Australia Timor-Leste Program of Assistance in Secondary Services – Phase II

(ATLASS II)

Six Month Progress Report

January – June 2015

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Royal Australasian College of Surgeons

CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

ATLASS I	Australia Timor-Leste Program of Assistance in Specialist Services Phase I
ATLASS II	Australia Timor-Leste Program of Assistance in Secondary Services Phase II
CHC	Community Health Centre
DFAT	Department of Foreign Affairs and Trade
ELS	Emergency Life Support
EAVP	East Asia Vision Program
EmOC	Emergency Obstetric Care
EoPO	End-of-Program Outcomes
ETAT	Emergency Triage Assessment and Treatment
FMP	Family Medicine Program
H.E	Her Excellency
HNGV	Hospital Nacional Guido Valadares
JSI	John Snow Inc Research and Training
MEF	Monitoring and Evaluation Framework
M&M	Morbidity & Mortality
MoE	Ministry of Education
MoH	Ministry of Health
NEC	National Eye Centre
NUH	National University Hospital
PG	Post Graduate
PTC	Primary Trauma Care
RACS	Royal Australasian College of Surgeons
UNTL	Universidade Nacional Timor Lorosa'e
VfM	Value for Money

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1. EXECUTIVE SUMMARY

In this reporting period, the focus of the Australian Government funded *Australia Timor-Leste Program of Assistance in Secondary Services – Phase II* (ATLASS II) was the continuing delivery of the Family Medicine Program (FMP). The FMP is a post graduate (PG) medical training program that prepares junior Timorese doctors trained through the Cuban medical school system to work independently in Community Health Centres (CHCs) across the 13 districts in Timor-Leste.

The Royal Australasian College of Surgeons (RACS) in collaboration with the Ministry of Health (MoH) and other key national and international partners have led the delivery of the FMP. The first cohort of FMP trainees commenced the training program in late June 2014 with 38 junior doctors. By the end of the reporting period, 36 FMP trainees had completed Year 1 of the two year training program (2 FMP trainees were formally excluded following performance reviews).

As well as training junior doctors in community family medicine, ATLASS II is also working with the national hospital, Hospital Nacional Guido Valadares (HNGV), to develop, support and embed hospital systems strengthening approaches which includes significant changes to clinical governance and supervision as well as overall strengthening of PG medical education and training.

Partner collaboration and consultation remained strong during the reporting period. Existing relationships with the MoH, HNGV and Universiade Nacional Guido Valadares (UNTL) continued to be productive and collaborative and the program also strengthened relationships with external organisations delivering specific components of the Year 2 FMP curriculum.

In a constantly changing environment, there have been a number of contextual issues which affected some program activity. Due to ministerial changes and subsequent revised priorities for medical education and training, the program faced some difficulties in seeking executive decisions on the FMP, namely the delivery of Year 2 training program at CHCs as well as commencement of the second intake of FMP Year 1 trainees. To accommodate the changes in priorities, ATLASS II redesigned the Year 2 program by modifying the FMP training approach (including redesigning the Year 2 curriculum and decreasing the number of places for FMP Year 2) and reinstating Post Graduate Diplomas in Year 4 as part of the Year 2 training pathway options. Once final approval from the MoH was received in June 2015, the program in consultation with the MoH decided to delay the commencement of first and second year training programs to ensure better preparation as part of lessons learned from 2014/15. At the time of report submission, these preparations was on track and the program is confident that all four End-of-Program Outcomes (EoPO) remain relevant and on track with some minor revisions to targets.

2. RELEVANCE

Timor-Leste, home to 1.1 million people (72% of whom live in rural and remote areas[1]), has been ranked as 128 of 187[2] countries on the most recent United Nations Development Program Human

[1]World Health Organization. 2013. 'WHO South-East Asia Region: Timor Leste Statistics Summary (2002-Present)', *Global Health Observatory Data*. Available at http://apps.who.int/gho/data/node.country.country-TLS
[2]UN Development Program 2015.*Human Development Report. Available at hdr.undp.org/en/data*

Development Index[3]. Maternal and child health outcomes[4] remain poor despite substantial investment into the health system by the Government of Timor-Leste (GoTL), international governments and private organisations.

Ill health and poverty is particularly prevalent amongst Timorese people who live in rural and remote areas and who visit CHCs as their first port of call when seeking health services. The quality of preventative and curative primary health care services at CHCs has been assessed as poor by the World Bank despite the large number of Cuban trained Timorese doctors returning to Timor-Leste (some 900 doctors between 2012 – 2015) and being sent to the CHCs and Health Posts[5]. The new medically trained personnel need to be provided with adequate supervision and appropriate further training in community health; sufficient resources (such as provision of medication and supplies); and good infrastructure[6]. The FMP training program is designed to contribute to achieving better accessibility and more efficient delivery of essential community health care that will be of ultimate benefit to the Timorese communities in the districts.

The GoTL is committed to providing better, more equitable and accessible health care services. This is described in the MoH's *National Health Sector Strategic Plan 2011-2030*[7] which outlines the need to (1) *produce adequate numbers and skills of the different cadres of human resources for the health sector*, and (2) *promote excellence and ethics in all cadres of health professional functions*. However, health financing as a percentage of overall government expenditure remains low, particularly in comparison to other East Asian countries[8]. Funding from international government and non-government agencies address some of the shortfalls in the GoTL's health spending however this can be provisional and therefore subject to those agencies' contextual needs (i.e government budget cuts, change in investment priorities).

For the Australian Government, the program aligns with the new Department of Foreign Affairs and Trade (DFAT) *Heath for Development 2015-2020* strategy which is focused on investments in health, in water, sanitation and hygiene, and in nutrition – three areas that are fundamental to improving health outcomes in a developing country context[9]. In line with DFAT's health strategy, the program is working towards improving the Timorese health system by training health professionals, developing improved systems and structures and providing technical support to hospital administrators[10]. By leveraging HNGV's clinical governance and accountability measures as well as ensuring an improvement in quality of patient care, ATLASS II will also contribute to the long term sustainability and self-sufficiency aims of the program in line with the *Health for Development* strategy.

[3] The HDI is a summary measure of average achievement in key dimensions of human development: a healthy life, decent standards of living and knowledge.
[4] According to the World Bank, in 2015 the maternal mortality ratio (per 100,000 live births) is 270 and the under-five mortality rate (per 1000 live births) is 55.
[5] World Bank. 2014. *Health Equity and Financial Protection Report – Timor-Leste,* Washington DC.
[6] Ibid
[7] Timor-Leste Ministry of Health. 2011. *National Health Sector Strategic Plan 2011-2030,* Dili.
[8] World Bank. 2014. *Health Equity and Financial Protection Report – Timor-Leste,* Washington DC.
[9] Department of Foreign Affairs and Trade. 2015. *Health for Development Strategy 2015-2020*, Canberra.
[10] Ibid

The program provides value for money (VfM), an aid investment priority for the Australian Government and a key target in DFAT's performance framework[11]. The program has five RACS clinicians based at the HNGV who are training, mentoring and upskilling 36 FMP trainees (and another 40 FMP Year 1 trainees in the second intake), 30 mid-level and senior doctors, 8 Consultants and 2 Timorese administrators (also Consultants) who form part of the HNGV Executive. Another RACS clinician[12] is providing support to the sole Timorese Ophthalmologist and is training four Timorese doctors undertaking a Post Graduate Diploma in Ophthalmology. All these clinicians are paid significantly less than if they were working in Australia. In addition, critical clinical and leadership training through short courses such as *Doctors as Educators*, *Primary Trauma Care* and *Emergency Life Support* have been provided by highly qualified RACS specialist volunteers who visit Timor-Leste on short term visits to deliver the training activities. The RACS managed program has resulted in a number of additional benefits to HNGV and the MoH as the RACS clinicians are specialists in their disciplines and are familiar with the realities of clinical practice in Timor-Leste, so are able to opportunistically provide advice and support in their clinical areas (further information about types of support and advice is provided in *Context 2.2 HNGV Executive and efforts to implement changes*).

The program has demonstrated that it can adapt and respond to the changing priorities of the MoH and DFAT. With a change in Minister of Health in February 2015, the program sought to ensure that the program's activities were in line with her priorities for the health sector (refer to *Context 2.1 New Minister of Health and revised priorities for health sector*). The Minister has decided that in addition to the delivery of the FMP, PG Diplomas in Surgery, Anaesthesia and Paediatrics will be reinstated in Year 4 of the ATLASS II program. This is being done with no cost increase to the program.

Training Timorese doctors in-country in line with global best practice for workforce development and training (therefore avoiding a large number of doctors undertaking their training overseas and being removed from the Timorese health system for a considerable length of time) is a tangible investment for the Australian Government. In addition to training a cadre of Timorese doctors at different postgraduate training levels, the program is also working hard to make PG medical education and training a reality for the GoTL. A national teaching hospital where medical education and training will be independently delivered by the Timorese remains the ultimate long term aim of the program and is in line with good sustainable development practices.

By working closely with the MoH, DFAT and other key health partners to ensure that the program's activities are delivered in a holistic manner and reflect all parties' needs, the program has adapted to the constant changing context by being more innovative and resourceful. As an example, due to issues in the Internal Medicine rotation in Year 1 (as reported in previous six month progress report), the program trialled different options for training delivery until a viable solution was identified (refer to *Context 2.3 FMP training program – Internal Medicine*).

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[11] Department of Foreign Affairs and Trade. 2014. *Making Performance Count: enhancing the accountability and effectiveness of Australian Aid.* Canberra. Available at http://www.dfat.gov.au/aid/Pages/australias-aid-program.aspx

[12] Funded through the Australian Avoidable Blindness Initiative – East Asia Vision Program

One of the key priorities for RACS as a leading surgical training and accreditation body in the Asia-Pacific region is that the organisation advocates and works to achieve universal access to safe surgery and anaesthesia. Currently, over five billion people around the world do not have safe and affordable access to surgical and anaesthetic care[13]. Following the *Safe Access to Surgery and Anaesthesia* resolution which was passed by the World Health Organisation in May 2015[14], RACS and its international partners are advocating for a global action plan to implement the strengthening of surgical, obstetrical, trauma and anaesthetic services in every country, which validates the *Universal Declaration of Human Rights* tenet that every human being should have access to safe and quality medical care.

The program is now working with Timor-Leste MoH, HNGV and WHO in addressing these key priorities to ensure that *Safe Access to Surgery and Anaesthesia* is a key priority for the GoTL. This is another example of the benefits offered to the Australian Government and the program by RACS as an internationally recognised organisation which has experienced clinicians based in Timor-Leste who are able to offer technical expertise, advice and support in relation to the development and strengthening of the health sector in Timor-Leste.

3. CONTEXT

During this reporting period, ATLASS II continued to be influenced by a range of environmental and contextual factors. While these issues were covered in detail in the previous six month progress report, some challenges remain in relation to program implementation in a regularly changing environment. The program continues to keep DFAT Dili Post regularly informed of any risks and contextual issues, including through monthly meetings and email correspondence.

2.1 New Minister of Health and revised priorities for health sector

As a result of the Timor-Leste Government changes, a new Prime Minister and a new Minister of Health were appointed in February 2015. His Excellency (H.E) Dr Rui Maria de Araujo, the new Prime Minister (Minister of Health between 2001-2006) is a trained doctor and highly aware of many of the issues in the health system. H.E Dr Maria do Ceu Sarmento Pina da Costa, the new Minister of Health, was previously the Vice Dean at UNTL and has a good working relationship with UNTL. As the previous Vice Minister for Health, H.E Minister Ceu is also very knowledgeable about the issues in the current health system.

The ministerial changes presented some challenges and delays for program planning and implementation. Initially, there was a gap before a new Minister of Health was appointed (about six weeks) followed by some difficulties securing a meeting with the Minister, given the many pressing and competing priorities in her new role. The program met with the Minister and her advisor in late March to provide a briefing on the program's activities and to seek advice on her priorities for health workforce development and medical education. Despite the meeting and active follow up by program personnel and DFAT, there was a two month delay in getting decisions about the next

[13] The Lancet Commission on Global Surgery. 2015. Accessed at http://www.globalsurgery.info/. Boston
[14] *Strengthening Emergency and Essential Surgical Care and Anaesthesia as a Component of Universal Health Coverage*, Resolution A68/15 passed at 68th World Health Assembly. World Health Organisation. 22 May 2015. Available at http://www.who.int/surgery/en.

steps in the FMP training program, including the commencement of the second cohort of new FMP trainees.

