# Australia Timor-Leste Program of Assistance for Specialised Services (ATLASS)

# ING418

# INDEPENDENT PROGRESS REPORT

**November 2010**

**Disclaimer:** The views in this report are those of the evaluation team and not necessarily those of AusAID.

## Aid Activity Summary

| Aid Activity Name | Australia Timor-Leste Program of Assistance for Specialised Services (ATLASS) | | |
|---|---|---|---|
| AidWorks initiative number | ING418 | | |
| Commencement date | 1 October 2006 | Completion date | 30 June 2011 |
| Total Australian $ | $8,149,666.00 | | |
| Implementing Partner(s) | Royal Australasian College of Surgeons (RACS) | | |
| Country/Region | Timor-Leste | | |
| Primary Sector | Health | | |


## Acknowledgments

The evaluation team would like to acknowledge the logistical support provided by Armandina Amaral, Natalie Mckelleher and Miriam Smith at AusAID Dili Post, and from the ATLASS team, to the in-country missions. We would like to thank everyone who generously provided their time and input as part of the consultation process, including comments on the initial Aide Memoire and subsequent draft evaluation report.


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# Acronyms

| | |
|---|---|
| AETSSP | Australia East Timor Specialised Services Project |
| ATLASS | Australia Timor-Leste Program of Assistance for Specialised Services |
| AusAID | Australian Agency for International Development |
| ENT | Ear, Nose and Throat |
| EOC | Emergency Obstetric Care |
| FSM | Fiji School of Medicine |
| HNGV | Hospital Nacional Guido Valadares |
| HSSP | Health Sector Strategic Plan |
| HSSP-SP | Health Sector Strategic Plan – Support Project |
| HIS | Institute of Health Sciences |
| LTA | Long-term Adviser |
| M&E | Monitoring and Evaluation |
| MNCH | Maternal, Neonatal and Child Health |
| MoH | Ministry of Health |
| PMC | Program Management Committee |
| PRET | Program Review and Evaluation Team |
| RACS | Royal Australasian College of Surgeons |
| SDP | Strategic Development Plan |
| SWAp | Sector Wide Approach |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNTL | National University of Timor-Leste |
| UPNG | University of Papua New Guinea |
| WHO | World Health Organisation |

# Contents

# Executive Summary

### Background and Context

ATLASS is a 4.75 year program (2006-2011) delivered by the Royal Australasian College of Surgeons (RACS). RACS have provided support for specialist surgical services in Timor-Leste since 2001, initially delivered through the Australia East Timor Specialist Services Project (AETSSP) 2001-2006. Both programs were initiated at the request of the Ministry of Health to address short falls in the provision of surgical services and to establish standards for clinical care.

The overall purpose of the program is to improve the availability and quality of essential general and specialist surgical services for the people of Timor-Leste. This was intended to be addressed through three main components: long-term advisors mentoring and training for surgical, anaesthetic and nurse anaesthetist trainees; short-term specialist visits; and creating linkages between Timorese and international institutions.

### Key Findings

In the context of post-conflict Timor-Leste, there is still limited national capacity to deliver services for treatable surgical conditions. The need for specialist services of a high quality at tertiary (national) and secondary (district) levels in the health system therefore remains highly relevant. At the same time ATLASS is less well positioned to make a significant contribution to joint Government priorities toward improving basic health services for women and children. And the scale of its contribution has diminished in the context of a large number of returning Cuban-trained Timorese doctors.

ATLASS has provided a very high quality of continuous clinical cover at the National Hospital. The contribution of short-term specialist visits is equally highly valued and contributes to district level health improvements otherwise unavailable. Important capacity development achievements have been made, particularly in providing pre- and in-service training to nurse anaesthetists who are responsible for ensuring safe anaesthesia services across the country.

The program has been less successful in producing the expected cohort of formally accredited specialist trainees, and has at times struggled to balance clinical service delivery pressures with formal training requirements and consistency of mentoring. There have been promising examples of institutional linkages, as with the St Vincent's Emergency Department, but the majority of activities have not been strategic and enduring. Anaesthesia services and ophthalmology capacities are likely to be sustainable; however additional support for specialist trainees and managing short-term visits will be required in the future.

ATLASS has performed well in implementing its activities in the context of continual socio-political unrest in Timor-Leste. The program has generally made efficient use of time and resources, especially for anaesthesia services and short-term sub-specialty visits. The latter have been managed extremely well with minimal disruption to district hospitals and are highly cost-effective as specialist team members are volunteers and costs relate to mobilisation and medical disposables only.

However, implementation progress has been hampered by difficulties in recruitment of the two LTA general surgery positions. This has impacted on program effectiveness through a lack of continuity to fully support and mentor the Head of the Surgical Department and surgical trainees, and increased the costs to deliver the same services. Institutional linkage activities overall have been fragmented and disbursed only one-fifth of their expected budget.

Men and women have equally benefitted from the program but it has not been successful with selection of female trainees. Despite improvements in the monitoring and evaluation framework, it remains unnecessarily complex, collating an excess of information, without attention to that which is most important, namely measures of capacity outcomes. ATLASS has performed well in terms of real-time analysis and learning, demonstrated by its responsiveness to recommendations to address training needs for district-based doctors, support emergency medicine and reduce its focus on nursing support. But long-term difficulties in recruitment affecting both AETSSP and ATLASS suggest the need to explore new strategies.

**Recommendations**

Further support for the development of specialist surgical and anaesthetic services in Timor-Leste beyond ATLASS remains relevant in the development context. At the same time, ATLASS, in its current form, makes only a limited contribution to the explicit stated priorities of the Australia-Timor Leste Country Strategy and the Timor-Leste Strategic Development Plan 2011-2030. Therefore any recommendations for future support must negotiate and trade-off these tensions to some degree. We explore three possible options below:

**Option 1: A one-year extension of the current ATLASS program with no further support to specialist services beyond mid-2012**

This option is designed to protect the sustainability of investments to date but recognises the limited contribution that ATLASS can make to significantly improving MNCH outcomes at district-level. It is proposed that the Governments of Australia and Timor-Leste should explore alternative investments to influence MNCH outcomes at district-level.

An extension would result in completion of external accredited training and support to the subsequent re-entry of the Timorese trainee surgeon at UPNG, and Timorese trainee anaesthetist at Fiji School of Medicine (FSM), due to return to the National hospital at end of 2010 and end of 2011 respectively. It would also support the completion of the training of the final cohort of six nurse anaesthetists through a one year course at HIS (to be completed mid 2011) and in-service support for the initial year of posting.

*Not Recommended*; this is not recommended as it ignores the clear preferences from the MoH for continued support in the area of specialised services (particularly short-term visits).

**Option 2: A new five-year program of specialised services with a more selective focus**

This option recognises the preferences of the MoH for continued support in this area. It would involve continued LTA support but reduce the number of LTA positions from four to three. This is justified as the focus would be on supporting sustainable National Hospital functions (particularly strengthening Departments and quality assurance), and moving away from such a dominant focus on clinical service delivery. The LTA Anaesthetist could continue to support training of nurse anaesthetists but with greater attention to ensuring the Timorese counterpart could perform this function by project completion. Short-term sub-specialty visits would be continued and focused on geographically underserved areas and priority sub-specialities determined by MoH. Institutional linkages would be phased out, and funding for new trainee overseas scholarships could be invested through the HSSP-SP and managed by MoH.

*Not Recommended*: this is not recommended as it does not sufficiently address the explicit and agreed strategic priorities agreed to by Governments of Australia and Timor-Leste.

