Delivery of clincical services in anaesthesia.	As for 1.1	As for 1.1	As for 1.1
Activities				
1.11.X	Clinical services provided by anaesthetists using anaesthetic monitoring machines.			
Output 1.12	Patient screening prior to visit by Australian personnel	Number of patients screened.	As for 1.1	As for 1.1
Activities				
1.12.X	Patients screened in advanced of team visit by Australian specialist.	Number of screened patients presenting for operation.		

Code	Narrative Summary	Verifiable Indicators	Means of Verification	Assumptions
Component 2	**Training**			
Objective	Training for medical and support staff to enable them to become more self-reliant in the provision of services in selected areas of tertiary health care.			
Output 2.1	Training for medical and support staff to enable them to become more self-reliant in the provision of services in selected areas of tertiary health care.	Nursing and paramedical staff better able to support local doctors and visiting specialist medical teams; Local doctors with improved skills to provide specialist medical care; Local staff with improved competence in preventative medicine; Effective links established with FSM for delivery of training activities; Patient follow-up undertaken by local staff.	Three-monthly and Annual Reports; PIC Health Department & hospital records; FSM reports.	PIC health workers interested in up-grading their skills; Medical teams willing to provide on-the-job training; Medical teams willing to prepare and conduct lectures & seminars Local training institutions willing to assist visiting teams with the conduct of training programs.
Activities				
2.1.X	Local medical and/or support staff conduct screening visits and/or accompany visiting teams to provincial centres.	Local health personnel support teams, assist with screening and provide post-operative follow-up.	Reports of visiting teams; Reports of PIC health authorities.	PIC health workers available to work with teams and keen to up-grade their skills; Visiting teams prepared to provide on-the-job training and lectures;
Output 2.2	Delivery of Primary Trauma Care Courses in the PICs.	Primary Trauma Care course material approved by FSM & PIC authorities; Local medical personnel attend courses.	Reports of course personnel, local health authorities, & evaluation reports by those attending courses.	Local personnel interested in attending courses; Local health authorities release staff to attend courses; Local health authorities provide venue and facilities for courses; Other PICs fund staff to attend courses.
Activities				
2.2.X	Provision of Primary Trauma Care Course in Fiji and other PICs.			
Output 2.3	Delivery of EMST courses in the PICs	EMST course material approved by FSM and PIC authorities; Local medical personnel attend courses.	Reports of course personnel, local health authorities, & evaluation reports by those attending courses.	Local personnel interested in attending courses; Local health authorities release staff to attend courses; Local health authorities provide venue and facilities for courses;
Activities				
2.3.X	Provision of EMST courses in Fiji and possibly the Solomon Islands.			
Output 2.4	Delivery of Anaesthetic refresher courses in Fiji	PICs medical personnel attend courses.	Reports of course personnel, local health authorities, & evaluation reports by those attending courses.	Local personnel interested in attending courses; Local health authorities release staff to attend courses; Fiji health authorities provide venue and facilities for courses; Other PICs fund staff to attend courses.
Activities				
2.4.X	Provision of Anaesthetic refresher courses in Fiji.			
Output 2.5	Delivery of Burns Workshops in the PICs.	Number of workshop participants.	Evaluation report of participants. Project records.	Local personnel interested in attending workshops; Local health authorities release staff to attend workshops. Australian specialists available to conduct workshops.
Activities				
2.5.X	Provision of Burns Workshops in Fiji and other PICs.			
Output 2.6	Delivery of Dermatology Workshops in the PICs.	Number of workshop participants.	Evaluation report of participants. Project records.	Local personnel interested in attending workshops; Local health authorities release staff to attend workshops. Australian specialists available to conduct workshops.
Activities				
2.6.X	Provision of Dermatology Workshops in the PICs.			
Component 3:	**Priority Health Needs Fund**			
Objective	To respond effectively to emerging priority health needs as identified by the RACS, agreed by AusAID and endorsed by PIC health officials.			
Output 3.1	Approved emerging priority health needs funded and implemented.	Activities undertaken to address priority health needs as identified.	Project reports.	Visiting teams and local health personnel identify needs that can be appropriately addressed by the Project; Local health authorities endorse requests; AusAID agrees to fund activities.
Activities				
3.1.1	Grants provided for approved activities.			