In response to the Minister's identified priorities, a number of changes were made to the Year 2 program. RACS responded by redesigning the Year 2 training program accordingly:

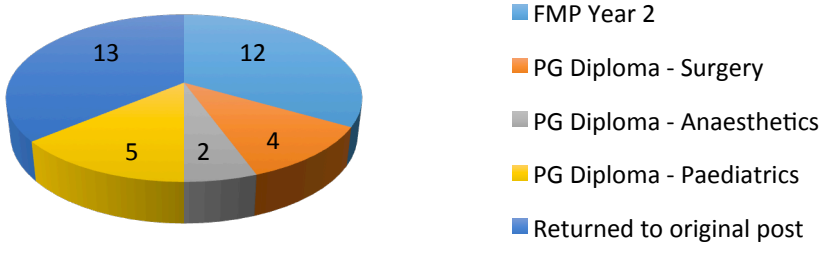
- The FMP Year 2 program would continue but in a redesigned format and with less resources and training positions. The original FMP design was collaborative with contributions from RACS, MoH, Cuban Medical Brigade, Marie Stopes International (MSI) and National Eye Centre (NEC). The revised program now calls for increased input from RACS (now responsible for providing teaching in the CHCs), decreased contributions from the MoH (4 teaching CHCs sites reduced to 2) and no contributions from the Cuban Medical Brigade. Contributions from MSI and NEC remain unchanged. As there were only two teaching CHC sites identified by the MoH as being able to take on FMP trainees, the number of training positions in FMP Year 2 had to be significantly reduced from 36 to 12.
- The PG Diplomas would be reinstated with Year 1 FMP trainees allocated to 11 training positions in PG Diplomas in Anaesthesia (2), Surgery (4) and Paediatrics (5) (the clinical specialties that RACS can currently offer with the resources available).
- A merit based selection process would be used to match FMP trainees' preferences for available Year 2 positions.

The Minister was satisfied with the redesigned program and provided approval in mid June 2015 to proceed with the changes. 12 trainees were accepted into FMP Year 2 and 11 trainees into PG Diplomas. Five trainees who had completed FMP Year 1 program chose to return to their original CHC posts for personal reasons. Eight trainees with the lowest scores in the final end of year ranking were asked to return to their original CHC posts by the MoH.

TABLE 1: Breakdown of Year 2 training positions

First cohort of FMP trainees

n = 36

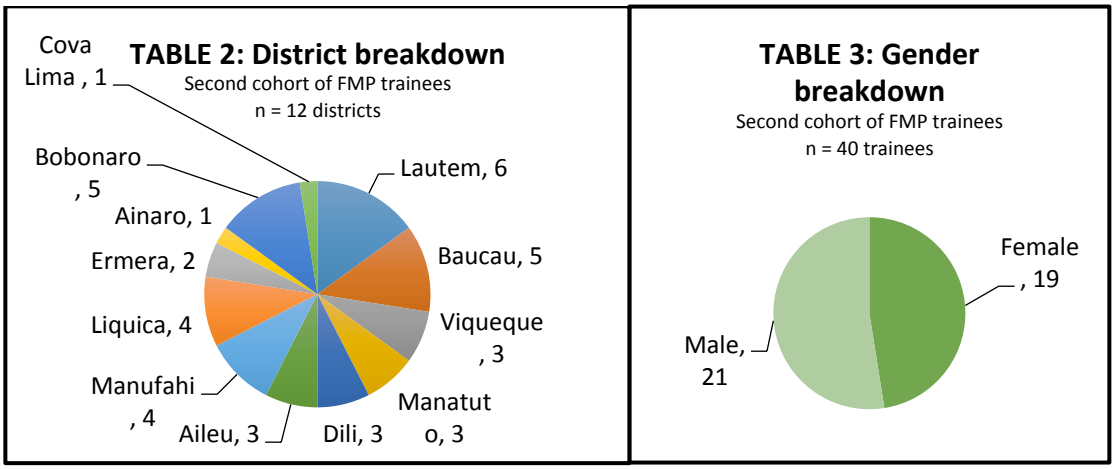


Whilst it is unfortunate that there were not sufficient Year 2 training positions available for all the FMP trainees (increasing the number of Year 2 places in 2016/17 for the second intake of FMP trainees will need to be identified as a priority by the MoH), the quality of training should be improved with two Dili-based CHCs that RACS can better oversee as well as assist with supervision. The change of supervision from Cubans to senior Timorese CHC doctors may mean a slight drop in quality of supervision (as there are few experienced Timorese CHC doctors and they

have had no training or experience in supervision). However, providing support and training in supervision to these Timorese CHC doctors will eventually lead to improvement in the quality of supervision in the CHCs. The trainees will also receive twice weekly tutorials from a qualified RACS supported General Practitioner(s) (GP) (a similar model which was employed for the delivery of the Internal Medicine rotation in FMP Year 1).

Despite the increased workload for RACS in the redesign and delivery of training activities, the reinstatement of the PG Diplomas, the delivery of FMP Year 1 and the overall coordination of the Year 2 training program (this was originally to be the Cuban Medical Brigade's contribution – refer to previous six month progress report for further information), this is being done at no cost increase to the overall budget.

Given the latest changes, RACS concentrated on working with the MoH to establish a merit selection process for the second cohort of new FMP trainees. While recognising that this would result in more delays to the training program, this was done to ensure that all trainees have the baseline knowledge to maximize the training opportunity and to ensure academic and procedural rigour. The establishment of a merit selection process resulted in 77 Timorese doctors from 13 districts applying for the training program in July 2015 and sitting a medical exam. The top 40 students from 12 districts (Oecussi was the only district that did not have a trainee who qualified) were selected based on their results. Gender and district balance was also achieved which is testament to the MoH, DFAT and RACS' desire to ensure that equal training opportunities are afforded to Timorese doctors.



2.2 HNGV Executive and efforts to implement changes

While ATLASS II has continued to work with HNGV Executive to strengthen and embed key hospital systems strengthening and health workforce development strategies and approaches at the national hospital, there remained a number of issues outside of the program's control that hindered some program activities in the reporting period. The new HNGV Executive, ambitious and keen to improve the hospital's systems, has been limited by expertise, funding and an existing

'medical culture'[15] in terms of what changes can be introduced and embedded into the hospital's existing systems.

Significant patient safety issues continue to have an adverse impact on the provision of good quality care and efficient service delivery that Timorese patients should expect to receive. Several reasons explain this: the hospital has a limited number of senior Timorese Consultants with the necessary expertise and skills (particularly in the Paediatrics, Obstetrics & Gynaecology (O&G) and Emergency Departments); efficient service delivery out of hours is still hampered by issues around overtime and rostering; very slow pathology and radiology services do not provide services out of hours and/or have to work with superseded equipment; as well as an existing medical culture that is difficult to revolutionize.

During the reporting period, there were issues in relation to the on call schedule due to a dispute between the MoH and the Timorese doctors regarding overtime payments. The issue had been ongoing since October 2014 and during that time the program ensured that the hospital was never left without appropriate clinical cover by RACS clinicians taking on extra on call shifts. This prevented many clinical problems but may have delayed resolution. During the period of the industrial disagreements, the clinical workloads for the RACS Surgeon and RACS O&G were significantly increased which impacted on their teaching responsibilities. As an example, the RACS Surgeon did 13 out of 30 on call shifts in a month (being on call for 24 hours every 3rd day) while most of the Timorese surgeons were exempted from doing any of the on call shifts because the hospital could not pay them for overtime. This meant the RACS clinicians carried an escalated clinical service delivery load including excessive work hours as well as full-time FMP teaching. The RACS clinicians took on this increased workload while the program strongly protested against the inequity and increased onerous on call requirements placed on the RACS clinicians by the hospital. The impasse was eventually resolved at a hospital wide meeting in June 2015 chaired by the MoH's Vice Minister Dr Ana Isabel Sousa Soares who made firm statements that all Timorese doctors must take on an equal share of on call responsibilities and outlined how they would be remunerated. Despite the apparent resolution of the issue, it has been noted that the excessive clinical workload was a significant contributing factor to the RACS O&G's decision to resign in June 2015, as confirmed at exit interview.

Where possible, the RACS clinicians have worked closely alongside HNGV Executive

'The ATLASS program has been very helpful. Because of its long term involvement, they have been instrumental in the long term planning and implementation of training of doctors and specialists, helping us with our aim of becoming a teaching hospital' – Dr Joao Pedro Xavier (HNGV Clinical Director) on impact of RACS training and strengthening activities on the national hospital.

[15] The existing 'medical culture' at HNGV is based on a service delivery hospital model rather than a teaching hospital model. While the transition to a teaching hospital has been occurring for a number of years, the 'medical culture' is only just starting to change. Self-directed learning, teaching of junior doctors and supervision support from senior doctors remains a work in progress as these activities are seen as not part of their jobs. Junior doctors' hospital positions are held indefinitely until they wish to move on and likewise these positions are not seen as valuable training opportunities. In a teaching hospital model, these junior doctor positions would be for a fixed term (6, 12 or 24 months) at which time the incumbent would move up or out and the position (and learning opportunity) would be given to a new junior doctor. Currently, HNGV does not distinguish the differing levels of experience and skills between junior doctors therefore all junior doctors consider themselves as equals. Subsequently, the newly graduated doctors do not naturally look towards their more experienced colleagues for support and the mid-level (and more experienced) doctors do not see teaching and mentoring their younger, more inexperienced doctors as part of their role. The FMP Year 1 program has been an example of how the teaching hospital model can work in practice and the culture is gradually changing with the recognition by HNGV Executive and some senior doctors that teaching and supervision are part of a doctor's role at HNGV. In addition, more doctors are becoming keen to engage in training around teaching and supervision.

to improve patient care and quality assurance, both of which are essential to good medical practice. It must be understood that the changes (in human resource personnel and improvements in accountability and performance management) required are long term, complex and difficult to implement given the existing medical culture and the need for 'buy in' from all parties. The RACS clinicians are helping HNGV Executive by providing regular technical advice and support, including through the establishment of committees such as clinical investigations into mortality and morbidity cases; medication safety; establishment of M&M data and audit requirements; assistance with revision of Essential Medicines List; Ebola response planning and training; and advice and guidance on human resources and performance management including internal regulations, on call scheduling and remuneration systems.

2.3 FMP training program – Internal Medicine

During the reporting period, issues with the delivery of the Internal Medicine rotation as part of the Year 1 FMP program continued. As originally agreed in the program design, the Cuban Medical Brigade were to be responsible for the delivery of the Internal Medicine rotations (as well as overall delivery of Year 2 training at the CHCs) however as previously reported, they withdrew from the partnership in early July 2014 due to not being provided with additional personnel resources by the MoH.

On the wards, the supervision of the Internal Medicine trainees by the mid-level doctors was limited and there seemed no engagement from the senior Timorese Consultants (with the exception of cardiologist Dr Andre Morteiro). Subsequently, the delivery of the Internal Medicine rotation during the first six months of Year 1 was very limited. The program mitigated the issue by engaging an internal medicine physician from Germany (based in Dili as a accompanying spouse) to deliver twice weekly tutorials to the FMP trainees to cover some gaps. Dr Celia Santos, a Timorese Consultant who recently returned from Fiji following completion of her Masters of Medicine (Internal Medicine), was asked to help with the supervision and teaching of the FMP trainees on the wards, which she willingly did.

Another issue identified with trying to involve mid-level doctors (in all the clinical departments) in the supervision of the FMP trainees is that very few of them have had any exposure to good medical teaching and supervision practices. To compensate for the lack of experience and training, the program organised for the mid-level doctors, including several from the Internal Medicine Department, to attend a *Doctors as Educators* course in June 2015 where participants were provided with strategies and tools for teaching and supervision. Interestingly, a number of the participants who had been previously identified as reluctant to be involved in teaching and supervision voluntarily attended the course. The *Doctors as Educators* trainers reported that there was good engagement from the mid-level doctors and that there were several requests for further courses. In order for the existing medical culture to change, it is important that there be good role modeling from top down and the program is working hard to ensure this is happening as part of the overall three tier clinical supervision hierarchy.

2.5 UNTL and MoH

The program continues to have a good working relationship with UNTL. Given the changes in the MoH, the relationship between the MoH and UNTL seems to have improved vastly. With H.E Minister Ceu having previously been the Vice Dean at UNTL, there appears to be a keen desire to improve the existing relationship. This is a positive outcome for the program.

The reinstatement of PG Diplomas in July 2015 has made it even more critical that the issues around course registration, tuition fees and accreditation between MoH and UNTL are urgently clarified. The MoH would like UNTL to accredit the FMP but there are a number of issues that may restrict this, including the current embargo on new PG training courses (university-wide, not just PG medical courses) by the Ministry of Education (MoE). Until this is lifted, the FMP is unable to be accredited.