**Option 3: A new five-year program of specialised services with a transitional focus from national to district-level**

This option adopts all of the key features of Option 2, except for the focus of LTA over the five-years. The first 2.5 years would be focused on strengthening National Hospital functions while investigating options for competency-based training and supervision for district hospital-based doctors in rural/general surgery, essential obstetrics, basic anaesthesia and emergency medicine and paediatrics. At mid-point this could involve different options such as:

- Transitioning LTA support from the National Hospital to a major referral hospital;
- Using the funding for the third LTA position to fund a panel of external specialists to undertake 2-3 monthly rotations at a major referral hospital;
- Rotating returning Timorese doctors from Cuba through the National Hospital under LTA training and supervision.

*Recommended*: this option recognises the current priorities of the MoH for continued specialised services, while also ensuring a strategy is in place to ensure a future program of support could make a greater contribution to district-level MNCH outcomes.

Additional recommendations are also provided to improve greater accountability and information sharing; increase the number of female trainees; ensure short-term visits are demand-drive and strengthen the performance orientation of any future program.

# Introduction

## Activity Background

ATLASS is a 4.75 year program (2006-2011) delivered by the Royal Australasian College of Surgeons (RACS). RACS have provided support for specialist surgical services in Timor-Leste since 2001, initially delivered through the Australia East Timor Specialist Services Project (AETSSP) 2001-2006. Both programs were initiated at the request of the Ministry of Health to address short falls in the provision of surgical services and to establish standards for clinical care.

The original goal of ATLASS was "to improve the health status and outcomes of people living in Timor-Leste with surgically treatable illness, disability or trauma". In 2008 this was revised to "improved health outcomes for people with surgically treatable illness, disability or trauma in Timor-Leste." The purpose or end of program outcome for which ATLASS is directly accountable is "to improve the availability and quality of essential general and specialist surgical services for the people of Timor-Leste." ATLASS is comprised of four components, each with a specific objective:

- Long-term Training, Mentoring and Capacity Building

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

- Short-Term Specialist Support and Planning

  To support surgical and other clinical care through short-term specialist visits and/or outreach to regional communities by long-term Advisors

- Institutional Linkages Initiative

  To provide targeted support for surgical and other clinical care and support services through strategic linkages with Australian and other overseas institutions

- Program Management and Mentoring

  To manage the Program effectively and efficiently, and maintain a Program office at the National Hospital of Guido Valadares (NHGV)

## Evaluation Objectives and Questions

The evaluation objectives of the IPR are:

- To assess the performance of ATLASS against AusAID's quality criteria;
- To provide recommendations to improve implementation progress for the remainder of the program; and
- Pending initial evaluation findings, assess the need for future specialist surgical support beyond ATLASS, identifying possible partnerships, delivery modalities and critical risks.

Detailed areas of enquiry can be found in Annex 1 – Terms of Reference (Scope).

## Evaluation Scope and Methods

A detailed Evaluation Plan can be found in Annex 2. This identifies the approach, information requirements, scope and sampling, methods used, responsibility for data collection and reporting, and a detailed set of evaluation questions.

## Evaluation Team

*Health Specialist (Team Leader): Professor Peter Deutschmann*

Peter Deutschmann is Associate Director of the Nossal Institute for Global Health and Executive Director of the University of Melbourne's subsidiary company within the Nossal Institute. Peter originally trained in clinical surgery and subsequently in public health whilst working in rural north India. With over twenty five years experience in international health, Peter has developed special interests in the integration and delivery of essential services through a primary health care approach in resource poor settings. He has considerable experience in the planning and implementation of health programs in many countries of the Asia Pacific, especially India, Nepal, Burma, Cambodia, Papua New Guinea and East Timor, for government and international agencies that include the Australian Agency for International Development, UK Department for International Development, UN agencies, the World Bank and the Bill and Melinda Gates Foundation.

*Monitoring and Evaluation Specialist: Aedan Whyatt*

Aedan Whyatt is a Performance Management Specialist for the Indonesia and East Timor Branch in AusAID. Aedan is primarily responsible for leading the development of performance management systems in both country programs and managing internal AusAID quality processes at initiative, sector and country-level. In addition, Aedan provides guidance on the development of high quality new designs (particularly program logic and monitoring and evaluation systems) and evaluations of existing initiatives. Prior to this Aedan worked in AusAID's Office of Development Effectiveness, where he managed high profile agency-wide evaluations and contributed to the Annual Review of Development Effectiveness.

# Evaluation Findings

The ATLASS program continues to make a valued contribution to the development of specialist surgical and anaesthetic services and capacity in Timor-Leste. The findings below are the result of an external evaluation of progress against the original program design and commitment undertaken by the RACS in a context and setting of increasing change and complexity (since the time of design and inception of the program).

## Relevance

ATLASS was designed and implemented in 2006 at the direct request of the Minister of Health. Where the *Australia East Timor Specialised Services Project* (AETSSP) focused predominantly on clinical service provision in Dili, ATLASS was intended to support training and mentoring of specialist East Timorese doctors and nurses and provide increased sub-specialty services in the districts. The focus was very appropriate at a time when Timor-Leste lacked any formally qualified medical specialists and a capacity building focus was not addressed by Government or other donors. ATLASS is the only program in Timor-Leste which provides preparation support for specialist trainees undertaking overseas accreditation, and integration support on their return.

ATLASS was designed to operate as a more flexible program through providing a combination of fixed resources and fully-flexible inputs. This approach was highly relevant as it ensured the program could be responsive to changing MoH priorities within well-defined areas (particularly component 1 and 2). Due to the slower than expected evolution of the SWAp, however, all parties agreed that project funding and management responsibilities should continue as originally planned. While this context has not changed, there is now greater capacity within Ministry of Health (MoH) to manage the scholarship component.

*The Changing Context of Specialised Services*

In the context of post-conflict Timor-Leste, there is still limited national capacity to deliver services for treatable surgical conditions. The need for specialist services of a high quality at tertiary (national) and secondary (district) levels in the health system therefore remains highly relevant. This is emphasised in the Basic Services Package and the Health Sector Strategic Plan which clearly recognise the critical role of specialised services in hospital settings and referral pathways.[1] However, since the inception of ATLASS the human resource context has changed considerably. The MoH is now developing a bold vision for human resource development.[2] This envisages a doctor-to-population ratio of 1:1000 (compared to approximately 1:5000 in 2005.)[3] And it emphasises the increased role of Timorese in filling these positions with a gradual reduction in externally provided medical support.

The primary means for achieving this is through funding of out-of-country training scholarships for Timorese by the Government of Cuba. In addition to the current Cuban Medical Brigade (CMB) contingent of approximately 230 medical staff, over 700 Timorese medical graduates will begin to return from Cuba from September 2010. They will participate in a two year rotation, from where interested graduates can subsequently pursue further specialist and sub-speciality training. An additional 180 Timorese trained in Timor-Leste by the CMB in cooperation with MoH and the National University of Timor Leste (UNTL) will enter the workforce over the next five years.[4] The Ministry of Health is also currently supporting formally accredited training for a cohort of 10 Timorese specialist trainees through arrangements with a University in Indonesia. This arrangement is likely to be further supported in future.

[1] Basic Services Package (2007) and Health Sector Strategic Plan (2007). Updates are currently underway but will almost certainly continue to emphasise these areas as priorities.
[2] A '2020 Vision' for human resource development is currently being developed by MoH.
[3] ATLASS Program Design Document (2006) p6.
[4] University of New South Wales (2009) Strengthening Human Resources for Health in Timor-Leste: Progress, Challenges and Ways Forward, p9.