Code	Narrative Summary	Verifiable Indicators	Means of Verification	Assumptions
Component 4:	**Regional Training Program for Diabetes**			
Objective	To increase the local capacity of Pacific Islands to deal with the increasing burden of diabetes and related Non-Communicable Diseases	Level of skills of PIC staff providing clinical services related to diabetes and NCD detection and control. Number of staff providing training for other local health professionals.	PIC Health Department records; Australian medical team reports; Records of participation in courses offered. Training materials provided.	Training contributes to improved skill base in PICs; PIC health workers are granted permission to work with visitors & the necessary release from duties to attend training programs. Australian Diabetes Centres agree to participate/contribute.
Output 4.1	Development of training program and training manual	Training program documented. Training manual produced and distributed.	Project reports.	Australian and PIC health professionals agree on content and delivery mechanisms for training program and manual. PIC MOH support program.
Activities:				
4.1.1	Training program and training manual developed and in use in PICs.			
Output 4.2	Involvement of participating Australian Diabetes Centres	List of Australian diabetes centres and their staff assisting with diabetes training in the Pacific Workshop attended by staff from Australian Diabetes Centres.	Project reports.	Australian Diabetes Centres agree to participate/contribute. PIC counterparts accept the nominated Australian personnel to assist with diabetes training.
Activities:				
4.2.1	Staff of Australian Diabetes Centres attend workshop			
Output 4.3	Delivery of clincial services/ training in diabetes management	PIC staff with improved skills to manage diabetes and NCD. PIC staff conduct training programs for other local health staff.	PIC Health Department records; Australian medical team reports;	Training contributes to improved skill base in PICs; PIC health workers are granted permission to work with visitors.
Activities:				
4.3.X	Diabetes teams visit Fiji, Kiribati, the Solomon Islands, Tonga, Tuvalu and Vanuatu to conduct training programs			
Output 4.4	**Training attachments in Australia**	Number of PIC non-medical staff who successfully complete training. Number of PIC medical staff who successfully complete training.	PIC Health Department records; Project reports.	PIC health workers are granted the necessary release from duties to attend training programs. Australian Diabetes Centres agree to participate/contribute.
Activities:				
4.4.1	Non-medical staff from PICs under-take clinical training attachments in Australia			
4.4.2	Medical staff from PICs undertake clinical training attachments in Australia			
Component 5:	**Project Management**			
Objective	To efficiently and effectively manage the project within the budget and time frame agreed.			
Output 5.1	Efficient and effective management of the project within the budget and time frame agreed.	Project objectives and targets are achieved in accordance with project TOR, work plans and budget.	Three-monthly reports; Annual Work Plans and Budgets; Project Completion Report.	AusAID budget will be approved.
Activities:				
5.1.1	Contractor submits three-monthly reports, annual work plans and budget	Timely response of all Governments to reports.	Three-monthly reports; Annual Work Plans and Budgets;	There will be scope to adjust/ improve project implementation in the light of feedback on its progress.
5.1.2	Contractor submits Project Completion Report			
5.1.3	Contractor appoints experienced personnel to arrange medical team visits	Specialist medical teams travel to PICs in accordance with the Implementation Schedule.	Reports to AusAID.	Australian medical personnel will be released by their employees and will agree to provide services to the project.
5.1.4	Contractor establishes Project Management Committee and Project Evaluation and Monitoring Committee	Committee members appointed and attend meetings; Recommendation of committees enacted.	Minutes of PMC meetings; Minutes of EMC meetings.	Suitable committee members identified and accept appointment.

Annex 5: PDD Risk Matrix

Risk	Likelihood	Consequence	Risk level	Required Action	Responsibility
Lack of adequate aftercare for patients.	3	4	Extreme	Teams are instructed to avoid procedures that require post-operative care beyond the skills and resources of the PICs. Training is provided and instructions are left with local staff to assist with providing appropriate care after the teams have departed.	AMC Volunteer Medical Teams Counterparts
Lack of local budget at the provincial and hospital level for additional expenses incurred by visits and procedures.	4	3	High	Minimise cost implications of visits by providing the majority of equipment and disposable supplies necessary for the services provided.	AMC
Poor local infrastructure limiting PICs population living outside major centres access to visiting teams' services.	5	1	High	Prior, adequate and wide information dissemination about team's scheduled visits recognising the limitations of communication within PICs. Where appropriate facilities exist teams to travel outside capital cities to regional centres. It should be recognised that teams' limited time in country has in the past been fully booked by patients under current access conditions.	AMC Counterparts
Lack of support facilities such as x-ray and pathology.	4	3	High	Teams are advised to undertake procedures that are safe and that can be maintained through materials and supplies available locally or brought by the visiting team.	AMC Counterparts
Lack of necessary equipment.	3	3	High	Teams take with them some items of essential equipment. The project will liaise with PICs' hospitals to determine the avilability of equipment and medical volunteers will be advised to perform appropriate procedures in response to the condition of the facilities and care available.	AMC PICs Ministries of Health Volunteer Medical Teams
PICs doctors leave the public health system or the country after training.	3	3	High	Many PICs have found it difficult to retain skilled health professionals. Postgraduate training in the region together with improved terms and conditions of employment may encourage them to remain in their country and with the public health system.	PICs Ministry of Health
The availability and willingness of PICs medical staff to act as liaison and coordinators for the visits.	1	4	High	The project will identify an interested and willing local coordinator to act as the single point of contact, to disseminate information and make arrangements. This will minimise the risk of poor communication and cooperation.	Counterparts AMC
Project activities are disrupted due to political or civil unrest in the PICs.	2	4	High	The project monitors AusAID and DFAT travel advice and will temporarily suspend activities if necessary. The schedule will be amended accordingly and if necessary respond with changes to planned activities if agreed by AusAID.	AMC AusAID