Another core issue that needs to be clarified is the registration status of future intakes. It will need to be collectively decided by all parties whether the course registration for PG Diplomas and FMP should be approved by UNTL or MoE. The MoH has advised that the registration should be under the UNTL umbrella, however despite a meeting between UNTL and MoH in early May 2015 where good intent to work collaboratively was demonstrated by both sides, including a verbal agreement to develop an overarching Memorandum of Understanding and technical agreements for the courses, nothing seems to have been actioned at time of report submission.

As reported in the previous six month progress report, the course tuition fees for the first PG Diploma intake remained unpaid by the MoH despite ongoing attempts by the program to achieve a resolution to the issue. Subsequently, the nine PG Diploma graduates in Surgery, Anaesthesia and Paediatrics were unable to receive their graduation certificates even though their convocation was celebrated at a UNTL ceremony in November 2014. As part of discussions with the MoH in May 2015, DFAT advised that RACS would pay for the outstanding PG Diploma fees using savings from the program's Year 3 budget. Whilst there are some concerns that this could set a precedent for future intakes, the program facilitated the payment while strongly advocating that the fees issue be urgently settled between MoH and UNTL for any future PG Diploma intakes.

During the reporting period, the program continued with preparations for a second intake of Year 1 FMP trainees plus the revised Year 2 training program and PG Diplomas. Curriculum endorsement has been delayed until UNTL makes a decision regarding the curriculum format. The program will continue to strongly encourage and support the MoH and Dr Joao Martins (Clinical Dean) and Dr Nelson Martins (PG Coordinator) at UNTL to identify ways forward for all parties to work together and resolve the outstanding issues.

2.6 DFAT and change in priorities

As a result of the Australian Government's changes to the aid investment portfolio, ATLASS II was requested by the DFAT Dili Post in June 2015 to cut the Year 4 budget by 15% as part of the broader cuts to the health sector in Timor-Leste. A 15% budget cut would have had significant implications for Year 4 as the program would have needed to lose a clinician to achieve this cut. Following a number of meetings and negotiations between DFAT Dili representatives and the program, the Year 4 budget cut was reduced by 9% and all clinical positions retained. The program will be able to deliver most of the Year 4 activities with some modifications to training activities, e.g. through using the Timor-Leste based RACS clinicians to deliver training activities such as *Primary Trauma Care* and *Burns* courses (instead of using international expert trainers as per the original FMP program design). With the redesigned post graduate training program requiring increased active management, coordination and inputs from RACS as well as the decreased budget, the program is doing more with less resources, a key indicator for the Australian Government.

The program is cognizant that it is making a tangible investment in strengthening the health system in Timor-Leste through workforce development and hospital systems strengthening approaches but is conscious that these investments are a long term process. It can also be difficult to report on

all of the program's activities due to the opportunistic nature of many activities in a hospital setting as well as due to the constant contextual changes.

4. EFFECTIVENESS

The effectiveness section of this report provides progress information against outcome indicators as set out in the ATLASS II Monitoring and Evaluation Framework (MEF). This is the second six monthly reporting period for the FMP. Qualitative, quantitative and baseline data continues to be documented (where possible) and analysed against the outcome indicators.

The program's Monitoring & Evaluation (M&E) Officer Ms Kate Moss along with Ms Jan Cossar, M&E Consultant, conducted a review of the ATLASS II MEF, EoPO and outcome indicators in late June 2015. The review team liaised with DFAT and the RACS clinicians. A number of changes were made to the program's MEF[16] including changing wording for some EoPOs to better capture the work being done by the program. In addition, reporting templates including rotation assessment templates and FMP trainee feedback forms were strengthened to ensure more consistency and rigour across assessment marking. The next six month progress report (July – December 2015) will also include another EoPO which is focused on the reinstatement of the PG Diplomas and the Masters of Medicine (in Paediatrics) as per the MoH's directive.

3.1 OUTCOME ONE – Family Medicine Program Year 1

Approximately 70-80 candidates will have successfully completed Year 1 of the FMP demonstrating capabilities in clinical areas needed to work at the Community Health Centres.

Summary Analysis

In June 2014, 38 trainees (29 males, 9 females) were nominated by the MoH and commenced the training program. At the end of the reporting period, 36 trainees (27 males, 9 females) completed Year 1 of the training program. Two FMP trainees were discontinued from Year 1 following an academic review process as agreed with the MoH and UNTL.

During this reporting period, *Rotations Three, Four* and *Five* were delivered by the RACS clinicians with support from Timorese mid-level doctors and Consultants. Currently, the Timorese counterparts are able to assist with clinical supervision and clinical work (on the wards, in theatres and at outpatient clinics) but are not ready to take on the lead in delivering lectures (with the exception of three Timorese Consultants assisting the RACS Surgeon with tutorials in the *Surgery* rotations). The ultimate aim of collaborating with the Timorese counterparts on this training program is to get them to eventually take over the teaching responsibilities however this remains a long term process particularly in Departments that have no or very few Timorese specialists.

An evaluation of FMP Year 1 baseline exam results compared to end of Year 1 exam results demonstrated the consistency in the FMP trainees' progress (or lack thereof). The results showed that there was a wide range in the FMP trainees' medical knowledge at baseline and that this

[16] The revised MEF and templates with an additional EoPO will be submitted to DFAT separately for review and final approval.

range was maintained in a similar ranking order after completion of Year 1. This emphasizes the need to have a merit selection process that assesses the trainees' abilities and medical knowledge base in order to ensure that the limited number of Year 1 positions are targeted to trainees who will maximize the training opportunity.

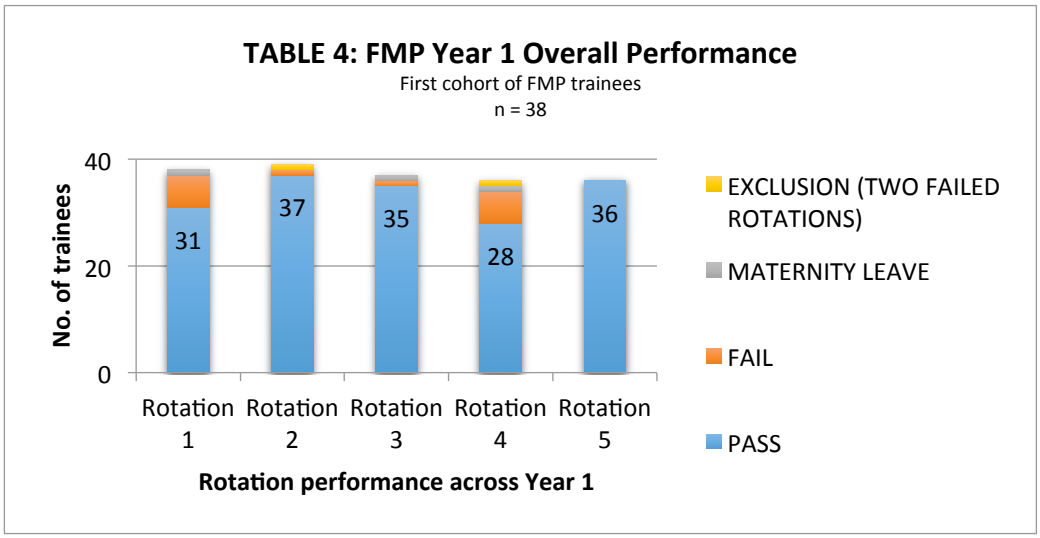
Progress against ATLASS II – FMP – MEF *Outcome Indicators*

Indicator 1.1 Percentage of FMP candidates who have successfully completed Year 1 rotations and demonstrate relevant capabilities across each subject area, by gender.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

The FMP commenced in late June 2014 with an intake of 38 trainees (29 males, 9 females) selected by the MoH from 12 districts. At the end of the reporting period, 36 trainees (27 males, 9 females) had passed Year 1 of the training program. The target for satisfactory completion (75%) remains on track with a Year 1 pass rate (out of 38 trainees) of 94% for the first intake.

During the reporting period, there were a number of discrepancies in rotation performance. In *Rotation Three*, one trainee failed; in *Rotation Four*, seven trainees failed (one trainee failed two rotations and was therefore excluded from the training program as per the academic assessment procedure); and in *Rotation Five*, no trainees failed.



At the commencement of Year 1, FMP trainees were categorized into five groups consisting of 7-8 trainees per group. The above chart demonstrates the improvement from *Rotation One* to *Rotation Two* when the FMP trainees realised that failure a real possibility if their performance did not improve. Likewise, there was a dip in *Rotation Four* where there was a higher than average failure rate due to poor motivation and interest in learning as reported by the RACS clinicians. This is likely to be in light of the delays in ministerial decisions regarding the future of program beyond June 2015. However once trainees realised that there would be a merit process for Year 2 training positions, motivation and overall performance in *Rotation Five* vastly improved.

The final assessment results from the end of Year 1 exam (refer to *Annex 1 – FMP Year 1 Overall Performance* with names de-identified) were compared to the baseline exam results and reveal some interesting results:

1. The trainees who performed well at the beginning of the year continued to perform well at the end of the year. They make up the group of the highest performing trainees and have now been transferred into the PG Diploma training stream following a preference allocation.
2. The trainees who performed at an average level made some progress throughout the year. These trainees have gone into FMP Year 2 training program.
3. With 1-2 exceptions, the trainees who performed poorly at baseline assessment have made relatively little progress and improvement with twelve months of training. This could be due to a combination of poor English language proficiency (confirmed by regular English language tests) and a poor medical knowledge base to begin with (as evidenced by baseline exam results) impacting on their ability to learn in a training setting.

This demonstrates the clear need to have a merit selection exam to ensure that candidates with appropriate medical knowledge are selected for the training program and are able to progress through the FMP and PG Diplomas training pathways.

FMP trainees at End of Year 1 Ceremony in July 2015 with representatives from MoH, UNTL, DFAT and RACS. The trainees were provided with a medical kit which will help them when they return to work in the districts.

Indicator 1.2 FMP Year 1 curriculum is relevant to Timor-Leste and includes assessment which will verify that FMP candidates have appropriate skills and knowledge to work at CHCs.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

The FMP curriculum was developed based on the Basic Services Package for CHCs and wide consultation with health partners working in Timor-Leste regarding the baseline skills of these CHC junior doctors in order to establish the learning objectives and needs. This was then developed into a two-year curriculum following the format of the Australian Curriculum Framework for junior doctors and then reviewed by an experienced medical education curriculum development specialist. The curriculum has been designed to be assessed as a whole (not as separate first and second year curriculums) however as the structure of the program is rotational and as the hospital-

based rotations occur in the first year (for logistical reasons), the five hospital-based rotations form the first year curriculum.

During the course of the Year 1 program, the delivery of rotations and their assessments were reviewed and modified appropriately by the FMP Academic Coordination Committee. As part of the review process, changes were made to the delivery of the Internal Medicine rotation and to assessment processes for the Surgery, Obstetrics and Paediatrics rotations. At the final FMP Academic Coordination Committee meeting for FMP Year 1, a decision was also made by the committee to review and strengthen all assessment processes for Year 1 rotations as part of lessons learned. This will be done in early 2015/16 by all RACS clinicians and Timorese counterparts.

Due to changes in available resources as well as the redesign of the FMP Year 2 program, the FMP curriculum will also need to be redesigned. A curriculum review is planned for September 2015 and the review team (led by experienced Australian GPs familiar with the requirements of community health training in developing countries) will be specifically tasked to look at the redesign of the Year 2 program (as well as Year 1 curriculum) and incorporate any changes.

FMP trainees watch on as Timorese Surgeon Dr Alito Soares demonstrates how to insert a chest drain as part of Primary Trauma Care course, February 2015

At time of report submission, the outstanding issue for the FMP curriculum is a review and endorsement by UNTL as the certifying body. As previously reported, this process has been delayed due to ongoing issues between MoH and UNTL which are not yet fully resolved. The program will continue to encourage the MoH and UNTL to urgently clarify the issues.

Indicator 1.3 The FMP Academic Coordination Committee reviews implementation and candidates' progress after each rotation and syllabus content at the end of each year

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

During the reporting period, the FMP Academic Coordination Committee[17] met six times to review and resolve rotation issues as well as discuss final assessment grades for rotations and for end of year ranking. Letters to trainees who failed a rotation/s were distributed following these meetings. All trainees who failed a rotation had their assessment results robustly discussed by the FMP Academic Coordination Committee before the rotation result was recorded as a fail.