*Changing Priorities for the Australia – Timor-Leste Health Partnership*

In late 2009 the Governments of Timor-Leste and Australia agreed to a Country Strategy for development assistance over 2009-2014.[5] The purpose of the *Country Strategy* was to mutually agree to a more selective focus for Australian assistance in Timor-Leste and establish priorities within each sector. While the health sector continues to be a significant priority for Australian assistance, the *Country Strategy* mandates a focus on basic health service delivery to improve maternal, neonatal and child health outcomes (MNCH) at the district level.

The Timor-Leste Government has also released their Strategic Development Plan 2010-2030 (SDP). Although it is more of a vision than action plan, the SDP gives a clear picture of health sector priorities: "Given the limited resources available the health development is focused on improving maternal and child health for the poor, rural, and other marginalised people so they can: improve access for the poor and rural population to primary and secondary health services; and improve the quality of primary and secondary health services with a variety of resources sufficient to provide adequate services in the achievement of Millennium Development Goals (MDGs)."[6]

The SDP does not provide a specific policy direction for specialised service provision. It does note, however, that "Health personnel resources are still lacking, both in terms of quantity and quality. The majority of doctors working in Timor-Leste are from overseas. But aside from doctors, Timor-Leste also has many other health shortages. In addition, there is an issue of dissemination and training of health workers who have not been handled properly. Lastly, national hospital's limitations in handling super-specialist cases."[7]

*Relevance of ATLASS and Implications for Future Support*

The combination of changes in the human resource context and joint Government health priorities has diminished the relevance of ATLASS. ATLASS has made an important contribution to increasing the availability of specialists by supporting the accreditation of Timor-Leste's first Ophthalmologist and Anaesthetist and a General Surgeon. But this is not at the scale to meet human resource needs especially when compared to other contributions in this area.

In the context of these new priorities, arguably the most relevant intervention of ATLASS is the training of nurse anaesthetists, who are at most times the sole provider of specialist anaesthetic services in the districts. ATLASS LTA specialists do continue to play a significant role in service provision at the National Hospital, despite the fact that international medical missions now account for the vast majority of service delivery and specialist staff at the National hospital.[8] The relevance of provision of services is justified as a vehicle to set and demonstrate standards and to teach trainees. However, the MoH has indicated that future specialist needs, including surgical and anaesthetic, are likely to be met by arrangements now in place in Indonesia for external training and accreditation of specialists. The role of ATLASS is limited to those current trainees engaged in external accredited training in Fiji, PNG and Indonesia, and to the establishment and fostering of quality standards at the National hospital.

Short-term visiting specialist teams continue to play an important role in providing services in sub-speciality areas otherwise unavailable and are highly valued by MoH. They have also increased their geographic coverage, with two-thirds of visits now occurring in the districts. Visits are well received by MoH staff and have met patient and hospital needs. However, it is not clear that decisions on the mix and coverage of sub-speciality visits are determined by MoH priorities and/or target those most in need. For example, during 2007 – 2009 there was almost no variation each year in the number of visits per sub-specialty or the absolute and proportionate number of visits to each hospital (with the exception of Maliana). Program management committee (PMC) meetings note that planning for the specialist teams still needs further discussion between the referral hospitals, MoH and ATLASS before a schedule

[5] Australia – Timor-Leste Country Strategy 2009-2014 (2009), p6-9.
[6] Timor-Leste Strategic Development Plan 2010-2030 (2010), Chapter IV: Sectoral Activity Framework – Education and Health, p15.
[7] Ibid, p14.
[8] ATLASS funded and supported staff account for 6 of 26 local and international specialist staff working at HNGV.

is developed.[9] ATLASS has recently identified the most under-represented districts (those without a referral hospital) and have planned strategies to increase uptake in 2010.[10]

Institutional linkage activities have been of mixed relevance. They have clearly benefited individuals in a variety of contexts but have not always been well targeted or long enough in duration to establish sustainable institution-to-institution linkages.

In this context of changing priorities, ATLASS has demonstrated a responsiveness to align to some extent with a district focus through an offer to train district hospital based doctors in surgical skills. Following a Program Review and Evaluation Team (PRET) mission in early 2009, ATLASS agreed to specifically address the need for basic surgical skills among doctors attached to district hospitals. A three-month basic course in surgical competencies was designed for district hospital doctors to be undertaken at the National hospital. However, the shortage of doctors within the district health system prevented the uptake of the program.

## Effectiveness and Sustainability

ATLASS has been effective in providing a high quality and continuous level of clinical cover for specialised services in Timor-Leste. It has provided pre-service training and in-service for almost all of Timor-Leste's nurse anaesthetists, who play a critical role in improving health outcomes at national and district levels – particularly in support of emergency obstetric care. ATLASS has been less effective in building the capacity of its surgical trainees to sustainably perform their functions. While some factors are beyond the program's control, the inability to recruit a LTA surgeon for an extended period to provide consistent mentoring and guidance has negatively impacted on program effectiveness in this area. There are limited examples where the Program's interventions supporting capacity building and institutional linkages have led to sustainable change. And although service delivery interventions are highly effective, they are not financially or institutionally sustainable.

*Goal: Improved health outcomes for people with surgically treatable illness, disability or trauma in Timor-Leste*

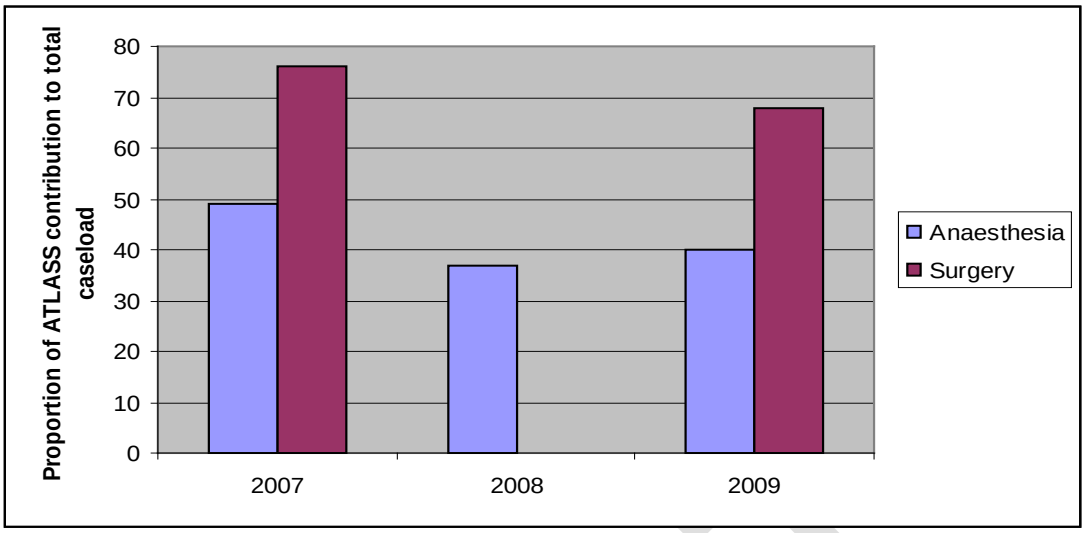
Measuring the impact of ATLASS' service delivery interventions is beyond the scope of this evaluation. M&E systems are not resourced to systematically collect this high-level information (and nor would that be appropriate). ATLASS has adopted a more targeted approach, supporting the Timor-Leste Eye Program to conduct a quality of life study in cataract surgery and undertaking its own small-scale beneficiary study in hernia repair to demonstrate impact in these areas.[11] There is a plausible and sufficient link between the high quality of service provision and the likelihood that patient's experience an improved quality of life and reduction of disabilities as a result of ATLASS.