Risk	Likelihood	Consequence	Risk level	Required Action	Responsibility
Disruption to PICs hospital routines.	3	3	High	Teams are advised to be aware and sensitive to additional demands they will be placing on hospital staff and resources and respond to the needs and constraints of the PICs.	AMC
Failure to gain the cooperation and participation of PICs staff.	1	4	High	The project will monitor local hospital and counterpart staff participation and feedback. It will also maintain communications between local staff and the project in order to engender a collaborative approach to project activities.	AMC Counterparts
Failure to identify appropriately qualified and experienced medical teams available to travel as scheduled in the PDD.	1	5	High	The Project maintains a database of potential volunteers. Visits are planned well in advance and the project administration maintains a flexible approach enabling it to amend schedules as necessary in response to PICs requests and availability of volunteers.	AMC
Lack of adequate pre-screening of patients in advance of visits.	2	3	Medium	Prior to each visit, project managers and the team leader will discuss plans for pre-screeningn with each PIC. Pre-screening visits by an Australian specialist will be arranged as required. The PMC will monitor team reports for comment on screening and take action to remedy shortcomings when necessary.	Counterparts AMC
Failure to produce and acceptable diabetes training manual.	2	3	Medium	Australian diabetes experts will work with PIC counterparts to develop a training manual and will take account of their views toensure cultural relevance. The manual will also be adapted to the particular requirements of each country.	AMC Counterparts
The start of Phase III is delayed.	3	2	Medium	Early action to approve PDD and negotiate a contract with the AMC is required to avoid a gap in service provision to PICs.	AMC AusAID
PICs health budget reduced or redirected from tertiary health services.	3	2	Medium	Project to monitor access to and condition of facilities in PICs hospitals and ensure that Project teams are self sufficient with disposable supplies.	AMC
Failure to gain release of counterpart staff from regular duties to enable training.	2	3	Medium	The training opportunities provided through the project are valued and supported by PICs. The project will maintain close liaison with key counterparts to allow planning for the release if staff to participate in training opportunities.	AMC PICs Ministries of Health
Failure to establish links with bilateral projects.	2	2	Medium	Dialogue is already established with health sector reform project personnel. AusAID assistance may be needed to formalise a proposed debriefing process invovling these projects and PIP teams at the conclusion of each visit. This will further consolidate the links already in place.	AMC AusAID
PICs health needs are reprioritised during the project.	2	3	Medium	PICs Ministries of Health have been consulted and the Design Document reflects their priorities at the time of preparation. The project is able to respond to some emerging requests through the Priority Health Needs Fund.	AMC PICs Ministries of Health

Risk	Likelihood	Consequence	Risk level	Required Action	Responsibility
Failure of PIC governments to follow through on recommendations of visiting teams	4	2	Low	Recommendations of visiting teams provide suggestions for changing and/or improving practices. Some are more feasible than others. It is entirely the discretion of each ministry as to whether they wish to enact recommendations. Most will not affect implementation of the project.	AMC PICs Ministries of Health
Duplication of project activities provided by other donors NGOs and church based organisations.	2	1	Low	The project will monitor health projects in PICs through liaison with PICs Ministries of Health and AusAID.	AMC

Key

Likelihood 5= Almost certain 4=Likely 3=Possible 2=Unlikely 1=Rare

Consequences 5= Severe 4=Major 3=Moderate 2=Minor 1=Negligible

AusAID

Internal Audit Report: Audit of Royal Australasian College of Surgeons (RACS)

February 2011

Prepared by: Protiviti

Table of Contents

Executive Summary

1.1. Background

AusAID is the Australian Government agency responsible for managing Australia's overseas aid program. The objective of the aid program is to assist developing countries reduce poverty and achieve sustainable development, in line with Australia's national interest.

AusAID has and is providing substantial support for Non-Government Organisation (NGO) activities through grant agreements. One such organisation funded through these arrangements is the Royal Australasian College of Surgeons (RACS).

Under the Funding Contract No.'s 10478, 11221 and 39677 AusAID entered into a contract with RACS to deliver specific activities under the Overseas Aid program on an as required basis. Each specific activity funded by AusAID is issued as a separate Funding Contract.

RACS have previously been audited in 2006.

1.2. Overall Risk Rating

Given the nature of the findings noted below, we have rated the operation of the RACS's Compliance with the Funding Contracts as **Moderate risk**. This risk rating stems from the inability of RACS to provide evidence of compliance with Division 102 of the *Commonwealth Criminal Code Act 1985* and regulations under the *Charter of the UN Act (Cth) 1945, as required under the contract between AusAID and RACS*.

1.3. Overall Assessment against Objectives

Our overall assessment with regards to the audit objectives is:

Objective 1: *The systems, procedures and controls of RACS are operating in an efficient and effective manner to enable it to discharge its contractual obligations to AusAID, including its financial and project management and advisory obligations.*

- The systems in place within RACS were noted to be satisfactory. Audit noted one exception where improvements to systems, procedures and controls could be made. This was in relation to RACS contractual obligation to comply with, and use their best endeavours to ensure that all of their delivery organisations comply with, relevant and applicable laws, regulations and policies, both in Australia and in the Partner Country including Division 102 of the *Commonwealth Criminal Code Act 1985* and regulations under the *Charter of the UN Act (Cth) 1945.*

Objective 2: *Improvements to RACS systems, procedures and controls could be made as a result of the findings of the audit.*

- The systems and controls in place within RACS were noted to be satisfactory.

1.4. Major Audit Conclusions

There were no organisational issues identified as part of this audit.

There was one (1) program issue (detailed below) that would impact on AusAID's contractual relationship with RACS Australia.