At the end of the reporting period, two trainees had failed two rotations in the FMP Year 1 training program and did not progress any further following a performance review. The rotation supervisors reported that these trainees failed because of poor performance, namely poor attitude to learning and to patient care as well as poor professionalism (i.e. not turning up for on call shifts, not completing allocated shifts). Even after mid-rotation feedback and failure of first rotation, the

[17]The FMP Academic Coordination Committee consisted of the five RACS clinicians and the Monitoring & Evaluation Officer. Timorese Consultants and senior Medico Geral and representatives from UNTL and MoH were invited to attend but none did.

trainees' performance did not improve. The MoH's HR Department was supportive of this process and unanimously agreed that exclusion from the FMP training program was a suitable academic outcome.

Following the new direction of the MoH to redesign the Year 2 training program based on revised priorities and to stream the FMP Year 1 trainees into FMP Year 2 and PG Diplomas, the FMP Academic Coordination Committee in collaboration with the MoH's HR department, developed a merit based ranking system using the final exam and rotation results. The merit based ranking was then matched against the trainees' listed preferences in order of merit with trainees streamed into three streams: (1) CHC based FMP Year 2; (2) PG Diplomas at HNGV; (3) or finishing the program after one year and returning to their original posts. Following the final exam in July 2015, this system was implemented successfully (refer to *Context 2.1 New Minister of Health and revised priorities for health sector*).

Outcome One Rating

The results from end of Year 1 has demonstrated that the program remains on track in meeting its aim of training a cohort of junior doctors with adequate competencies and skills in community medicine. The program remains confident that it will be on track to meet the EoPO target with the first cohort pass rate exceeding the initial expected pass rate (94% pass rate compared to 75% expected target) and only 2 out of 38 FMP trainees failing FMP Year 1.

No outcome	Less than expected outcome	Expected outcome	Exceeded the expected outcome

3.2 OUTCOME TWO– Family Medicine Program Year 2

Approximately 35-40 FMP candidates have successfully completed Year 2 and graduated from the FMP demonstrating capabilities in clinical areas needed to work at the Community Health Centres.

Summary Analysis

Due to changes at the MoH including a new Minister of Health in February 2015, the program could not start early preparations for the implementation of the Year 2 training program, which was to commence in July 2015 (refer to *Context 2.1 New Minister of Health and revised priorities for health sector*).

The MoH was only able to provide two teaching CHCs in Dili instead of four teaching CHCs as required in the original FMP program design (two urban and two rural CHCs). Along with the withdrawal of the Cuban Medical Brigade as teachers / supervisors in the CHC rotations and a reduced number of teaching CHC sites, this meant the program had to significantly reduce the number of FMP Year 2 positions from 36 to 12. The trainees will now spend three four-month long rotations with two rotations at a CHC and the third rotation split between the NEC and MSI.

As previously reported, the withdrawal of the Cuban Medical Brigade from the partnership meant the program also had to investigate other options to ensure the trainees continued to receive good

community health training. Australian GPs will be engaged as Short Term Advisers to provide formal community health teaching to the trainees.

Despite the lower number of FMP trainees able to be accommodated, there are some improvements in the revised Year 2 program. The longer rotations at MSI and the NEC mean the trainees will get more exposure to those clinical areas as well as improve their general skills in family planning and ophthalmology. In addition, having the Year 2 rotational training program entirely delivered in Dili will make it easier for RACS to facilitate a high quality tutorial teaching program by experienced Australian GPs consecutively delivered over 12 months.

The next six month progress report will better capture how FMP Year 2 training program is tracking against the expected EoPO outcome indicators once the trainees have completed six months of the Year 2 training program.

Progress against ATLASS II – FMP – MEF *Outcome Indicators*

2.1 Percentage of FMP candidates who have successfully completed Year 2 rotations and demonstrate relevant capabilities across each subject area, by gender

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

As previously covered, the 36 FMP trainees who successfully completed Year 1 training were allocated to three streams following an end of year ranking process in July 2015. These trainees will form as the baseline for this indicator and their progress will be reported on in the next six month progress report.

2.2 FMP Year 2 Curriculum is relevant to Timor-Leste and approved by UNTL

Indicator data available – Yes / **No** Baseline data available – Yes **/ No**

Following the changes to the original FMP Year 2 program design, the curriculum will need to be substantially revised. A curriculum review will be held in early September 2015 with GPs from Australia to review the Year 2 curriculum (as well as the broader curriculum). There will be a focus on community medicine with input from community medicine experts and to ensure that the curriculum remains suitable to the Timorese context.

Starting in late July 2015, the program will teach the FMP trainees topics around family and community practice as part of the weekly tutorial teaching program.

2.3 The FMP Academic Coordination Committee reviews implementation and candidates' progress after each rotation and syllabus content at the end of each year

Indicator data available – Yes / **No** Baseline data available – Yes **/ No**

Outcome Two Rating

No outcome	Less than expected outcome	Expected outcome	Exceeded the expected outcome

3.3 OUTCOME THREE– Medical Education and Clinical Supervision

Timorese specialist doctors and senior Medico Geral have increased capacity to deliver the FMP curriculum and provide clinical supervision.

Summary Analysis

During this reporting period, the RACS clinicians continued to work closely alongside Timorese Consultants and senior Medico Geral[18] to deliver teaching and training activities. In addition to assisting with FMP program delivery, Timorese counterparts worked on strengthening their teaching skills and approaches in bedside teaching, ward rounds and case presentations.

To strengthen the Timorese faculty's teaching role in an assessor capacity, the RACS clinicians organised for several mid-level and senior Medico Geral as well as Timorese Consultants to assess the FMP trainees' rotation performances. This was important as by directly involving them in the performance review process, the Timorese doctors learn more about assessment of junior doctors. In a hospital setting where the three tier clinical hierarchy model was previously non-existent, this is a relatively novel concept. This assessment process will continue to be used in 2015/16 for all training programs.

> *'I do like supervising and teaching the FMP trainees. The assessment process is very fair and involves all aspects needed'* – Dr Celia Santos (Internal Medicine Consultant) on the FMP trainees and assessment processes.

A number of Timorese doctors also participated in a *Doctors as Educators* course delivered by trainers from National University Hospital in Singapore. Further analysis of this course is provided in *Outcome Indicator 3.2*.

Whenever the RACS clinicians do clinical work, a doctor (either an FMP trainee or mid-level doctors) is always allocated to work alongside them in the wards, theatres or in outpatient clinics.

Progress against ATLASS II – FMP – MEF *Outcome Indicators*

Indicator 3.1 Has the Timorese specialists and senior Medico Gerals' capacity to provide clinical supervision increased to HNGV Clinical Director's satisfaction?

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

An interview on the capacity of the Timorese specialists and senior Medico Gerals' to provide clinical supervision was conducted with Dr Joao Pedro Xavier (Clinical Director) in late July 2015. Dr Joao Pedro was asked a number of questions in relation to the performance of Timorese Consultants and senior Medico Geral in supervision of FMP Year 1 trainees. He expressed satisfaction with the new three tier clinical hierarchy model and other quality improvement activities noting that 'these are important improvements for our National hospital and health system. We all have to work together to ensure the cultural changes necessary actually happen'. He also stated

[18] Any Timorese doctor who holds an undergraduate medical degree and has not yet specialised.

that while the clinical supervision model has improved, the hospital still needs more time 'to strengthen this and make every doctor understand their role'.

Whilst Dr Joao Pedro had a number of concerns around some of the Timorese Consultants and mid-level doctors' ability to provide teaching and mentoring (given they have limited experience in teaching and mentoring), he believed that the new lines of supervision has led to improved accountability and communication. The program will continue to work with HNGV Executive at delivering more training workshops in 2015/16 focused on improving the Consultants and mid level doctors' teaching and supervision abilities.

Indicator 3.2 Percentage of Timorese clinical teachers/supervisors with improved confidence/skill levels after completing Trainer-the-Trainer course.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

A *Doctors as Educators* course was successfully delivered in June 2015 by trainers from National University Hospital in Singapore. This faculty had previously visited Timor-Leste to deliver a separate self-funded pilot course in *Basic CHC Management* to the FMP trainees in February 2015. Such was the success of that course that a decision was made to invite the faculty back to deliver a medical education course to the Timorese Consultants and mid-level Medico Geral to enhance their ability to function as teachers and supervisors to the junior doctors. It had been previously identified by Dr Jose Antonio Gusmao Guterres (Hospital Director) and Dr Joao Pedro Xavier (Clinical Director) that there were significant gaps in the Consultants and senior Medico Gerals' ability to teach the junior doctors, both in large and small group settings.

'*The presentation on role play was the most useful aspect of the workshop. I would like more workshops on how to teach junior doctors'* – Feedback from Dr Ifdefonso da Costa (mid-level doctor in Internal Medicine Department) on the *Doctors as Educators* course, June 2015

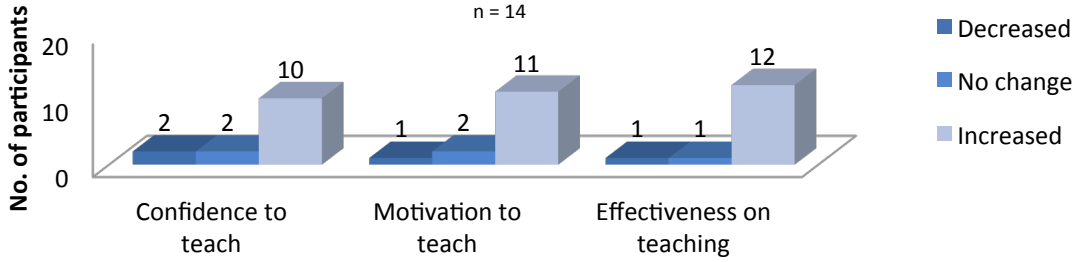
The course was designed for two separate levels – Consultants and mid-level Medico Geral. Following consultation with Dr Joao Pedro Xavier on preferred teaching topics and format, modules were then designed to focus on how to teach large and small groups as well as advice on lecture content and visual aids. In addition, a module on teaching in the clinical environment was also provided.

Feedback forms indicated that 85.7% of participants (12 out of 14 participants) rated overall reaction to the workshop as 'Excellent' or 'Good' and all participants (100%) indicated strong interest in additional workshops. As also evidenced in *Table 5: Participants' self-assessment of how workshop impacted on three teaching areas*, a strong increase in the participants' self-assessment of their teaching abilities was reported. The program will ensure that doctors continue to be provided with further short courses on teaching and supervision.

TABLE 5: Participants' self-assessment of how workshop impacted on three teaching areas

Doctors as Educators, 24 - 26 June 2015

n = 14



In addition to the *Doctors as Educators* course, the RACS clinicians encouraged and mentored Timorese Consultants and senior Medico Geral to continue to assist with teaching and training activities to FMP trainees and mid-level Medico Geral. Examples of best practice in teaching included role modeling and practical demonstrations on teaching and supervision strategies. Some examples where strengthened clinical skills teaching and leadership was evident during this reporting period include:

- Dr Jose Antonio Gusmao Guterres and Dr Joao Pedro Xavier were provided with support on resolving the industrial workplace issues around overtime and on call scheduling.
- Dr Joao Pedro Xavier and Dr Flavio Brandao (Head of Anaesthetics Department) have been working with the RACS Anaesthetist and RACS Surgeon on making *Safe Access to Surgery and Anaesthesia* a priority.
- Dr Alito Soares (ATLASS I scholarship recipient and Head of Emergency Department) assisted the RACS surgeon with tutorials for FMP trainees. He is one of the few Timorese Consultants actively contributing to the formal FMP teaching program with regular tutorials provided.
- Dr Saturnino Saldanha (Orthopaedic Surgeon and Head of Surgery Department at HNGV) delivered ward tutorials on orthopaedics to FMP trainees.
- Dr Joao Ximenes (Burns management and cleft lip specialist) regularly assisted the RACS Surgeon with teaching the FMP trainees on the wards in the Department of Surgery and in outpatient clinics. In addition, the FMP trainees assisted him with surgical procedures in the operating theatre.
- Dr Mingota da Costa (PG Diploma Anaesthetics) regularly delivered airway anaesthetics teaching to the FMP trainees in theatre. She also assisted the RACS Anaesthetist with research on post caesarean section anaemia which was presented at a *Grand Round* in April 2015.
- Dr Lyta assisted the RACS O&G with teaching the FMP trainees how to do vaginal deliveries on the wards. Out of all the mid-level doctors in the O&G Department, Dr Lyta was identified as the only doctor able to perform safe deliveries and was therefore an appropriate teaching model for the FMP trainees.
- Dr Rosye da Silva, Dr Maria dos Santos, Dr Dulce Pereira and Dr Carla Madeira (PG Diploma Paediatrics) regularly assisted the RACS Paediatrician with preparing PowerPoints and data audits for Morbidity & Mortality review meetings as well as with direct supervision of FMP trainees on the wards. In 2015/16, they will be actively encouraged to deliver formal teaching to the FMP trainees with support and guidance from the RACS

Paediatrician. These doctors have also received mentoring on doing their own timetabling for on call and ward rostering.