*Purpose: to improve the availability and quality of essential and general specialist surgical services for the people of Timor-Leste*

ATLASS has directly improved the availability of specialist services in Timor-Leste. However, this has been achieved through direct service provision rather than significantly increasing the number of Timor-Leste formally accredited specialists. Since November 2006, short-term visits have provided 1577 operations in six sub-specialty areas. Over two-thirds of visits took place in district referral hospitals ensuring a high level of outreach to rural communities. At the national hospital (HNGV), 1885 surgical operations have been performed and 2258 anaesthetics administered.[12] During 2007-2009, ATLASS accounted for approximately 70% of all general surgeries performed and approximately 40% of all anaesthetics administered at HNGV.

[9] PMC Minutes 2009.
[10] ATLASS Six-Monthly Report (July – December 2009), p13. Manatuto, Liquica and Ermera continue to be the most under-represented districts each contributing less than 1% of total patients seen by visiting teams.
[11] ATLASS Six-Monthly Report (July – December 2009), p14. The cataract impact assessment will run throughout 2010 and compare the results and experiences of patients in 4 districts. Initial results demonstrate a general improvement in vision and a self assessed improvement in functionality for all participants. Over 90% of patients surveyed are now able to complete one or more tasks that were not possible prior to surgery because of their vision.
[12] Logbooks, 7 April 2010.

**Graph 1: ATLASS Contribution to HNGV Caseload 2007-2009[13]**




These statistics demonstrate that ATLASS continues to play a very significant role in the provision of surgical and anaesthetic services at the National Hospital. But the dominance of ATLASS in general surgery is at odds with the number of surgeons operating; ATLASS currently accounts for only 1-2 of up to 5 general surgeons based at the National Hospital. It is likely the very high quality of ATLASS service delivery is having the unintended effect of displacing other national and international efforts to appropriately share the workload – explained to occur as patients 'vote with their feet'. The implications of this are twofold: it undermines the cost effectiveness of other surgeons and reinforces a dependence on ATLASS to provide the majority of surgical service (despite MoH recruiting other international specialists for this purpose). In doing so, it potentially impacts on ATLASS ability to devote sufficient time to its core function: capacity development of trainees. This is not the case for anaesthesia, where 3 anaesthetists appropriately share the workload between them.

ATLASS has greatly contributed to the standard and quality of services at the National Hospital with the Departments of Surgery and Anaesthesia led by Timorese and mentored by LTAs. For example, the Department of Surgery has benefited from regular audit meetings, surgical case studies, and support to revisions of Standard Treatment Guidelines and addressing supply problems (Essential Drugs List). And more recently planning for a national anaesthesia policy has begun with the national counterpart. However, where the Department of Anaesthesia has benefited from a consistent long-term engagement of a LTA, this is not the case with the Department of Surgery. The current head of the Department of Surgery would benefit from the appointment of a LTA for a period of at least one year. Such an arrangement would increase the likelihood of further and sustainable increase in quality of service and related policies and protocols. Development of curricula for the proposed competency based training of district-level doctors, and the informal tutorial system for trainees at the National hospital demonstrate commitment despite the constraint of failure to recruit to the two LTA positions in surgery.

*Component 1: To strengthen general surgical, anaesthetic and peri-operative nursing capacity and clinical skills through a combination of in-country mentoring and short courses and out-of-country specialist training*

*Nurse Anaesthetist trainees*

ATLASS has made a significant and sustainable contribution to anaesthesia services through training of six nurse anaesthetists and providing in-service training for 21 nurse anaesthetists. A one-year training program is run by the Institute of Health Sciences with the majority of

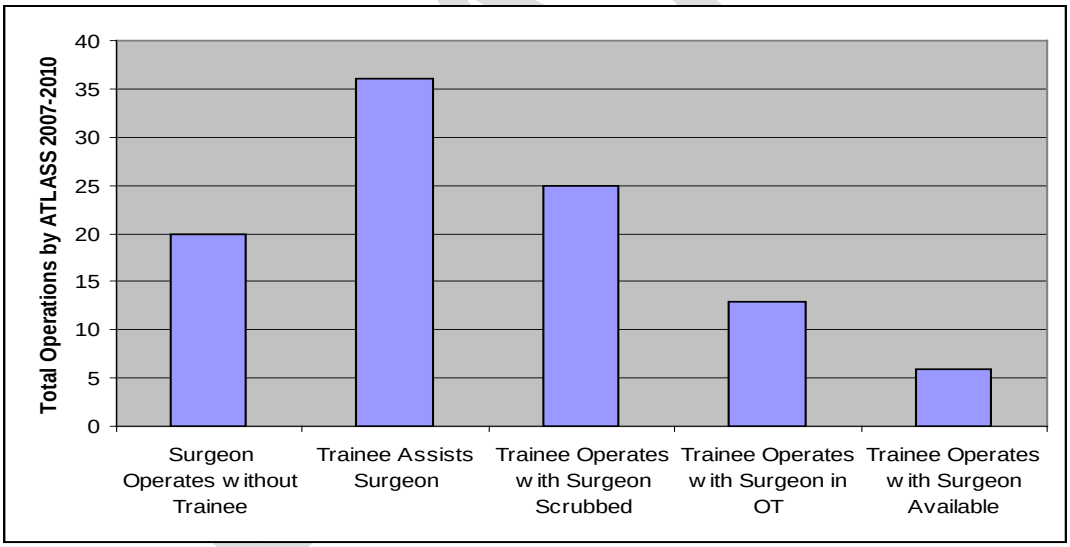
[13] HNGV data for general surgeries performed in 2008 was unavailable. While data from Hospital records is considered to be variable and inconsistent, and therefore prone to error in these estimates, the ATLASS team have confirmed that overall proportions do accord with their impressions.

teaching performed by ATLASS advisers (and more recently the anaesthetic trainee, who will play this role in future). ATLASS and its predecessor are almost exclusively responsible for the training and provision of all accredited nurse anaesthetists in Timor-Leste. Anaesthesia services have now greatly improved and are at a level appropriate to the level of surgery performed. Every hospital in Timor-Leste now has at least one nurse anaesthetist. In Maliana in 2009, three AETSSP/ATLASS trained nurse anaesthetists were solely responsible for administering anaesthetics for 326 operations. They provided anaesthesia services for 38 caesarean sections out of a total of 530 live births (7.1%).[14] Unfortunately ATLASS does not routinely monitor the contributions of nurse anaesthetists to district-level health service delivery, limiting the opportunity to tell a more comprehensive story.

*Surgical and Anaesthetic trainees*

ATLASS has played an important role in strengthening the capacity and clinical skills of six surgical and one anaesthetic trainee. During program implementation 74% of ATLASS assisted or performed surgical operations and 98% of anaesthetics administered were performed or assisted by a trainee.[15] For surgical operations, those which were assisted or performed by a trainee significantly increased from 51% in 2006 to 91% in 2010. However, there is a reasonable difference in the spectrum of a trainee assisting an operation and being competent to perform an operation independently – which has not been systematically captured in program reporting[16]. Graph 2 indicates that between mid-2007 and early 2010 approximately 44% of operations were performed by a trainee with some degree of independence. The fact that less than 20% of these operations were performed solely by a trainee suggests that further experience and skills transfer would be required for this to be sustainable beyond ATLASS.[17]

**Graph 2: Breakdown of Operations at HNGV Performed by ATLASS Staff or Trainees (Q3 2007 – Q1 2010)**




ATLASS LTAs have provided a high standard of mentoring and supported informal and formal training opportunities for all surgical and anaesthetic trainees. Significant improvements have been noted in the professionalism of the surgical trainees since the start of the program. Trainees now follow up with patients, take responsibility for patient care, do on-call duties out of hours, demonstrate improved punctuality and actively participate in the operating theatre.[18] However, ATLASS has ultimately not been able to substantially increase the number of