Compliance with Anti-Terrorism Legislation

A review of the procurement process undertaken by RACS identified that there is no documentary evidence that RACS have conducted anti-terrorism checks in accordance with the Funding Contract No.39677.

There were no minor management issues identified which would impact on the performance of RACS Australia's administrative obligations towards AusAID.

Protiviti reviewed the findings and implementation of recommendations from the previous internal audit conducted in 2006 with the RACS Project Manager and noted that the implementation of the

recommendations from the audit had been satisfactorily implemented.

1.5. Appreciation

We would like to put on record our thanks for the assistance shown by all of the AusAID and RACS stakeholders who were contacted during this audit.

2. Part A – Organisational Issues

There were no organisational issues noted in relation to RACS that would have agency-wide implications or affect AusAID's Strategic Plan.

3. Part B – Significant Program Issues

There was one (1) Significant Program issue, in relation to compliance with anti-terrorism laws that could affect AusAID's delivery of services to its staff and third parties.

3.1. Compliance with Terrorism Laws

Background

Contract No.39677 between RACS and AusAID requires RACS to ensure:

- "..when providing any Services and procuring the Supplies have regards to and comply with, and use their best endeavours to ensure that all Delivery Organisations comply with, relevant and applicable laws, regulations and policies, both in Australia and in the Partner Country including"
    - "those in relation to organisations and individuals associated with terrorism, including 'terrorist organisations' as defined in Division 102 of the Commonwealth Criminal Code Act 1995 and listed in regulations made under that Act and regulations made under the *Charter of the UN Act (Cth) 1945*.

      The Organisation must use their best endeavours to ensure that funds provided under this Agreement, do not provide direct or indirect support or resources to organisations and individuals associated with terrorism. If, during the course of this Agreement, the Organisation discovers any link whatsoever with any organisation or individual associated with terrorism it must inform AusAID immediately." (Clause 36.1(h))

Detailed Finding

A review of the procurement process undertaken by RACS identified that there was no documentary evidence that RACS had conducted terrorism checks in relation to organisations and individuals it contracted with as required by Funding Contract No.39677.

Implication

- Non compliance with contractual conditions;
- Increased risk that contracts will be entered into with inappropriate organisations or individuals; and
- Reputational damage to AusAID.

Recommendation

Recommendation 1:

- RACS should ensure that all suppliers and volunteers that it contracts with comply with all of RACS contractual obligation with the Australian Government (AusAID) including the following:

  "..when providing any Services and procuring the Supplies have regards to and comply with, and use their best endeavours to ensure that all Delivery Organisations comply with, relevant and applicable laws, regulations and policies, both in Australia and in the Partner Country including"
    - "those in relation to organisations and individuals associated with terrorism, including 'terrorist organisations' as defined in Division 102 of the Commonwealth Criminal Code Act 1995 and listed in regulations made under that Act and regulations made under the *Charter of the UN Act (Cth) 1945*.

      The Organisation must use their best endeavours to ensure that funds provided

under this Agreement, do not provide direct or indirect support or resources to organisations and individuals associated with terrorism. If, during the course of this Agreement, the Organisation discovers any link whatsoever with any organisation or individual associated with terrorism it must inform AusAID immediately." (Clause 36.1(h) of contract number 39677).

Management Comment

We have been requiring all our volunteers and personnel to sign their adherence to the College's terms and conditions prior to mobilisation for some years. This document requires all project participants (including volunteers) to comply with all relevant and applicable laws, regulations and policies, both in Australia and in the Partner Country.

We have now included an additional clause in the code of conduct for participants and supplying organisations to sign, which includes abiding by the appropriate laws relating to organisations and individuals associated with terrorism and 'terrorist organisations' as defined in Division 102 of the Commonwealth Criminal Code Act 1995 and listed in regulations made under that Act and regulations made under the Charter of the UN Act (Cth) 1945.

In instances where a participant is being mobilised overseas for the first time, we have usually required a Certificate of Good Standing from the relevant Medical Board or Medical Council where the participant is registered, to certify that there are no health, fitness to practice, or conduct issues present.

We can now provide evidence that we do use our "best endeavours to ensure that funds provided under agreements with AusAID, do not provide direct or indirect support or resources to organisations and individuals associated with terrorism and will if we discover any link whatsoever with any organisation or individual associated with terrorism inform AusAID immediately."

These are all included in the Anti-Terrorism Procedure which are now part and parcel of our standard operating procedures.

4. Part C – Minor Management Issues

There were no Minor Management issues that could impact on the performance of RACS Australia's administrative obligation towards AusAID.

4.1. Audit Testing

Background

A detailed test program was developed during the fieldwork phase of this audit which was directly referenced to the areas outlined in the Review Scope of the Terms of Reference for this audit. This included assessment of management systems, contract administration, recognised development expenditure, project procurement and asset control and fraud risk. Our testing included interviews with key stakeholders within RACS Australia and review of documentary evidence.