- Dr Alito Soares received support and mentoring from the ATLASS II Team Leader on chairing M&M audit and review meetings and other Emergency Director responsibilities in the Emergency Department.
- Dr Colombianus da Silva (PG Diploma Anaesthetics and currently undertaking his Masters in Medicine (Anaesthesia) in Fiji) was the course director for the two day *Primary Trauma Care*, delivered to FMP trainees in early February 2015.

An FMP trainee shown how to do intubation by Dr Colombianus da Silva at a Primary Trauma Care course, February 2015

Indicator 3.3 Percentage of FMP candidates who give a satisfactory or higher rating overall of Timorese teachers/clinical supervisors, FMP rotations, supervision and teaching.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

Analysis of FMP trainee feedback forms assessing respective rotations and teaching showed that the trainees were satisfied with the quality and delivery of the rotations as well as the overall training program. Both quantitative and qualitative answers were provided.

During this reporting period, 24 FMP trainees completed the feedback form for *Rotation Three,* 27 for *Rotation Four* and 22 for *Rotation Five.* Completion of the form is confidential and completely voluntary.

A snapshot of some qualitative feedback provided by FMP trainees revealed interesting insights:

1. *What do you think are the strengths of the FMP?*
    - The best thing about this Surgery rotation is that I can participate in theatre and learn how to perform some minor surgeries that GPs can do in districts.
    - I learnt a lot in this O&G rotation about how to be professional and responsible. Dr Flavia is very good and very dedicated to teaching us.
    - I really liked this Paediatric rotation because everything is well organised - the work, classes, shifts etc. Dr David is approachable anytime we need and guided us really well in this rotation. I got to learn more in detail about Paediatrics and I found it interesting, although 10 weeks is not enough time.

2. *What do you think are areas the FMP needs to improve on?*
    - Internal Medicine tutorials by Dr Sylvia are good but please choose one of the specialists in Internal Medicine to do FMP tutorials on the ward. Please change the Internal Medicine structure as it is not good.
    - I am uncertain for the second year of FMP program. It's really uncomfortable studying under unclear future.

The feedback from the FMP trainees has raised some valid concerns and criticisms. The program takes the trainees' feedback seriously and proactively tries to resolve the issues as highlighted earlier. In addition, during a review of the MEF templates in June 2015, the review team found the existing FMP Rotation Feedback form template to not provide enough satisfactory data to be able to properly analyse and interpret the feedback from trainees. Following discussions with the RACS clinicians, a decision was then made to overhaul the template to make it more suitable to the teaching context as well as more applicable to the FMP trainees (consultation with an English language teacher will also occur to ensure the language is clearly defined and suitable to the Timorese context). This will be piloted for the second intake of new FMP trainees.

The program is also cognizant that it is challenging to ask the FMP trainees to assess their Timorese teachers given the small cohort of Timorese teachers actively involved in the formal teaching program. However for the 2015/16 intake, the program will ask the second cohort of new FMP trainees to assess the Timorese mid-level doctors and Consultants' roles as teachers and supervisors in clinical practice (on the wards, in theatre and in outpatient clinics).

Outcome Three Rating

While the Timorese Consultants and senior Medico Geral continue to be actively mentored and encouraged to take a lead in teaching and training activities, this remains a long term process. At the end of Year 3 of the ATLASS II program, the program remains on track in strengthening clinical teaching and supervision at HNGV and is making satisfactory progress in encouraging a 'teaching hospital culture'.

No outcome	Less than expected outcome	**Expected outcome**	Exceeded the expected outcome

3.4 OUTCOME FOUR– CLINICAL GOVERNANCE AND TEACHING HOSPITAL

HNGV has strengthened clinical governance and increased capacity as a teaching hospital.

Summary Analysis

Clinical governance is an inherent feature of any teaching hospital worldwide. However this 'teaching hospital' approach remains relatively new to HNGV which is reflective of where Timor-Leste's health system is today. To ensure the development and embedding of HNGV as a teaching hospital, there is a need to introduce performance management mechanisms such as clinical governance and supervision.

> *'The new three tier clinical hierarchy model is very helpful for the system at HNGV. It has made it easier with rostering and supervision'* - Dr Saturnino Saldanha (Head of Department of Surgery) on three tier supervision model.

While the change of hospital executive administration in June 2014 has helped change some processes and systems to facilitate improvements and to strengthen HNGV as a teaching hospital, it remains a long term process given the 'medical culture' issues at HNGV as highlighted earlier. The relatively new HNGV Executive remains fully committed to embedding governance and supervision changes to help

them address issues around staff performance and clinical supervision. The three tier clinical hierarchy continues to be embedded in the Departments and is now recognised as an inherent feature of the hospital's structure with on call rosters also reflecting the three tier hierarchy.

The commitment to hospital improvements from HNGV Executive has extended to the request for technical advice from the RACS clinicians and Train-the-Trainer teaching faculties on managing poorly performing doctors. Accountability remains a core concern for the HNGV Executive and the program. However, while the HR issues of poorly performing medical personnel and staff accountability are recognised as key issues by HNGV Executive, they have difficulty implementing changes due to a number of issues. The lack of skills and experience in HR management amongst the HNGV Executive team; the long term nature of some issues and how they are firmly embedded into the hospital's existing medical culture; and the lack of clearly defined training pathways (i.e poorly performing staff are not able to moved on due to a lack of alternative options) are some of the issues.

During this reporting period, there have been renewed attempts to improve the clinical training pathways for all doctors, regardless of what training level they are at. This forms part of the broader attempt to offer all doctors opportunities to progress (based on merit) or be moved on if they are performing unsatisfactorily (so that their training position can be offered to someone else). One of the strong examples of change being driven by the HNGV Executive was the request to have all HNGV mid-level doctors sit the FMP selection exam in July 2015 (this same exam was developed for the second cohort of new FMP trainees) so that HNGV Executive could rank the mid-level doctors accordingly to their level of medical knowledge (either promote them to a new training position or be moved on elsewhere). While the program assisted with the supervision and marking of exam papers, this is very much an HNGV driven process that demonstrates the new and strong focus of the Executive team on performance management of the hospital's workforce.

The lack of any formal structure and arrangement between HNGV and UNTL to manage and deliver both undergraduate and postgraduate medical training remains a barrier to HNGV's progression to be a true teaching hospital. The program is hopeful that with the improved relationship between MoH and UNTL, there will now be some progress in formalising this relationship better.

Progress against ATLASS II – FMP – MEF *Outcome Indicators*

Indicator 4.1 A three tier clinical supervision hierarchy of junior Medico Geral, senior Medico Geral and specialists is in use at HNGV with appropriate lines of supervision and responsibility.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

The three tier clinical supervision hierarchy remains embedded in the departments where clinical services take place after being rolled out in July 2014. While there were some teething issues in the initial months, during this reporting period the lines of supervision between FMP trainees, mid-level doctors (who do first on calls) and Consultants (second on calls) are now established in the clinical departments and functioning well. The quality of supervision varies between departments but junior doctors in all departments are now more engaged with training opportunities in teaching

and supervision which demonstrates that they now recognise the broader benefits of improved supervision and teaching. The RACS clinicians have also reported that there is better accountability in ensuring quality patient care.

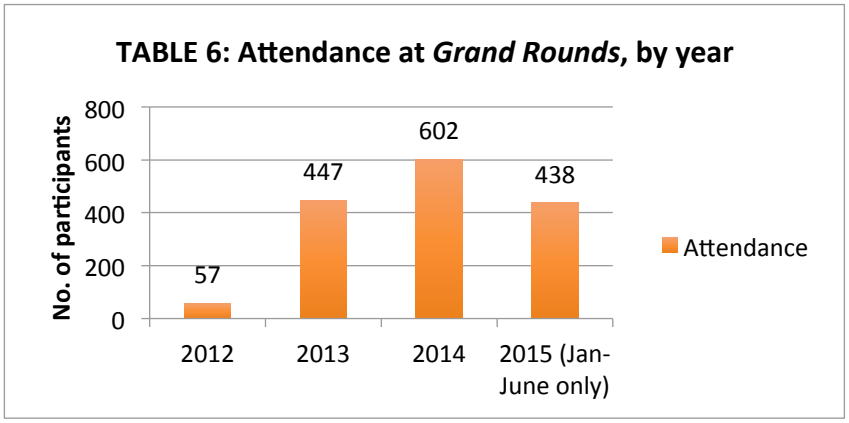
Indicator 4.2 (a) Grand Rounds increasingly led and coordinated by Timorese doctors; (b) number of participants at Grand Rounds, and (c) topics covered.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

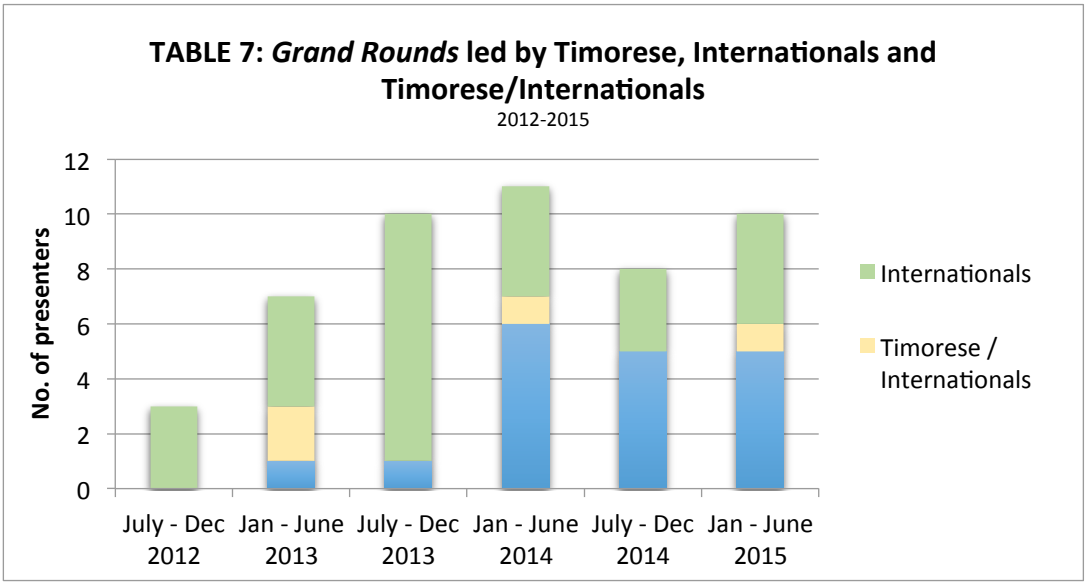
During the reporting period, 10 *Grand Rounds* were hosted by Timorese and international doctors and represented a range of diverse topics. Turnout continued to be excellent. Typically, a Timorese junior doctor would present the case, a mid-level doctor would discuss interesting aspects of the case and a Timorese Consultants would provide higher level teaching. Feedback and robust discussion from the audience is common at *Grand Rounds* and doctors now recognise *Grand Rounds* as a platform for interesting and informative discussions on clinical issues and patient safety issues.

'I think Grand Rounds are helpful for junior doctors and it adds to their knowledge. The discussions between all the doctors is also good' – Dr Joao Ximenes (Burns management and cleft lip specialist) on benefits of *Grand Rounds.*

The chart below demonstrates that attendance continues to be excellent and shows no sign of waning interest in *Grand Rounds*. It has gone from being held on a monthly basis since mid July 2012 to being held on a fortnightly basis from mid 2013 onwards (noting that some *Grand Rounds* are cancelled due to public holidays, conflicting hospital priorities or lack of preparation by presenting team).



In addition, *Grand Rounds* continued to be increasingly led by Timorese doctors during the reporting period compared to twelve months ago. It has now reached the point where the RACS clinicians no longer have to be the lead on *Grand Rounds*, which is crucial in ensuring the sustainability of this teaching and learning activity.



Indicator 4.3 Number of morbidity and mortality audits and review meetings held.

Indicator data available – **Yes** / No Baseline data available – **Yes** / No

Having morbidity and mortality (M&M) audit and review meetings is crucial in a 'teaching hospital' as a way to highlight clinical issues that may have had an adverse impact on the quality of patient care and for the clinical team to learn from these issues. In a hospital environment where accountability remains a core concern, having these meetings is beneficial in ensuring issues are not ignored or minimized and that clinical governance and quality assurance is maintained.