[14] Atingimento Servico Hospitalares e encaminhamento 2009 Hospital de Referencia Maliana, February 2010, p16-17.
[15] ATLASS Surgical and Anaesthesia Logbooks, 7 April 2010.
[16] In particular, logbook data from October 2006 to June 2007 did not systematically code the different levels of trainee involvement in surgical operations.
[17] ATLASS Surgical and Anaesthesia Logbooks, 7 April 2010.
[18] ATLASS Six-Monthly Report (July – December 2009), p4.

formally accredited Timorese specialists as per the original design's intent (currently only an Ophthalmologist and a general surgeon and anaesthetist by 2010 and 2011 respectively).[19] Reasons for this include highly competent trainees unable to undertake overseas training for personal reasons, failing examinations, and difficulties recruiting new trainees. The MoH has consistently raised concerns about this and now feel that sending specialist trainees through the Health Sector Strategic Plan – Support Project to the University of Bandung is a more sustainable alternative.[20]

*Challenges in balancing service delivery with training needs*

The increased proportion of operations involving ATLASS trainees demonstrates that on-the-job capacity development has been an effective approach. However, in circumstances where only a single ATLASS LTA general surgeon was available, complementary capacity development activities were compromised. Progress reports in 2007 noted that "...heavy clinical and on-call demands come at the expense of the training activities" and "…the clinical workload again increased to such an extent that it regularly impacted on the ability of the long term surgeon to deliver tutorials and to engage in other non-clinical activities."[21] Conversely when two LTA surgeons are available there is evidence to suggest that neither trainee teaching nor service delivery is compromised: "The complement of four general surgeons made the clinical and on call rosters sustainable. In addition, having two RACs surgeons improved the teaching; the time for tutorials could be safeguarded and the frequency of tutorials was doubled."[22]

*Challenges in measuring ATLASS contribution to capacity development*

There are a number of challenges in measuring the ATLASS contribution to strengthening trainee capacity and clinical skills. Firstly, evidence is not systematically presented on individual trainee progress – such as improved competency to perform operations; perform new operations; perform more complex operations or perform operations with a greater degree of independence. Where positive examples exist, they are presented in progress reports in an ad hoc manner, limiting the program's ability to tell a coherent performance story. Secondly, without individual capacity building plans or targets for specific skills, success is open-ended and impossible to measure. Finally, the progressive increase in skill development of surgical trainees in part reflects the contribution of the LTA in surgery but is also the result of the formal training received through the external accredited specialist placements for training.

*Component 2: To support surgical and other clinical care through short term specialist visits and/or outreach to regional communities by long-term Advisors*

ATLASS has directly increased access to sub-specialty services at the national and district referral hospitals. Each year an average of 15 international teams provide services in six sub-specialty areas: ophthalmology, orthopaedics, plastic and reconstructive surgery, paediatrics, paediatric cardiac surgery, and ear, nose and throat (ENT) surgery. Between November 2006 and December 2009 external teams performed 1577 operations during 43 separate visits. Geographic reach has gradually increased over time from 57% (2007) to 69% (2009) of all visits occurring outside Dili. Maliana largely accounts for this increase due to improved facilities (particularly the operating theatre).

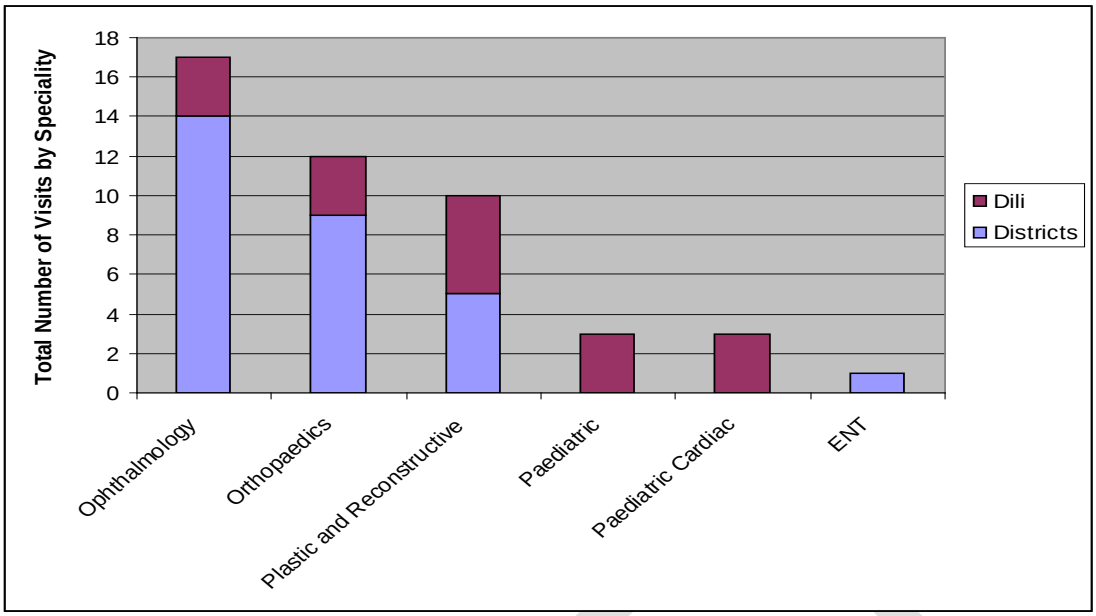
[19] The Project Design Document expected by June 2011 that ATLASS would support enrolment for eight medical graduates to undertake and complete specialist training – three who already commenced training under AETSSP (General Surgery, Ophthalmology and Orthopaedic Surgery) and a further five (2 x General Surgery, 2x Anaesthesia, and Ophthalmology) and support a fourth surgical candidate to undertake the first two years of surgical training (p26-27)

[20] PMC Minutes July and October 2009 and in-country discussions in February 2010.

[21] ATLASS Six-Monthly Report (January – June 2007), p6, ATLASS Six-Monthly Report (July – December 2007), p11.

[22] ATLASS Six-Monthly Report (July – December 2007), p10.

**Graph 2: Short Term Specialist Visits to Timor-Leste 2007-2009**[23]




As graph 1 indicates, ophthalmology, orthopaedics and plastic and reconstructive surgery account for the majority of services delivered. In the case of orthopaedic surgery, in-country surgeons have only been able to focus on management of acute trauma, allowing the short-term visiting teams to add value by focusing on elective surgical needs. Ophthalmology is the only service reaching all referral hospitals, and in the cases of Suai and Oecusse, the only service. This reflects the fact that most procedures can be performed in resource and capacity limited settings. It is also the only sub-speciality area that is likely to be sustainable by mid-2011. In contrast paediatric and paediatric cardiac services have been restricted to Dili, and plastic and reconstructive services restricted to Dili and Baucau (the largest of district referral hospitals). In the case of paediatric surgery, a 'coloured card' referral systems implemented by ATLASS has been very successful in ensuring almost all patients who were originally consulted returned for surgery. The program is looking to expand this system to other groups of patients.

A variety of factors also limit the effectiveness of short-term visits. Firstly, visiting teams are often unable to perform complex operations and focus on operable cases only. A lack of adequate medical equipment and limited (nursing) post-operative care are the main factors here. Secondly, in a number of visits patient turnout was considerably lower than expected. Visiting teams have suggested a need for greater planning and awareness-raising in advance. [24] Thirdly, due to the short time frame for visits (usually a week or less), opportunities for sustained capacity building through mentoring and training are limited. Fewer but longer visits could increase prospects for success; but if this is unrealistic, expectations for capacity development outcomes should be more modest.