Detailed Finding

As part of our testing we undertook the following steps:

- **Management Systems**: Ascertained the adequacy and integrity of the systems, controls and procedures applied by RACS to funds provided by AusAID, including for any imprest or trust accounts operated in conjunction with the activities or contracts under audit, for:
    - Financial management;
    - Risk management;
    - Project management; and
    - Administrative systems.
- **Contract Administration**; Assessed the adequacy of contract and imprest/trust account administration including testing of samples of claims submitted to AusAID for validity and substantiation;
- **Project Procurement and Asset Control**: Assessed the adequacy of RACS systems for tendering and procurement of goods and/or services (including where applicable, imprest/trust accounts, sub-contracting and selection of project/advisory personnel) to meet Commonwealth Procurement Guidelines, and assess the adequacy of asset control procedures; and
- **Fraud Risk**: Identified risk areas where the fraudulent use of Commonwealth funds could or has occurred.

The results of testing indicated that, apart from the issues identified in Section 3 of this report, RACS appeared to be satisfactorily complying with the terms and conditions of their Funding Contracts with AusAID.

For Funding Contract 11221, Protiviti restricted their testing to reviewing the adequacy of the source documentation of the transactions. This was agreed with the AusAID Audit Manager. Protiviti did not identify any issues during the review.

Implication

- None noted.

Recommendation

- There are no recommendations associated with this finding.

Appendix A - Terms of Reference

Background

AusAID is the Australian Government agency responsible for managing Australia's overseas aid program. The objective of the aid program is to assist developing countries reduce poverty and achieve sustainable development, in line with Australia's national interest.

AusAID has and is providing substantial support for Non-Government Organisation (NGO) activities through grant agreements. One such organisation funded through these arrangements is the Royal Australasian College of Surgeons (RACS).

As part of the approved internal audit program for 2010/2011, AusAID included an audit of RACS. RACS was previously audited in 2006.

AusAID entered into a number of agreements over the financial years ending 30 June 2008, 30 June 2009 and 30 June 2010 with RACS as part of the overseas aid program. These included:

Agreement Number	End Date	Type	Value ($)
39677	30/6/2011	Grant	$8,149,666
37223	30/9/2008	Procurement	$499,797
50745	30/6/2009	Funding Order	$1,100,000
10478	31/12/2010	Procurement	$2,181,202
10478	31/12/2010	Procurement	$11,461,826
11221	28/4/2009	Procurement	$235,212
11221	28/4/2009	Procurement	$4,450,781

Audit Objectives

The objectives of this audit were to provide assurance to AusAID as to whether:

- the systems, procedures and controls of RACS were operating in an efficient and effective manner to enable it to discharge its contractual obligations to AusAID, including its financial and project management and advisory obligations;
- whether prior audit recommendations had been satisfactorily implemented; and
- improvements to AusAID systems, procedures and controls could be made as a result of the findings of the audit.

Review Scope

The scope of audit coverage was to examine, report and make recommendations to both RACS and AusAID on:

- Management Systems: Ascertain the adequacy and integrity of the systems, controls and procedures applied by RACS to funds provided by AusAID, including for any imprest or trust accounts operated in conjunction with the activities or contracts under audit, for:
  - Financial management;
  - Risk management;
  - Project management; and
  - Administrative systems.
- Contract Administration: Assess the adequacy of contract and imprest/trust account administration including testing of samples of claims submitted to AusAID for validity and substantiation;

- Project Procurement and Asset Control: Assess the adequacy of RACS systems for tendering and procurement of goods and/or services (including where applicable, imprest/trust accounts, sub-contracting and selection of project/advisory personnel) to meet Commonwealth Procurement Guidelines, and assess the adequacy of asset control procedures; and
- Fraud Risk: Identify risk areas where the fraudulent use of Commonwealth funds could or has occurred.

Sampling

All contracts for the last three financial years between AusAID and RACS were included within the scope of the audit. There was no sampling of contracts to be subjected to audit.

Within each contract, sampling was undertaken to test operation of controls and evidence supporting transactions.

The sample sizes that were used when performing the review were selected using the 'Protiviti Way' methodology. This methodology endeavours to use statistical parameters to support samples being representative. Judgment was exercised when selecting samples, specifically considering:

- expected error rates
- required effort to obtain supporting documentation for the sample
- nature of the population being tested
- quality of supporting documentation and underlying processes.

All sample sizes were confirmed with the AusAID Audit Manager prior to commencement of testing.

Scope Limitations

The audit was not designed to ascertain program effectiveness in either AusAID or RACS. The audit operations were restricted to reviewing the systems and application of procedures of RACS and the systems and procedures used within AusAID taking account of the scale and complexity of activities reviewed and within these terms of reference.

The audit did not assess all aspects of legal or contractual compliance with contractual obligations.

We did not visit project sites, interview sub-contractors or interview project recipients.

The audit did not validate certain management representations which would require a significant amount of further audit work, where there is no reason not to rely on the representation or where testing of the representation was not possible given constraints on the audit.

Stakeholders

The key stakeholders in this audit were:

- AusAID Audit Section;
- AusAID NGO Partnerships Section; and
- RACS.

Review Process

The Review was conducted in accordance with the relevant auditing standards identified by the Institute of Internal Auditors (IIA).

Fraud Risk

For the purpose of this section of the work, fraud risk refers to fraud against the Commonwealth.

- reviewed any existing fraud risk assessments and fraud control plans developed by AusAID or RACS in connection with AusAID contracts generally or RACS contracts and operations in particular.