In April 2015, HNGV Executive requested help from RACS clinicians and St John of God Health Care (a health partner working at HNGV) to develop a hospital wide mortality reporting system. This was in response to a number of serious medication safety issues. A system of standardized data collection forms (with a standard classification of deaths including when there is a need for higher review) that collates data for all deaths in all departments was designed. All deaths are to now be reviewed at departmental level with key data collated and reported. Deaths classified as requiring a higher review would be referred to the HNGV Clinical Director. In late June 2015, the Emergency Department trialled the form using the mortality cases for June. Following this, the HNGV Clinical Director decreed to all heads of department that all departments must use this form as part of their mortality reporting. This is a positive step and will help ensure improved accountability at HNGV.

The Department of Paediatrics continues to have fortnightly audit and review meetings alternating between paediatric and neonatal cases. This is now accepted as a normal quality assurance practice by the Timorese doctors working in Paediatrics. The three PG Diploma Paediatric graduates continue to take the lead on presenting the M&M cases and discussing

'M&M meetings are important meetings and a good practice to learn case management by retrospectively discussing the mortality case. Knowing the prevalence of disease each month allows us to identify common diseases among children as well as the pattern of each disease' - Dr Rosye da Silva (PG Diploma Paediatrics) on the usefulness of M&M meetings in the Department of Paediatrics.

the findings and preventable steps that could have been taken, with assistance from the LTA Paediatrician.

In the Department of Surgery, there were monthly audit meetings during the reporting period. Dr Saturnino Saldanha, as the Head of the Surgery Department, was active in ensuring the meetings were held.

While there were strong plans to introduce formal M&M audit and review meetings in the O&G Department in early 2015, the current difficulties and existing culture in the department where there are no other teaching Consultants (with exception of RACS O&G) made formal audits difficult to implement as a teaching tool. Instead, the normal practice was to discuss any M&M cases at handover. The RACS O&G delivered a *Grand Round* on Maternal Mortality in May 2015 as a way to ensure the issues in the department were not minimized. Members of the HNGV Executive were in attendance at that *Grand Round* and made firm statements that M&M audits are necessary in all departments.

'These morbidity & mortality review meetings are important for our hospital as they help us learn from mistakes so we do better next time'. - Dr Alito Soares (Timorese Surgeon) on value of M&M meetings.

In the Emergency Department, there were two M&M meetings in March and June 2015. The June M&M data was used to trial the hospital-wide mortality reporting form.

Outcome Four Rating

While improvements in clinical governance, accountability and patient safety is marginally improving, it remains a long term process given the need to substantially change the hospital's existing 'medical culture'. *Grand Rounds* and M&M audit and reviews are now recognised as important teaching activities and are fully embedded. The strong stance taken by HNGV Clinical Director with regards to M&M auditing and reporting is a positive step towards improving accountability.

No outcome	Less than expected outcome	**Expected outcome**	Exceeded the expected outcome

5. EFFICIENCY

4.1 MANAGEMENT

Program Management and Quality Assurance

Despite the number of significant challenges and delays (covered in the *Context* section) during this reporting period, the program continued to perform in an efficient and effective manner as evidenced in two recent DFAT's overall assessments of the program - *Quality at Implementation* and *Partners Performance Assessment* (April 2015).

The program is overseen by program management staff in Dili and in Melbourne (RACS Head Office). In Melbourne, Associate Professor Glenn Guest (Clinical Director – voluntary) and Ms Daliah Moss (Director of External Affairs) continued to provide strategic oversight of the program.

At the RACS office at HNGV in Dili, Dr Antony Chenhall (ATLASS II Team Leader) coordinated and implemented the FMP training program in conjunction with the program support team.

In early July 2015, Associate Professor Glenn Guest and Ms Daliah Moss had a number of positive meetings with H.E Dr Rui Maria de Araujo, H.E Minister Ceu, H.E Australian Ambassador Mr Peter Doyle and DFAT representatives as well as other health partners working in Timor-Leste.

Program Governance

During this reporting period, the FMP Academic Coordination Committee met on five occasions to discuss rotation assessment results as well as end of year ranking and allocation to Year 2 training programs. In addition to discussion of assessment results, the Committee also reviewed the overall delivery of the FMP training program, including assessment procedures and curriculum.

In addition to the FMP Academic Coordination Committee, the program is also held accountable by RACS' internal governance mechanisms, namely RACS Global Health Committee, Professional Development and Standards Board and College Council.

Human Resources

Position / Specialty	Name	Dates
Team Leader / Emergency Medicine	Dr Antony Chenhall	1 January – 30 June 2015
General Surgeon	Dr Sayed Hassen	1 – 30 January 2015
	Dr Raj Dayal Singh	5 February – 30 June 2015
Anaesthetist	Dr Eric Vreede	1 January – 30 June 2015
Paediatrics	Professor David Brewster	1 January – 30 June 2015
Obstetrics & Gynaecology	Dr Flavia Horth	1 January – 26 June 2015
Ophthalmology (funded via Australian Avoidable Blindness Initiative)	Dr Manoj Sharma	1 January – 30 June 2015
Senior Operations Officer	Ms Karen Myers	1 January – 30 June 2015
Monitoring & Evaluation Officer	Ms Kate Moss	1 January – 30 June 2015
National Coordinator	Mr Sarmento Correia	1 January – 30 June 2015

4.2 COLLABORATION

During this reporting period, the program focused on strengthening and nurturing relationships with key national and international partners working in the health and medical education and training sector in Timor-Leste.

The program continues to have a strong relationship with HNGV Executive, regularly assisting, advising and supporting them on clinical governance and quality assurance issues concerning patient safety including through establishing committees around mortality cases, M&M data collection and medication safety. In addition, RACS clinicians have provided technical advice on a

number of major industrial issues such as overtime and rostering. The program also works closely with St John of God Health Care Timor-Leste, collaborating with them on issues concerning medication safety and M&M audits and data collection.

As part of the preparations for the Year 2 FMP training program, the program had a number of discussions with health partners MSI, NEC and PRADET who will be responsible for delivering specific training activities as part of the Year 2 curriculum. All three key partners have made firm commitments to deliver the training activities.

As an indication of the program's desire to pursue new opportunities, the program also investigated a number of opportunities with partners working in the private sector such as John Snow Inc (JSI) Research and Training, a private nonprofit company based out of United States. JSI was responsible for coordinating and implementing the Timor-Leste Health Improvement Project (TL-HIP) which supports the MoH in upgrading CHCs and providing training to health workers in three selected districts as part of the USAID health program. In collaboration with JSI, the program is investigating the possibility of having JSI support training at a rural CHC beyond 2015/16 when the second cohort of FMP trainees begin Year 2. Given that the MoH is only able to provide two Dili based teaching CHCs, exploring a partnership with JSI could be a good opportunity for ATLASS II to add a third rural based teaching CHC to the FMP training program.

The program also enjoyed developing a closer relationship with the National University Hospital (NUH) in Singapore. The program had a number of meetings with a representative from NUH where potential areas of collaboration were explored. As part of the discussions, the NUH offered to deliver a pilot *Basic CHC Management* course to the FMP Year 1 trainees at their own expense. The course was positively received by the FMP trainees and the program asked NUH to come back in June 2015 deliver a Train-the-Trainer *Doctors as Educators* course to the Timorese doctors. This was also well received. Discussions around other potential areas of collaboration are ongoing.

The Team Leader was invited to present on PG medical education in Timor-Leste at the Rural Health Conference in Darwin in May 2015 held by the National Rural Health Alliance. A number of contacts within the rural Australian GP community and the Australian College of Rural and Remote Medicine were made which has now led to opportunities in getting Australian GPs to assist with the community health medicine teaching aspects of the FMP Year 2 training program.

Another area of collaboration for the program was the Rotary *Safe Surgery* program which was implemented between 2013-2015 in collaboration with Rotary Club of Wellington (New Zealand). This project was focused on improving the perioperative nursing standards at HNGV Operating Theatres and continues to provide support to the nursing and sterilizing staff at HNGV.

As well as the ATLASS II program, RACS also implements a number of other activities in the health sector including a comprehensive eye health program (as part of the Australian Government's East Asia Vision Program (EAVP) which will no longer be funded beyond February 2016). The eye health program is now in the process of training four Timorese doctors in PG Diploma in Ophthalmology with another two Timorese doctors to commence in July 2015. RACS and the East Timor Eye Program Director, Associate Professor Nitin Verma, continue to advocate strongly on behalf of the National Eye Centre for additional funding post EAVP to ensure that the

important work of the eye program can be handed over to the MoH by 2017. This is part of RACS' wider efforts to develop and strengthen the health workforce in Timor-Leste.

Surgical clinical services delivered by visiting teams in Plastic and Reconstructive surgery, Paediatric surgery, Orthopaedic surgery and Ophthalmology are also provided under the RACS umbrella. These collaborations with Australian and New Zealand medical personnel are provided in a pro bono capacity and always incorporate a capacity building and mentoring focus with visiting teams working alongside national counterparts and trainees.

4.3 MONITORING & EVALUATION

Ms Jan Cossar, M&E Consultant, delivered an in-country visit to Dili in June 2015 to review the program's MEF, tools and data. While Ms Cossar was in-country, she and M&E Officer Ms Kate Moss had a number of discussions with key partners, including with Mr Dave Green, First Secretary Aid Management at DFAT Dili post. In light of the MoH's revised priorities, the program updated the MEF by revising some targets for the FMP as well as reinstating the original PG Diplomas EoPO (2012-2014) and outcome indicators.

Throughout the reporting period, Ms Kate Moss also attended a number of workshops hosted by DFAT Dili and external facilitators to identify ways and strategies for improving the program's monitoring, evaluation and learning approaches. In addition, regular discussions concerning some of the challenges with capturing the program's qualitative activities were also held with Mr Dave Green.

4.4 SUSTAINABILITY

While getting Timorese doctors to actively engage in teaching and learning activities remains a long term process, there is evidence that this is gradually improving. The mid-level doctors are now involved in supervising the FMP trainees on the wards whereas in the FMP *Surgery* rotations, three Timorese doctors are providing regular tutorials as part of the formal teaching program. In the O&G, Emergency and Internal Medicine Departments, none of the current Timorese doctors are at the required level to deliver the formal teaching program as they are either too junior (and therefore don't have the experience), they are too busy with other commitments or they have no interest in teaching. However in recent months, the program has identified a new Timorese doctor in the Internal Medicine Department who has recently returned to HNGV from Fiji to deliver ward tutorials to the second cohort of FMP trainees. In addition, the RACS Paediatrician has identified that the PG Diploma Paediatric graduates are now ready to take on some formal teaching activities in 2015/16.

One of best measures of sustainability in ATLASS II is the *Grand Rounds* teaching hospital activity, which is now fully coordinated and led by the Timorese doctors. At a recent *Grand Round* discussion on antibiotic resistance, discussions between several Timorese Consultants, including those on HNGV Executive, and mid-level doctors was particularly robust. This clearly demonstrates that the Timorese doctors' now have full ownership of *Grand Round* discussions.

> *'My opinion that all the teaching activities happening at HNGV like the Grand Rounds and M&M audits which RACS has introduced has improved quality services at this hospital. Hope all this will be continued and supported by RACS'*. - Dr Alito Soares (Timorese Surgeon) on RACS training activities

Another sustainable activity delivered by the program is the embedded three-tier clinical supervisory model and which is now evident in all the clinical departments. Despite accountability and performance management remaining core issues at HNGV (and which will remain a long term process), HNGV Executive and the RACS clinicians have reported that there have been significant improvements in supervision including in on call rostering.

By providing HNGV Executive regular opportunities to elicit advice on technical and performance management issues, the program is actively ensuring that the Executive team can participate in an open forum with the RACS clinicians. Providing strong support and encouragement to HNGV Executive is essential in allowing them to implement the necessary changes to the existing 'medical culture'. Changes in leadership behaviour are a step towards improving the overall clinical governance model, which will lead to improved patient care and professionalism amongst the HNGV medical community.

4.5 LESSONS LEARNT

As this reporting period saw the completion of Year 1 of the FMP training program, this has given ATLASS II a significant opportunity to review the program's progress, challenges and achievements, particularly given the change in the MoH's priorities (covered in *Context* section). As part of this ongoing monitoring and review, several lessons were identified and taken into consideration for Year 4 program planning and implementation.