With 17 visits currently planned for 2010 (and estimating an additional 7-10 for January – June 2011), ATLASS will likely undertake a total 70 specialist visits by completion. Trends indicate approximately 70% of services will be targeted to districts in 2010, including a four-fold increase in the provision of ENT services. Sub-specialty visits make an important contribution to improving the quality of life of children through correction of hearing and vision, repair of cleft palates, and corrections of burns contractures and club feet.

[23] All data derived from ATLASS 'Specialist Visits Masterfile' updated May 2010.
[24] These issues were raised in visit reports for Orthopaedics (Maliana, March 209; Dili & Baucau, November 2009), Paediatric Cardiac (Dili, 2009), Ophthalmology (Maubesse, August 2009; Maliana, October 2009) and ENT (Maliana, July 2009).

*Component 3: To provide targeted support for surgical and other clinical care and support services through strategic linkages with Australian and other overseas institutions*

The effectiveness of institutional linkage activities has been mixed with prospects for sustainability limited. The most successful linkage has been in the area of emergency medicine, where a relationship has been forged with the Emergency Department of St Vincent's Hospital in Melbourne. This has involved a scoping mission and attachments for East Timorese hospital staff, who have since redesigned of the Emergency Department area and implemented a triage system to improve patient flow through the department and ensure priority cases are seen as quick as possible.[25] ATLASS has now recruited a LTA emergency physician to strengthen trauma care at National and referral hospitals, in partnership with nursing support provided by St John of God. The risk to sustainability is the recent departure of the national as the administrative head of Emergency Department at the National Hospital.

Another effective linkage activity has been the introduction of the non-invasive Ponseti technique to manage club feet in children. This activity was done in partnership with ASSERT (a Timorese NGO working for the rights of people with a disability) and supported by delivered primarily through workshops and practical training sessions for Timorese physiotherapists and doctors. Where previous surgical procedures have been undertaken only by visiting specialist teams, one of the ATLASS trainees is now competent in performing the tenotomy procedure. However, the program faces challenges with access to services and ability for patients to attend treatment centres in Dili and Baucau, and sustainability will be dependent on MoH budget and human resources (currently lacking).

Aside from these activities institutional linkages have generally been without a clear and deliberate strategy. Fifteen separate linkage activities have been funded to a total value of less than $100,000.These have largely met individual needs of trainees or hospital staff through participation in scientific conferences, basic surgical training courses, nursing conferences, English language courses, and ophthalmology and urology training. These activities could have been supported from other Program components, and whilst each has merit, they do not meet the strategic intent of an enduring institutional linkage. Other linkages which have had a promising rationale, such as the histopathology service, have now deteriorated due to issues of supplies and equipment and staff turnover.[26]

## Efficiency

*Security context*

ATLASS has performed well in implementing its activities in the context of continual socio-political unrest in Timor-Leste. The program has been flexible in cancelling and re-scheduling activities, particularly short-term specialty visits, to address concerns about security and safety. Civil strife, and the presence of internally displaced persons (IDP) camps on the hospital grounds, placed huge demands on the health service. ATLASS trainees were also affected by the civil unrest, ranging from their houses being looted, being displaced to live with other relatives and helping out disadvantaged family and friends.

*Long-term placements*

Implementation progress has been hampered by recent difficulties in recruitment to the two LTA general surgery positions. ATLASS was able to secure two one-year placements for a single LTA surgeon in 2007 and 2008. However, in 2009 this position was filled by 9 separate rotations (an average of less than six weeks per rotation). A second LTA surgeon position was also filled by three separate surgeons over 5 weeks. This has impacted on program effectiveness through a lack of continuity to fully support and mentor the Head of the Surgical Department and surgical trainees. All parties agree that a minimum period of continuity for six months is preferable with the ideal being a two-year appointment. Whilst services of a high quality continue to be provided, the impact has largely been in the area of capacity development. For example, surgical trainees commented that while useful to be exposed to different ideas, strict approaches and methods can create confusion and uncertainty. This

[25] ATLASS Progress Report (January – June 2009), p5.
[26] Ibid, p24.

may have also contributed to the postponement of the short course for district hospital doctors as a result of the inability to offer any form of support to a short course in skills competencies at a Referral hospital.

Whilst delays in appointment of long-term personnel to LTA positions have contributed to a lack of sufficient staffing resources, ATLASS has been very responsive to changing needs. It has generally made effective use of time and resources with short term inputs into the LTA surgical positions drawing on very experienced and committed personnel and where possible surgeons with previous experience in Timor-Leste. Outreach visits by the LTAs have been placed on hold as agreed with the MoH in 2007. This was due to low patient turnout during previous outreach visits and the Cuban medical presence in the districts. However, visits by the recently recruited Emergency Medicine physician demonstrate the benefit of LTA visits and the delivery of short course instruction at district hospitals for those doctors and nurses who otherwise would not be able to attend such courses at the National hospital.

*Trainee preparation*

One of the main challenges in increasing the overall number of formally accredited specialists through ATLASS is the difficulties trainees have faced with English language requirements to succeed in examinations. ATLASS has been responsive to this in providing English language support, but the program also acknowledges that it "needs to improve the preparation and ongoing support of out-of-country trainees to ensure a higher rate of success."[27] It is important to acknowledge that AETSSP and ATLASS have explored and repeatedly recommended training links with Indonesia because of language and cultural contexts. However, the MoH's decision at the time of ATLASS commencement was that all post-graduate training should be done outside Indonesia. The current MoH has reversed this decision.

*Short-term visits and institutional linkages*

The short-term sub-specialty visits remain highly regarded and have been managed extremely well with minimal disruption to district hospitals. The preparation and logistic support required is very demanding and well coordinated between the Melbourne office of RACS and the Dili office of ATLASS without disruption of the other services and activities coordinated from the Dili office. In contrast, institutional linkage activities have not made the most effective use of resources – less than one-fifth of budget allocation has been expended.

*Coordination with other health service providers*

Coordination between international medical missions at the National hospital remains problematic and poses a serious medical risk. Although cooperation and collaboration is reasonably well fostered between individual specialists, language barriers and unclear roles preclude the establishment of a more harmonised system. If the MoH desires ATLASS to lead on establishing quality standards and protocols for the National hospital, it needs to clearly communicate this to all parties and support this process to take place. On the part of ATLASS, greater information sharing of its activities with MoH and National hospital management would improve MoH planning. This is particularly the case with the status of ATLASS trainees receiving or planning for out-of-country training. The situation has resulted from an absence of any formal arrangements between the respective stakeholders. Individual contracts (or career plans) for each trainee would improve accountability and could be reviewed jointly with all parties to assess progress annually.

*Cost effectiveness*

The cost-effectiveness of ATLASS' interventions is mixed. Salaries paid to LTA surgeons and anaesthetists are well below prevailing rates in Australia. Timor-Leste therefore can access specialised services of the highest quality at a modest expense. However, an external review of the previous program (AETSSP) identified that lower salaries may predispose a high turnaround rate among resident specialists.[28] This issue has had direct cost-effectiveness and performance implications for ATLASS. For example, the mobilisation and administrative costs for the LTA general surgeon position were three times as expensive in 2009 compared with

[27] ATLASS Progress Report (July – December 2008), p15.
[28] External Review of Australia East Timor Specialised Services Project (AETSSP), November 2004, p20.