- inquired of RACS management of any evidence or awareness of fraud in connection with AusAID contracts over the past six years.
- within the audit team, undertook a desktop fraud risk assessment of RACS contracts generally (based on the services provided by RACS under the contracts under audit). This was validated with AusAID Performance Review and Audit.
- for each fraud risk, discussed with RACS personnel the key controls in place to mitigate those fraud risks.
- for each of those key controls, Protiviti formed an opinion on the design effectiveness of key control and mitigation. On the basis of that opinion:
    - where it was determined that the control was not effectively designed, report the gap and proposed a recommended improvement in control.
    - where it was determined that the control was effectively designed, it will be tested as part of transaction testing referred to in "Contract Administration" below.

Contract Administration

- reviewed general contract administration processes in place for RACS. As part of this review, identified key controls in the process designed to ensure that:
    - funds was used effectively in accordance with the contract; and
    - costs charged to AusAID was valid, substantiated, value for money and related to the contract.
- reviewed any project or contract-specific contract administration processes in place for individual AusAID contracts under review. As part of this review, identified key controls in the process designed to ensure that:
    - funds was used effectively in accordance with the contract; and
    - costs charged to AusAID was valid, substantiated, value for money and related to the contract.
- once key controls were identified, developed a test program for testing a sample of transactions to assess operating effectiveness of key controls for contract administration and fraud control. At a minimum the test program tested existence and quality of documentation supporting charges to AusAID.
- under the Funding Contract No. 10478, 11221 and 39677, obtained a full detailed list of all charges and costs billed to AusAID for all RACS contracts.
- used the Protiviti Way sampling methodology, established a sample size and selection methodology for each contract under review. This sample size was approved by the Audit Managing Director and confirmed with the AusAID Audit Manager.
- selected sample in accordance with the agreed sample size and sampling methodology.
- implemented the test program developed above for the sampled transactions.
- reported findings and established any process improvement recommendations.
- determined if sampled findings required additional testing. This decision was approved by the AusAID Audit Manager.

Management Systems

- reviewed general financial management processes (as they relate to contracts with AusAID) in place for RACS. This review was undertaken both through review of procedures manuals and walkthrough of Funding Contract 10478 and 39667. For each of those key financial management controls, Protiviti formed an opinion on the design effectiveness of key control and mitigation. On the basis of that opinion:
    - where it was determined that the control is not effectively designed, reported the gap and proposed a recommended improvement in control.

  - where it was determined that the control was effectively designed, assessed whether there was a requirement for specific testing. This decision was approved by the Audit Managing Director and confirmed with the AusAID Audit Manager.

- reviewed general risk management processes (as they relate to contracts with AusAID) in place for RACS. This review was undertaken both through review of procedures manuals and walkthrough for Funding Contract 10478 and 39667.
- for each of those key risk management controls, Protiviti formed an opinion on the design effectiveness of key control and mitigation. On the basis of that opinion:
  - where it was determined that the control was not effectively designed, report the gap and proposed a recommended improvement in control.
  - where it was determined that the control is effectively designed, assessed whether there was a requirement for specific testing. This decision was approved by the AusAID Audit Manager.
- reviewed general project management processes (as they related to contracts with AusAID) in place for RACS. This review was be undertaken both through review of procedures manuals and walkthrough for Funding Contract 10478 and 39677.
- for each of those key project management controls, Protiviti will form an opinion on the design effectiveness of key control and mitigation. On the basis of that opinion:
  - where it is determined that the control is not effectively designed, report the gap and propose a recommended improvement in control.
  - where it is determined that the control is effectively designed, assess whether there is a requirement for specific testing. This decision should be approved by the Audit Managing Director and confirmed with the AusAID Audit Manager.
- reviewed general administration processes (as they relate to contracts with AusAID) in place for RACS. This review was undertaken both through review of procedures manuals and walkthrough of Funding Contract 10478 and 39677
- for each of those key administration controls, Protiviti formed an opinion on the design effectiveness of key control and mitigation. On the basis of that opinion:
  - where it was determined that the control was not effectively designed, reported the gap and proposed a recommended improvement in control.
  - where it was determined that the control was effectively designed, assessed whether there is a requirement for specific testing. This decision was approved by the Audit Managing Director and confirmed with the AusAID Audit Manager.

Project Procurement and Asset Control

- reviewed general procurement and asset control processes in place for RACS. As part of this review, identified key controls in the process designed to ensure that:
  - procurements was ethical, efficient, effective and designed to achieve value for money; and
  - assets were used for project purposes only and are protected and managed effectively.
- reviewed any project or contract-specific procurement and asset control processes in place for individual AusAID contracts under review. As part of this review, identified key controls in the process designed to ensure that:
  - procurements was ethical, efficient, effective and designed to achieve value for money; and
  - assets were used for project purposes only and are protected and managed effectively.

- once key procurement controls was identified, developed a test program for testing a sample of procurement transactions to assess operating effectiveness of key controls. At a minimum the test program tested compliance with Commonwealth Procurement Guidelines as appropriate.
- using the sample established for Contract Administration (refer above), implemented the test program developed above for the sampled transactions.
- determined if sampled findings required additional testing. This decision was approved by the Audit Managing Director and confirmed with the AusAID Audit Manager.
- reported findings and establish any process improvement recommendations for procurement management.
- walkthrough asset management processes for Funding Contract 10478 and 39667 to assess operating effectiveness of key controls for asset management.
- determined if walkthrough findings for asset management required additional testing. This decision was approved by the Audit Managing Director and confirmed with the AusAID Audit Manager.
- reported findings and established any process improvement recommendations for asset management.