FMP training program

- The comparison between the FMP baseline exam and end of Year 1 exam was significant as it demonstrated that the selection process for the first intake of FMP trainees did have an overall impact on the FMP training program. As the MoH provided 38 trainees (the program requested 40), all candidates were therefore accepted. Based on the baseline exam results, it was evident that there was a significant variation in ability and knowledge within the cohort. It is evident here that the trainees who performed well on the baseline exam are generally the trainees who have more ability and are keener to work harder and study more (and as testified by the RACS clinicians) and vice versa. This was also confirmed when the majority of those ranked in the bottom 12 – 15 at baseline performed poorly on the end of Year 1 exam (and did not progress to Year 2). This demonstrates the importance of having a well selected intake of junior doctors in order for the training program to have maximum impact. Had the program been able to apply a merit selection process to the first intake, these trainees would likely not been selected and the opportunity given to others. To avoid a repeat of this, the program has worked hard with the MoH to ensure that the second intake of FMP trainees was merit selected. At the time of the report submission, these efforts had paid off with the MoH advertising the training program widely, resulting in 77 candidates sitting the selection exam in late July 2015 and the top 40 candidates selected to undertake FMP Year 1 in 2015/16.
- English language proficiency also proved to be a significant factor in the comparison between baseline and end of Year 1 exams. Trainees who had been categorized as having poor proficiency in English language performed poorly on the baseline exam

whereas trainees who excelled at English language proficiency performed well on both the baseline and end of Year 1 exams. Despite weeks of intensive English language, the varying levels of the FMP trainees' English language proficiencies necessitated a need for the cohort to be categorised into four groups according to their level of proficiency. While some trainees' English proficiency improved over the year, a small group of trainees made little to no progress at all. When undertaking the selection of candidates for the second intake of new FMP trainees following their merit selection ranking, for the final few places, the program selected candidates who had similar results on the medical exam but had better English results. It was also decided that the new trainees should be given three weeks' English language intensive classes to ensure that the trainees have better preparation prior to commencing Year 1. The program has accepted that this will result in delays but recognises that this is an important first step in the successful delivery of the training program.

- While the gender balance was not achieved with the first cohort with 9 females to 29 males, the nine female trainees performed well in the overall training program (with the exception of one female). Interestingly, at the baseline exam, the females' results were not evenly distributed in the baseline ranking but were predominantly ranked in the upper echelon of the overall ranking. By the time the trainees had completed Year 1, 3 of the 9 females progressed into the PG Diploma training stream (1 in Anaesthetics and 2 in Paediatrics), 4 progressed into FMP Year 2 and 2 are returning to their original CHC posts (one elected to return to the CHC despite being ranked as 5 out of 36 on the final ranking and one because she did not pass the merit process). For the second cohort of new FMP trainees, there were 35 female applicants out of 77 applicants with 19 females successfully passing the merit process and selected for the second intake. Of the 19 females, 9 were in the top 20, which bodes well for their progress over the course of their training, based on previous experience with higher performing female trainees from 2014/15.
- Out of the 9 females in FMP Year 1 in 2014/15, 3 took maternity leave for 10 weeks, yet all 3 returned to the training program following their maternity leave signifying a strong interest in continuing with their FMP studies. The trainees were not penalized for taking maternity leave in that they were not requested to repeat their missed rotations. That these three trainees still finished in the top half of the 36 trainees is an impressive achievement. This is consistent with their baseline scores and likely reflects that they were strong candidates. It is also a testament to the program's active efforts to ensure they were not discouraged from re-commencing their studies.
- Given that there will be 19 females in the second intake of FMP trainees, it could be reasonably assumed that a number of them will be taking maternity leave in Year 1. They will continue to be supported to undertake their studies in a flexible way to ensure completion. The program will actively monitor this in 2015/16.

HNGV

- The relationship between HNGV and the program remains strong. The improved leadership and dialogue from HNGV Executive on issues around performance management, clinical governance and quality assurance is of mutual benefit to the

program. However it has become clear during the reporting period that HNGV completely relies on the clinical services provided by the RACS clinicians in order for the hospital to function. The dependence on the RACS clinicians to provide service delivery was exacerbated by the industrial dispute between the Timorese Consultants and the MoH regarding on call scheduling and overtime as highlighted previously. Initially, the RACS clinicians were accommodating of HNGV's needs as the program believed it was better to have a hospital with a functioning clinical service delivery where patient care was not compromised (and also did not want to alienate the HNGV Executive). However the onerous on call commitments had an adverse impact on the RACS clinicians' teaching activities and so the program lodged strong protest letters with HNGV Executive. On reflection, RACS accommodating HNGV's needs for several months likely meant that the hospital actually postponed resolving the industrial issues.

4.5 CROSS-CUTTING ISSUES

RACS Global Health has a number of cross-cutting issues that are taken into important consideration as part of its international development and advocacy work. These policies can be referred to in the FMP program design. A snapshot of some cross-cutting issues are listed below:

Gender

Gender equity is an important issue for the program and it has made efforts to ensure that gender is appropriately and adequately addressed across the program, including in the selection of new trainees.

As part of the discussions with H.E Minister Ceu, the program flagged the need to ensure there was a better gender balance for the second intake of new FMP trainees to ensure better representation in the training program as well as reflect the priority of gender equity and participation for the Australian Government and for ATLASS II. H.E Minister Ceu fully supported this and of the final 40 candidates in the second cohort of new FMP trainees, there were 19 females which is a pleasing result.

Out of the nine females who completed FMP Year 1, three females went on maternity leave. All three returned to the training program following their 10 week maternity leave. Considerations had been made for these trainees as the program was conscious that these trainees had additional family responsibilities outside of the training program.

In addition, out of the nine females in the first intake of FMP trainees, four were ranked in the top 10 with another four ranked between 10 - 20. Only one female did not progress (finishing 35 out of 36 FMP trainees) and was therefore returned to her original CHC post. This is a remarkable achievement in light of some of the females' absences from the training program due to maternity leave as well as vast gender disparity. Three of the nine females elected to go into the PG Diplomas (1 in Anaesthetics and 2 in Paediatrics). Another three could have gone into the PG Diploma training program had they wished but elected not to apply for PG Diplomas (one elected to return to her original CHC post and two elected to continue with FMP Year 2). The program will monitor this for the 2015/16 intake and do further research on the rationales behind these females' training choices.

Disability Inclusiveness

ATLASS II is focused on ensuring that the program is cognizant of the challenges with regards to inclusion and access faced by people with disabilities. The Team Leader and M&E Officer met with a technical advisor from CBM (funded as part of DFAT's Disability Inclusion funding stream) to identify opportunities where the program could deliver training on disability inclusion to the FMP trainees as part of the overall training program. A number of discussions ensued and the program is now looking at having CMB (or a relevant national implementing partner) deliver a short course on disability inclusion to the Year 2 FMP trainees in early 2016.

RACS also has a policy on disability inclusiveness as part of the RACS Global Health's portfolio of policies around cross-cutting issues.

4.6 ISSUES & RISKS

The ATLASS II Program Management team continues to actively monitor issues and risks on an ongoing basis. Please see attached *Annex 2 Risk Management Matrix* for an updated summary of risks realized and newly identified during the reporting period. Some of these have been highlighted in the context section above. Where the issues are serious and/or were having an adverse impact on the program's activities, the program kept DFAT Dili regularly informed.

While some issues such as the relationship between the MoH and UNTL are ongoing and are beyond the program's scope and ability to resolve, the program still actively tries to encourage all parties to resolve issues through regular and effective meetings.

Due to the change in the MoH's priorities and the unreadiness of the teaching CHC sites, there was the possibility that the FMP training program would have to stop at the end of June 2015 and there would be no further intakes. This would have significantly impacted the delivery of PG medical education and training in Timor-Leste. The program presented the MoH and DFAT with several options for future PG medical education and training, utilising existing resources. It has been able to minimise the risks by coming up with alternative strategies that were in line with the MoH's revised priorities and met DFAT's priorities. This proved to be a successful strategy.

6. FINANCIAL SUMMARY

TABLE 8: ATLASS II financial summary update

CONTRACT 63702
AUSTRALIA – TIMOR-LESTE PROGRAM OF ASSISTANCE IN SECONDARY SERVICES – PHASE II

PROGRAM EXPENDITURE SUMMARY

CLAIM SUMMARY AS AT 30 June 2015

LINE ITEM/DESCRIPTION	FY 2014 - 2015		YEAR 3 BALANCE
	YEAR 3 BUDGET	YEAR 3 ACTUAL	
Long Term Adviser Fees	997,938	982,952	14,986
Short Term Adviser Fees/Honorarium	31,412	30,894	517

Adviser Support Costs	221,274	212,759	8,515
Locally Engaged Staff	16,640	14,467	2,173
Program Operation	233,978	206,983	26,995
Management Fees	272,025	272,025	0
T O T A L	**1,773,267**	**1,720,080**	**53,187**

7. REFERENCES

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ANNEX 1 - FMP Year 1 Overall Performance

No.	Name de-identified	Sex	DISTRICT	ENGLISH %	ENTRY-EXAM MEDICINE %	ROTATION 1	Comment	ROTATION 2	Comment	ROTATION 3	Comment	ROTATION 4	Comment	ROTATION 5	Comment
1432		M	Manufahi	90	72	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS
1428		M	Manatuto	80	62	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS
1427		M	Ainaro	76	58	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS
1416		M	Viquque	90	57	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1439		F	Ermera	77	55	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS
1403		M	Manufahi	57	52	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1438		F	Dili	96	61	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS
1413		F	Baucau	80	52	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1409		F	Ainaro	71	49	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1406		M	Dili	90	48	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1402		F	Oecusse	65	35	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1401		F	Ainaro	70	55	Emergency Medicine	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	Maternity Leave	Surgery	PASS
1437		M	Lautem	62	53	Emergency Medicine	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	FAIL	Surgery	PASS
1412		M	Baucau	62	57	Emergency Medicine	FAIL	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS
1417		M	Lautem	64	54	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	FAIL	Internal Medicine	PASS
1420		M	Manufahi	67	37	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1429		M	Baucau	56	42	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1425		F	Ermera	77	52	Surgery	PASS	Emergency	PASS	Paediatrics	Maternity leave	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1431		F	Dili	82	45	Emergency Medicine	Maternity leave	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	FAIL	Surgery	PASS
1410		M	Baucau	60	45	Emergency Medicine	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS
1414		M	Ainaro	64	43	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1433		M	Lautem	61	41	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS
1404		M	Bobonaro	71	46	Emergency Medicine	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS
1422		M	Aileu	65	40	Emergency Medicine	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	FAIL	Surgery	PASS
1411		M	Manatuto	54	39	Surgery	PASS	Emergency	PASS	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS
1405		M	Baucau	45	34	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	FAIL	Internal Medicine	PASS
1434		M	Manatuto	55	27	Paediatrics	FAIL	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1435		M	Viquque	70	39	Paediatrics	FAIL	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1423		M	Bobonaro	72	39	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS
1419		M	Manatuto	54	36	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1418		M	Covalima	73	33	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS
1421		M	Lautem	52	29	Paediatrics	FAIL	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS
1430		M	Covalima	74	44	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS
1408		M	Oecusse	72	38	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	FAIL	Internal Medicine	PASS
1436		F	Oecusse	49	33	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	PASS	Emergency	PASS	Paediatrics	PASS
1407		M	Bobonaro	33	33	Internal Medicine	PASS	Obstetrics & Gynaecology	PASS	Surgery	FAIL	Emergency	PASS	Paediatrics	PASS
1426		M	Covalima	56	38	Obstetrics & Gynaecology	FAIL	Surgery	FAIL						
1415		M	Ainaro	87	56	Emergency Medicine	FAIL	Paediatrics	PASS	Internal Medicine	PASS	Obstetrics & Gynaecology	FAIL		

Annex 2 Risk Management Matrix

	Risk	Likelihood	Impact	Explanation	Responsibility	Mitigation Strategy
	FMP Specific Risks					
1	MoH does not provide sufficient number of appropriate trainees for the FMP.	Likely	Moderate - High	Depending on how few trainees are available for selection, this could lead to a smaller cohort of trainees starting and shorter rotations.	MoH, RACS	Work closely with MoH to ensure that trainees are aware of FMP and given adequate notice of selection taking place. Work closely with MoH to strengthen selection processes for future cohorts.
2	Some activities e.g. selection of trainees, trainees not relocated to HNGV in time, will not be completed in time and may affect rotations starting on time.	Likely	Low	The short lead time to select trainees and then give them 3-4 weeks' English language intensive may mean the rotations are shortened. While rotations may be shortened, this should not affect the delivery of the program.	MoH, RACS	The second cohort of new FMP trainees commenced English language training on 20 July 2015. Any subsequent delays may be addressed either by shortening the length of the Year 1 rotations or completing the delivery of the second cohort of Year 1 FMP trainees' final rotations after June 2016.
3	Selection and refurbishment of CHC rotation sites will not be completed on time and may affect the delivery of Year 2 rotations	Likely	High	Year 1 activities are mainly based at HNGV. For Year 2 rotations, the MoH was only able to provide two teaching CHCs (Comoro and Vera Cruz).	MOH	The number of FMP Year 2 positions was reduced from 36 to 12 training positions. The revised Year 2 structure now includes three four-month long rotations at CHCs (two placements each) and another rotation split between Marie Stopes International and National Eye Centre. For the second intake of FMP students (finishing Year 1 in June 2016), the MoH will need to identify two additional teaching CHCs (rural based preferably) to accommodate the second intake of FMP trainees. RACS will work closely with the MoH in 2015/16 to try to ensure that these sites are ready well in advance.