2008 due to high staff turnover *and* significantly less effective in trainee capacity development. [29] If ATLASS LTA surgeons and anaesthetists primary mandate was service delivery, it is likely that specialist staff from other missions such as Cuba, China and Indonesia would be considerably less expensive and represent better value-for-money. ATLASS' value therefore has to be justified by its ability to also ensure a quality assurance at the National hospital and mentor and build the capacity of trainees. Given mixed success on the latter, future funding for trainees to undertake externally accredited training would be more cost effective and sustainable if it were to be provided through the MoH executed HSSP-SP.

Short-term visits are highly cost-effective as specialist team members are volunteers and costs relate to mobilisation (e.g. $5,750 per member) and medical disposables only. A conservative estimate based on 40-50 hours of clinical time provided during a specialist visit would be costed at $15,000 - $25,000 per team based on market rates. On this basis it is estimated that ATLASS short-term visits in 2009 provided an in-kind contribution of $305,000.[30] For the entire duration of ATLASS this in-kind is estimated to be $1,050,000 – $1,750,000.[31] In addition, ATLASS has effectively exploited its networks to raise extra budgetary support for other specialist service activities in Timor-Leste (such as the Timor Leste Eye Program and Orthopaedic Outreach). Incomplete estimates suggest $323,400 for 2007-2009 but actual support is likely to be considerably higher.[32] However, activities supported through extra budgetary support were not assessed during this evaluation so it is not possible to provide a judgement on how effective or well targeted this funding has been.

Institutional linkage activities have typically not been a cost-effective means to achieve the objective of sustainable institution-to-institution linkages. Individual professional development opportunities – valuable in their own right – could have been funded through other program components.

## Gender Equality

The ATLASS design indicates that it "will not discriminate … among patients who are potential candidates for surgical treatment." On this basis, the program's contribution to service delivery has benefited male and female patients in a relatively balanced and equal manner:

- 1258 (58%) male patients and 925 (42%) female patients benefited from surgical operations provided by ATLASS LTA / trainees
- 991 (44%) male patients and 1267 (56%) female patients benefits from anaesthetics administered by ATLASS LTA / trainees[33]
- 915 male patients (58%) and 597 female patients (38%) benefited from operations by sub-speciality visiting teams.[34]

ATLASS has also made a valuable contribution to improving access to emergency obstetric care. At the national hospital approximately one-fifth of anaesthetics administered by ATLASS were for mothers undertaking caesarean sections.[35] At district referral hospitals 21 nurse anaesthetists who receive in service-training by ATLASS have provided critical assistance in support of emergency obstetric care.[36] For example, in 2009 three nurse anaesthetists at Maliana referral hospital were solely responsible for providing anaesthesia services in support of 38 caesarean sections.[37]

[29] Using a breakdown of specialist visit costs of $5750 per person, this equates to an additional $34,500.
[30] The estimate provided for 2009 takes account of 15 visits and the composition of each team.
[31] This estimated is based on 70 short-term visits taking place, each providing an additional contribution of $15,000 - $25,000.
[32] ATLASS Institutional Linkages Budget and Extra Budgetary Funding Tracking, March 2010.
[33] These statistics are drawn directly from ATLASS LTA Logbooks as at 5 May 2010.
[34] 65 or 4% of operations were unrecorded.
[35] As at 5 May 2010, 493 or 22% of total anaesthetics administered by ATLASS supported caesarean sections.
[36] As data on caesarean sections assisted by ATLASS trained nurse anaesthetists at district referral hospitals are not captured in ATLASS M&E systems, it is impossible to quantify this contribution.
[37] Atingimento Servico Hospitalares e encaminhamento 2009 Hospital de Referencia Maliana, February 2010, p17.

The ATLASS design also indicates that it "will not discriminate by gender for selection of long- or short-term trainees … attention will be given to ensuring that women have opportunities to undertake training." The fact that all program trainees are male largely reflects the gender balance in the medical work force and small pool of potential candidates for training. In two instances the program actively encouraged and supported female doctors to undertake training in anaesthetics and ophthalmology. However, their decisions to take on promotions in the health sector prevented them from pursuing these opportunities further.

## Monitoring and Evaluation

The monitoring and evaluation (M&E) systems for ATLASS are of less than adequate quality.[38] Reports provide detailed information on implementation progress and the quality and quantity of outputs delivered. However, little evidence is routinely *presented* on the systematic improvements in the capacity of its trainees to perform sustainable functions (behaviour change). And while the contribution to service delivery is more adequately captured, further improvements are needed. Ongoing monitoring of trained nurse anaesthetists would provide a clear picture of the ATLASS contribution at district and referral hospitals, particularly maternal health outcomes. Monitoring of all operations in HNGV would demonstrate the significance of ATLASS' contribution to the overall caseload, and provide an opportunity to further strengthen MoH information systems. ATLASS clearly makes important contributions to development outcomes but these are not captured well in existing M&E systems and/or reported on. Relatively simple and cost-effective solutions would deliver significant improvements to the utility of M&E systems. Suggested improvements to program logic, the M&E framework and progress reporting are currently under discussion with ATLASS.

*Program Logic and End-of-Program Outcomes*

The ATLASS M&E system is designed on a simple program logic which broadly outlines a results-chain from inputs to goal-level.[39] Rather than starting with clearly defined end-of-program outcomes, the program logic is driven by components and inputs (incorrectly labelled outputs). Relationships between components are not explored despite the interrelated role they have in practice. For example, surgical trainees receiving long-term training, mentoring and capacity building (C1) clearly benefit from participation in institutional linkages (C3). Similarly, trained nurse anaesthetists (C1) are expected to acquire new knowledge and skills during short-term specialist visits (C2). Inputs, activities and outputs for each component are clear and measurable but there is much less clarity in the end-of-program outcome. Without clear baseline information and targets, "to improve the *availability* and *quality* of essential general and specialist surgical services" is not a meaningful definition of program success. The same critique applies to each component. This has resulted in a lack of clarity on whether a primary focus is on service delivery or capacity development (or an appropriate balance).

*Performance Measures and Priority Information*

ATLASS has continually improved its M&E framework (assisted by the PRET). Inappropriate indicators have gradually been replaced with more accurate measures of success. Two beneficiary studies have been initiated to measure the impact of interventions in cataract surgery and hernia repair. Logbooks are now being reformatted to reflect trainee progress and surgical trends. The M&E framework provides sex-disaggregated, age and geographical data both for services delivered by the in-country team and trainees, and visiting teams.

Despite these efforts, the M&E framework is still unnecessarily complex. It collates information on over 40 indicators that are largely input, activity and output focused. Outcome

[38] This assessment is based on the value of the program, legacy of the program (in its second phase), and relatively straight-forward nature of interventions. Responsibility also lies with AusAID and the PRET. As early as July 2007 (refer PMC Minutes) AusAID indicated the need for greater reporting against outcomes. Yet it has continued to accept progress reports which have not addressed this issue, and only recently provided guidance on a more appropriate report format. While PRET has provided continual advice on improving M&E systems, changes to the program logic and M&E framework have been minimal and not addressed fundamental problems with the design logic which was focused too heavily on inputs and less on behaviour change of its key beneficiaries.

[39] This model is also adopted in a program implemented by RACS in the Pacific Islands. It has been criticised along similar grounds (see Annex 5 for more detail).

statements using imprecise language such as “to improve”, “to strengthen”, “to support” are not generally supported by precise and meaningful indicators. Critically, it does not capture priority information on the context and capacity outcomes. Service delivery indicators include volumes of operations performed and anaesthetics administered. However without monitoring of overall HNGV case loads it is impossible to determine the relative contribution of ATLASS.[40] Non-operative management is another area that isn’t captured. There is also an opportunity to complement qualitative measures with qualitative assessments, such as *Most Significant Change* technique.[41] These methodologies should not necessary be intensive in terms of time of resources but may enable ATLASS to reflect quality of life improvements observed by LTAs and visiting teams in reporting.