Review Management

The audit was co-sourced. Protiviti was responsible for:

- the deployment of all audit resources;
- the development and implementation of the test program, according to the audit process outlined above;
- day to day relationship management;
- reporting; and
- quality assurance.

The AusAID Audit Section was responsible for:

- approval of the test program;
- overall relationship management;
- guidance on internal AusAID policies and procedures; and
- quality assurance and clearance of reports.

As part of the management of the audit, Protiviti worked with the AusAID Audit section to confirm that activities were coordinated and did not conflict with other organisational processes.

Reporting

During the audit, Protiviti team management discussed any issues arising from the fieldwork with the relevant AusAID Audit Manager to provide advice on the progress of the audit.

While on site, we communicated daily with the AusAID Audit Manager to assess progress, issues and findings. In addition, we will hold progress discussions with the key contact at RACS over the course of the fieldwork.

Reporting occurs in two parts:

- A draft to be provided four weeks after completion of the fieldwork; and
- A final draft report to be provided two weeks after delivery of the draft report.

The format of the report used is the AusAID Internal Audit reporting template, as per the standard reporting clause in the Service Order. Where appropriate, it included better practice material as appropriate for consideration by AusAID management.

Appendix B - Recommendation Implementation Action Schedule

Recommendation Category

Organisational issues – Issues that could have agency-wide implications or affect AusAID's Strategic Plan.

Significant Program issues – Issues that could affect AusAID's delivery of services to its staff and customers.

Minor Management issues – Issues that could impact on the performance of AusAID's administrative obligations towards its staff and customers.

Report Finding No.	Recommendation	Agreed/Disagreed (with reasons)	Implementation Timeframe	Action Area
	Recommendation Category – Significant Program issues			
Finding No 1. Compliance with Anti-Terrorism Laws	Recommendation 1 ▪ RACS should ensure that all suppliers and volunteers that it contracts with comply with all of RACS contractual obligation with the Australian Government (AusAID) including the following: ▪ "..when providing any Services and procuring the Supplies have regards to and comply with, and use their best endeavours to ensure that all Delivery Organisations comply with, relevant and applicable laws, regulations and policies, both in Australia and in the Partner Country including" o "those in relation to organisations and individuals associated with terrorism, including 'terrorist organisations' as defined in Division 102 of the Commonwealth Criminal Code Act 1995 and listed in	Agreed. We have been requiring all our volunteers and personnel to sign their adherence to the College's terms and conditions prior to mobilisation for some years. This document requires all project participants (including volunteers) to comply with all relevant and applicable laws, regulations and policies, both in Australia and in the Partner Country. We have now included an additional clause in the code of conduct for participants and supplying organisations to sign, which includes abiding by the appropriate laws relating to organisations and individuals associated with terrorism and 'terrorist organisations' as defined in Division 102 of the Commonwealth Criminal Code Act 1995 and listed in	Implemented	RACS

AUDIT-IN-CONFIDENCE

Report Finding No.	Recommendation	Agreed/Disagreed (with reasons)	Implementation Timeframe	Action Area
	regulations made under that Act and regulations made under the *Charter of the UN Act (Cth) 1945*. The Organisation must use their best endeavours to ensure that funds provided under this Agreement, do not provide direct or indirect support or resources to organisations and individuals associated with terrorism. If, during the course of this Agreement, the Organisation discovers any link whatsoever with any organisation or individual associated with terrorism it must inform AusAID immediately." (Clause 36.1(h) of contract number 39677)	regulations made under that Act and regulations made under the Charter of the UN Act (Cth) 1945. In instances where a participant is being mobilised overseas for the first time, we have usually required a Certificate of Good Standing from the relevant Medical Board or Medical Council where the participant is registered, to certify that there are no health, fitness to practice, or conduct issues present. We can now provide evidence that we do use our "best endeavours to ensure that funds provided under agreements with AusAID, do not provide direct or indirect support or resources to organisations and individuals associated with terrorism and will if we discover any link whatsoever with any organisation or individual associated with terrorism inform AusAID immediately." These are all included in the Anti-Terrorism Procedure which are now part and parcel of our standard operating procedures.		

Appendix C – Glossary of Terms

NGO	Non Government Organisation
CPGs	Commonwealth Procurement Guidelines
RACS	Royal Australasian College of Surgeons
ToR	Terms of Reference

Annex 7: PIP EMC TOR Policy

Royal Australasian College of Surgeons

Division: **Department:** **Title:**	**External Affairs** **International Projects** **TERMS OF REFERENCE - PACIFIC ISLANDS PROJECT EVALUATION AND MONITORING COMMITTEE**	**Ref. No.**	**EXA_INP_005**

1. PURPOSE AND SCOPE

This policy governs the terms of reference for the Royal Australasian College of Surgeons (College) Pacific Islands Project (PIP) Evaluation and Monitoring Committee (EMC) which provides overall guidance in implementing, monitoring and evaluating the Project.