Annex 2 Risk Management Matrix

	Risk	Likelihood	Impact	Explanation	Responsibility	Mitigation Strategy
4	An appropriate junior Medico Geral workforce structure and associated rostering of the FMP trainees at HNGV and teaching CHCs is not established early in the delivery of the program and/or does not continue.	Unlikely	High	The appropriate workforce structure (3-tiers) is essential to delivery of the program and as such is listed as a program outcome.	MoH, HNGV, RACS	The three tier clinical hierarchy model, introduced in July 2014, is well embedded in the clinical departments and is fully supported by HNGV Executive.
5	Hospital departments do not have enough senior Medico Gerals and Consultant rostered appropriately to provide supervision to FMP trainees and this has an affect on the provision of an adequate standard of patient care.	Likely	Moderate	Patient safety, service delivery and quality of care must not be compromised. The number of Consultants, mid level and senior Medico Geral and FMP trainees needs to be evenly balanced to ensure adequate supervision.	HNGV Executive / MoH	The three tier clinical hierarchy model was rolled out in July 2014 and is now fully embedded in all the clinical departments. There are clear lines of communication between Consultants, Medico Geral and FMP trainees which has lead to improved accountability.
5.1	Hospital departments do not have enough senior Medico Gerals and Consultants with appropriate supervision and teaching skills rostered appropriately to provide supervision to FMP trainees and this has an affect on the quality of teaching and supervision available to FMP trainees.	Likely	Moderate	There need to be enough senior Medico Gerals and Consultants available in each department so that FMP trainees are adequately supervised. In addition, senior Medio Geral and Consultants also need to be able to provide appropriate levels and quality of supervision to the FMP trainees	HNGV, MoH, RACS	At FMP Academic Coordination Committee meetings, staffing levels in each of the rotation specialities was reviewed and confirmed that supervision was adequate. RACS has organised (and will continue) Train-the-Trainer courses for the Consultants and Medico Geral. The medical education courses are designed to equip them with tools and strategies for teaching and supervision.
6	In support of the revised doctor structure, there will be a need for appropriately trained nurses to adequately staff the departments at HNGV and at the CHCs.	Possible	Low	This is important both for patient safety / service delivery and to support training program.	MoH	St John of God will be responsible for the training of the nursing staff but it will be MoH responsibility to ensure that appropriate levels of nursing staff are released for training and subsequently posted to areas of need.

Annex 2 Risk Management Matrix

	Risk	Likelihood	Impact	Explanation	Responsibility	Mitigation Strategy
7	The Hospital Executive and Departments do not place adequately prioritise adjuncts of a teaching hospital. e.g. Grand Rounds and M&M audits and reviews.	Unlikely	Moderate	These teaching activities are instrumental to the development and strengthening of a teaching hospital and will ensure that FMP trainees are exposed to best clinical practice as they progress through the FMP.	HNGV Executive / HNGV Department heads	These activities need to be given priority by the hospital and department leadership. Attendance at these unit and hospital wide meetings must be compulsory for all junior and senior Medico Geral and Consultants as decreed by HNGV Executive. Grand Rounds have been supported by RACS since the beginning of ATLASS II and have become part of the hospital system. RACS will continue to support these to ensure that they remain part of the system over the course of the FMP and beyond.
8	The FMP relies on collaboration with a number of key program partners, the program may be severely affected if one of the program partners pulls out or is unable to fully deliver the aspects of the FMP assigned to them.	Likely	Moderate - High	The FMP is designed as a collaborative partnership between numerous partners. If one of the partners pulls out, this will have a moderate to high impact of the delivery of the program.	All program partners, RACS, MoH, DFAT	The Cuban Medical Brigade withdrew from the partnership in July 2014 (they were to be responsible for delivery of Internal Medicine rotation and Year 2 CHC teaching / supervision. RACS trialled several options for the Internal Medicine rotation until a viable solution was identified. For the Year 2 teaching, RACS will be overseeing the teaching by recruiting Australian General Practititioners to deliver a formal teaching tutorial program. The FMP Academic Coordination Committee meetings also continues to regularly monitor program planning and policy context to ensure program remains closely aligned with the MoH priorities. If necessary, find alternative partners to deliver aspects of course.

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9	The teaching CHCs are not adequately resourced and maintained	Possible	Moderate	Two Dili based (Comoro and Vera Cruz) have been identified by the MoH as responsible for delivery of Year 2 CHC rotations.	MoH	RACS has outfitted and equipped the two CHCs with teaching resources. Continue to work with MoH to identify another two rural based CHCs for the second intake of FMP trainees (for 2016/17).
10	The career path for junior doctors is not adequately defined, changes over the course of the FMP, and/or successful trainees are not placed by the MoH at a CHC or equivalent position	Possible	Moderate	The possible career paths for junior doctors and where the FMP fits, needs to be clearly explained to potential trainees so they make an informed choice when applying. They need to know what effect participating in the training program will have on their career path and prospects over the course of the two year program and beyond.	MoH, RACS	Due to revised MoH priorities, not all FMP Year 1 trainees were able to be accommodated in the Year 2 training program and some trainees were asked to return to their original CHC post as requested by the MoH. RACS to continue discussions with MoH about various training options for 2016/17 to ensure future intakes are given options.
11	MoH and HNGV do not agree to put in appropriate performance management systems for junior and senior doctors.	Possible	Moderate	If FMP trainees who are not meeting expectations are allowed to continue on in the program this will have consequences for patient safety and will impact on the effective delivery of the program to other students.	RACS, MoH	In FMP Year 1 (2014/15), two trainees were excluded from the training program following a performance review. Their final assessments were robustly discussed by the FMP Academic Coordination Committee and the MoH unanimously agreed with the academic assessement outcome. This academic process will continue in

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	Risks related to Program Implementation					
12	RACS Clinicians time is spent on service delivery that does not have a teaching focus or other capacity building purpose	Possible	High	Clinical services delivered by senior doctors (e.g Timorese ConsuCliniciannts, RACS Clinicians, Senior Cuban doctors) form part of the daily teaching of the other doctors on the ward/in the departments (i.e. FMP trainees, senior Medico Geral, other junior doctors). There are shortages of appropriately qualified specialist doctors and RACS Clinicians are expected to help share service delivery, including being on-call. There are rare circumstances where Clinicians may deliver services and there are no junior or trainee doctors present to observe, assist or otherwise learn. Situations where service delivery is conducted without a training / teaching / supervision component are very rare given the large number of junior doctors in every department at HNGV.	MoH/RACS	RACS Clinicians' Terms of References are primarily focused on capacity building. Clinicians are required to report on contributions to end-of-program outcomes. RACS Clinicians are encouraged to (and are conscious of doing so) report on situations where there is no trainee or junior doctor allocated, particularly if due to rostering issues. If these situations arise, the program will advise HNGV Executive on rostering and student allocation so that trainees are present when RACS Clinicians are rostered. In 2014/15 there were times when the HNGV on call roster was unfairly skewed towards the RACS clinicians which had to potential to disrupt the teaching responsibilities of the RACS clinicians. RACS actively engaged with the HNGV Executive and MoH to voice concerns about the onerous on call requirements and its impact on teaching. The program will continue to monitor this in 2015/16.
13	MoH priorities change and the FMP is no longer the preferred model for ATLASS II to implement.	Possible	High	This is possible - particularly if there is a change of government or Minister.	RACS, DFAT	Following Timor-Leste Government changes in February 2015, RACS met with the new Minister of Health and updated her on the program's activities. The Minister requested some changes to the Year 2 training program which RACS accommodated by redesigning the Year 2 program and curriculum. RACS and DFAT need to monitor the program's context and remain responsive to changing MoH priorities.

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14	The proposed activities do not result in the expected program outcomes	Unlikely	High	The FMP has been designed based on the identified clinical skills requried for junior doctors to work in the CHCs. Training and teaching activities have been designed to address this need.	RACS, MOH	Ongoing review of the program / curriculum will be undertaken by the program and the FMP Academic Coordination Committee to ensure that the activities continue to be the most suitable approach to achieving the intended outcomes. Training activities will be modified if required as directed / agreed by MoH / HNGV and negotiated with DFAT.
15	An appropriate junior Medico Geral workforce structure and associated rostering of the FMP trainees at HNGV and teaching CHCs is not established early in the delivery of the program and / or does not continue.	Possible	High	Inadequate comprehension for knowledge transfer or supervision, mentoring. Challenges for coordination due to the different languages used in the hospital environment (Tetun, English, Spanish)	UNTL, RACS, MOH, clinical supervisors.	Prior to commencing FMP Year 1 training program, trainees are provided with 2-3 weeks' English language intensive. They are also provided with regular English language classes throughout the year. The use of English exam as part of the selection process to complement the medical exam has ensured that trainees have a high level of English proficiency than previously.
16	Program unable to identify appropriately qualified and experienced Clinicians who are able to relocate to Timor-Leste for at least 2 years	Possible	High	Potential disruption of teaching, mentoring and supervision relationships with FMP trainees, senior Medico Gerals and Consultants and in relationship with MOH.	RACS	Current RACS Clinicians have all committed to staying with the program for the longer term. RACS also has a bank of volunteer clinicians from which to draw short-term cover for Adviser positions if necessary.
17	Complaint made against a RACS Clinician regarding patient care.	Possible	High	This is an issue because there is no medical board or other body qualified to adjudicate.	RACS, DFAT, MoH, Hospitals	As part of recruitment and ongoing management processes, ensure that all RACS Clinicians and volunteers have appropriate qualifications, medical registration and good standing (both for Timor-Leste and all countries where they have previously practiced), medical indemnity insurance, and are up to date with CPD.

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18	A RACS Clinician is involved in a case where there is a bad patient outcome.	Possible	Moderate	This is an issue because there is no medical board or other body qualified to adjudicate.	RACS, DFAT, MoH, Hospitals	Ensure that all RACS Clinicians and volunteers have appropriate qualifications, medical registration and good standing (both for Timor-Leste and all countries where they have previously practiced), medical indemnity insurance, and are up to date with CPD.
	Financing and Financial Risks					
19	New / amended training activities to achieve desired outcomes are unable to be delivered because of budget contstraints (see Risk 14).	Possible	High	The RACS components of the FMP were designed based on the existing ATLASS II budget for Years 3 and 4. The training activities were based on identified needs in the lead up to implementation. Under resourcing is a common occurrence in any program where a lot of variables are unknown due to the constant contextual and environmental factors.	RACS, DFAT, MoH, Hospitals	Flexibility in contract arrangements allowing budget line item re-allocation to ensure that activities can be modified to best address partner delivery requirements if required.
20	Program funds are fraudulently diverted	Unlikely	High	DFAT and RACS have a zero-tolerance approach to fraud. Fraudulent use of funds may jeopardise the future of the Program; and/or attract legal action.	RACS	Clear communication as to position on fraud and reporting requirements; high-level financial checks and limitations in place including regular account reviews.
	External Risks					
21	Emergence or re-emergence of epidemic or pandemic threat	Possible	High	Could overwhelm health services, result in social and civil disorder, potentially resulting in diversion of significant program resources or suspension (or even cancellation) of program	RACS, DFAT, MoH, Hospitals	National pandemics and emerging infectious diseases preparedness plan in place, updated in response to 2009 H1N1 influenza pandemic. RACS and MoH to work pro-actively with WHO to maintain service provision as much as possible while addressing direct consequences of pandemic.

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22	Political and/or civil and /or military instability	Unlikely	Moderate	Could disrupt health services, and potentially result in suspension (or even cancellation) of some aspects of Program. When faced with similar challenges in 2006-07, ATLASS was able to maintain both capacity development and service delivery with little impact on program model (even though HNGV was disrupted by large displaced persons camp on-site until 2009).	RACS and DFAT	Beyond control of program management; staff security plan and contingency plan developed under ATLASS (and still relevant), and security risks reviewed regularly. ATLASS II Program Management to analyse contextual issues that could affect program performance annually and advise any necessary modification of design or implementation methods (including feasibility of travel to or periods of residence in districts).