2. KEYWORDS

Pacific Islands Project, Evaluation, Monitoring, Terms of Reference

3. BODY OF POLICY

3.1 Terms of Reference of the EMC

3.1.1 Duties and Responsibilities

The PIP EMC is responsible for monitoring and evaluating the efficiency and effectiveness of each PIP team visit in terms of:

- Effectiveness of the visit to deliver predetermined goals.
- Clinical service delivery (e.g. number and type of procedures performed, adverse outcomes, if any);
- PIP team report compliance with AusAID requirements that the age, gender and place of residence of patients treated by visiting teams are recorded;
- Training provided to local counterparts (e.g. appropriateness, timeliness, follow-up);
- Efficiency and effectiveness of pre-visit preparation (both by the College and by the Pacific Island Country); and
- Difficulties reported prior to, during and after visit.

Where necessary, the PIP EMC will also:

- Recommend improvements in planning, administration and implementation of visits (including scheduling of visits, composition of teams, pre-departure preparation, arrangements at RACS and in the recipient country, post-visit debriefing and preparation of team reports etc);
- Forward suggestions made in visiting team reports which it deems worthy to the International Projects Management Committee (IPMC) and International Committee (e.g. further training of local medical personnel, possible funding under International Projects Foundation Fund);
- Consider and report on non-PIP activities (of which it is aware) which may be of interest to the IPMC and International Committee; and
- Identify and advise the IPMC and International Committee of possible activities to be included in any future phases of the project.

3.1.2 Key Performance Indicators

The EMC will ensure that predetermined goals are established for PIP visits and will ascertain whether these predetermined goals have been achieved.

3.1.3 Composition

The PIP EMC shall consist of four members who are medical and nursing professionals with experience in international development work.

A representative from the Pacific who is either in country or temporarily in Australia or New Zealand and who is not directly involved in PIP project management is to be co-opted on the Committee on advice from the Pacific Islands Surgeons' Association

Occasionally, where available, the PIP EMC should have an evaluation and monitoring expert co-opted to provide advice to the International Committee on Monitoring and Evaluation matters.

3.1.4 Mechanisms of Appointment

EMC committee members to determine appointment of the Chair which will be confirmed by the International Committee.

3.1.5 Terms of Office

Terms of Office for the Chair and the Committee members should be up to 3 years per term and no more than 3 terms (9 years maximum) in line with standard RACS Policy.

3.1.6 Quorum

50% of PIP EMC committee members will make up a quorum.

3.1.7 Frequency of Meetings

The EMC is to meet at least twice each year. The PIP Project Manager will advise EMC Committee members as to the EMC meeting dates after consultation with the Chair. The Chair is entitled to call additional meetings where s/he deems this necessary.

3.1.8 Governance and Reporting

The EMC reports directly to the International Projects Management Committee which reports to the College Council via the International Committee and the Professional Development and Standards Board.

4. ASSOCIATED DOCUMENTS

International Projects Management Committee Policy

Approver CEO
Authoriser Council

Annex 8: Patient Data Gender Distribution

PIP Bridging/Transition Phase – Gender Distribution Of Major Surgical Activities														
Specialty	**Consultations**							**Operations**						
	Numbers				**%**			**Numbers**				**%**		
	Total	**M**	**F**	**NR***	**M**	**F**	**NR***	**Total**	**M**	**F**	**NR***	**M**	**F**	**NR***
Cardiac	**632**	**73**	**100**	**459**	11.55	15.82	72.63	**113**	**31**	**36**	**46**	27.43	31.86	40.71
ENT	**3,689**	**1,688**	**1,657**	**344**	45.75	44.92	9.33	**665**	**333**	**282**	**50**	50.07	42.41	7.52
Ophthalmology	**2746**	**362**	**427**	**1,957**	13.18	15.55	71.27	**982**	**416**	**418**	**148**	42.36	42.57	15.07
Orthopaedics	**1695**	**583**	**441**	**671**	34.39	26.02	39.59	**393**	**191**	**91**	**111**	48.60	23.16	28.24
Paediatrics	**112**	**42**	**31**	**39**	37.5	27.68	34.82	**67**	**39**	**22**	**6**	58.20	32.84	8.96
Neurosurgery	**273**	**6**	**4**	**263**	2.20	1.46	96.34	**44**	**6**	**6**	**32**	13.64	13.64	72.72
Plastics	**888**	**318**	**324**	**246**	35.81	36.49	27.70	**592**	**204**	**177**	**211**	34.46	29.90	35.64
Urology	**374**	**236**	**77**	**61**	63.10	20.59	16.31	**127**	**70**	**27**	**30**	55.12	21.26	23.62
General Surgery	**42**	**11**	**26**	**5**	26.20	61.90	11.90	**22**	**10**	**12**	-	45.45	54.55	-
Maxillofacial	**58**	**28**	**30**	**-**	48.28	51.72	-	**20**	**12**	**8**	-	60	40	-
Renal/Vascular	**152**	**80**	**72**	**-**	52.63	47.37	-	**37**	**30**	**7**	**-**	81.08	18.92	-
Total	**11134**	**3587**	**3379**	**4168**	**32.22**	**30.35**	**37.43**	**3062**	**1342**	**1086**	**634**	**43.83**	**35.47**	**20.71**