Changes to the M&E framework now purport to measure “new surgical and anaesthesia skills acquired by an ATLASS trainee”. This information is captured in Logbooks yet progress reports do not *systematically* report on individual capacity improvements (either to perform operations more independently or perform more complex operations). Instead they aggregate measures – such as “proportion of operations done or assisted by a trainee”. In the case of surgical trainees, consistent professional development is put at risk by the failure of a long-term appointment to the position of the LTA surgeon required to consistently monitor the progress and development of the trainees.

*Performance Reporting*

Six-monthly progress reports typically focus on implementation progress with much less attention on adequate progress toward sustainable outcomes. The July-December 2009 progress report is an important exception here, addressing PRET recommendations[42] and guidance provided by AusAID. Typically reports are too long, descriptive and lack sufficient analysis on key issues. This is largely the result of reporting against 12 – 14 separate areas that are directly centred on program inputs and interventions. A more effective approach would be to structure the report against key outcome areas; for example improvements in the capacity of trainees and protocols/standards and contributions to service delivery at national and district-levels. Short-term visit reports could also be strengthened, as approximately half of reports are of poor quality (e.g. hand written notes) or do not follow the structured template.

## Analysis and Learning

The ATLASS program has performed well in terms of real-time analysis and learning, and being responsive to new priorities. Specific examples include:

*Responsive to the need for district-based doctors to be equipped with basic surgical skills*, and in response to a recommendation of the PRET with PMC endorsement, ATLASS designed a three-month course for district hospital doctors. Unfortunately the MOH could not release doctors from district hospitals for three months to attend a course to be delivered at the National hospital. Linked to the delivery of this course was the PRET recommendation with PMC endorsement that a second LTA surgeon be appointed to ensure there was LTA capacity at the National hospital to deliver additional training at both National and Referral hospital level. ATLASS has acknowledged and confirmed the importance of developing surgical competencies for district hospital based doctors but remains committed to delivering a short training program from the National hospital. The inability to recruit a second LTA surgeon (position approved by the PMC following a PRET recommendation) and reluctance to deliver the short course at selected Referral hospitals may have limited the impact of the short course training had it been approved by MOH.

[40] ATLASS originally budgeted to support a Hospital Data Analyst but unfortunately could not fill the position. Subsequently the 2007 PRET mission recommended that a broader role was required to support MOH (Health Information Adviser) and would go beyond the remit of ATLASS. However, while recognising that developing a Health Information System is a complex task, it is likely that basic indicators such as total number of operations and anaesthetics administered could be collected and monitored with support from ATLASS.
[41] http://www.clearhorizon.com.au/flagship-techniques/most-significant-change/
[42] The 2009 PRET mission recommended addressing a series of limitations including: under reporting of achievements; inaccurate reporting against indicators/incorrect information; an absence of analysis and discussion of issues; lack of presentation of key risks; and an absence of reporting against cross-cutting issues.

Despite attempts to *strengthen peri-operative and critical care nursing* through LTA attachments to the operation room and the critical care unit, the leadership of the program concluded that the ATLASS program was not the best vehicle to deliver capacity development for nurses. This has subsequently been taken up by another agency. This decision was confirmed by the PRET and PMC as appropriate.

*Emergency care* at the National hospital has been strengthened by the recruitment of a specialist in Emergency Medicine. This followed a successful engagement of the Emergency Department of St Vincent's Hospital, Melbourne, through the institutional linkages component. A commitment to improved emergency care inclusive of the needs of women and children and extends to the district health system by the delivery of short courses at selected Referral and district hospitals. This is one of the competencies included in a potential short course to support the skills development of district hospital based doctors (as outlined in recommendation 2).

ATLASS has been responsive to PRET and AusAID guidance to *strengthen internal M&E systems*. ATLASS six monthly reports now track progress against PRET recommendations ensuring key issues are regularly monitored. RACS have now resource an additional staff member to support the further refinement of M&E systems across all of its international programs.

At the same time, *the difficulty of recruitment of long-term surgeons has been the experience of RACS for the past ten years*.[43] The implicit response to this persistent problem has been the successful deployment of short-term surgeons, many of whom make repeat visits. ATLASS hasn't responded to this problem in a strategic manner and missed an opportunity to develop and formalise an alternate program of support, such as a panel of short-term specialists that make predetermined and repeated visits by rotation (a mechanism that can provide a form of continuity that may prove more beneficial to trainees that their experience to date). Fortunately this has not been the case with the appointment of a LTA in anaesthesia. The successful completion of the nurse anaesthetic training program resulting in s cohort of 27 nurse anaesthetists demonstrates the importance in continuity of LTAs.



[43] External Review of Australia East Timor Specialised Services Project (AETSSP), November 2004, p9-10.

## Evaluation Criteria Ratings

| Evaluation Criteria | Rating (1-6) | Explanation |
|---|---|---|
| Relevance | 4 | The provision of specialist services and the development of specialists remain highly **relevant** to the context of Timor-Leste. However, shifting Timor-Leste and Australian government priorities suggest the current approach is less relevant in terms of contributing to improved MNCH outcomes at the district-level. |
| Effectiveness | 5 | ATLASS has been highly **effective** in providing high quality specialist services at the National hospital and in district hospitals through short-term visits and training of nurse anaesthetists. While it has contributed to capacity development of trainees, this approach has been affected by inconsistency in mentoring by LTA surgical staff. It has also been less effective in producing a full cohort of formally accredited specialists as per the design expectations. |
| Efficiency | 4 | The sustained presence of the LTA in anaesthesia and the efficient mobilisation and contribution of short-term sub-specialty visits demonstrate efficient areas of ATLASS. However, the failure to adequately recruit to the LTA surgical positions and the absence of an alternate strategy, and a fragmented institutional linkages component, has reduced the **efficiency** of ATLASS. |
| Sustainability | 3 | The training of a cohort of nurse anaesthetists, and imminent return of a Timorese surgeon and the first anaesthetist, will contribute to sustained specialised services beyond ATLASS. However, remaining surgical trainees will require continued professional and financial support, and MoH capacity (and funding) to manage short-term visits and institutional linkage activities is unsustainable. |
| Gender Equality | 4 | The equal benefit to men and women from the services provided through ATLASS is commendable but the lack of adequate representation and participation of women in the ATLASS training activities reduces the overall **gender equality** ranking. |
| Monitoring & Evaluation | 3 | Despite improvements in the **monitoring and evaluation** framework, it remains unnecessarily complex, collating an excess of information, without attention to that which is most important, namely measures of capacity development outcomes. |
| Analysis & Learning | 4 | ATLASS has performed well in terms of real-time analysis and learning, and being responsive to new priorities. But long-term difficulties in recruitment affecting both AETSSP and ATLASS suggest the need to explore new strategies. |

**Rating scale:**

| Satisfactory | | Less that satisfactory | |
|---|---|---|---|
| **6** | Very high quality | **3** | Less than adequate quality |
| **5** | Good quality | **2** | Poor quality |
| **4** | Adequate quality | **1** | Very poor quality |

# Recommendations

Further support for the development of specialist surgical and anaesthetic services in Timor-Leste beyond the current commitment remains relevant in terms of the development context. And particular aspects such as the short-term visits have been specifically requested to continue by the Minister for Health. At the same time, ATLASS, in its current form, makes only a limited contribution to the explicit stated priorities of the Australia-Timor Leste Country Strategy and the Timor-Leste Strategic Development Plan 2011-2030. It is highly likely that attempts to strictly accommodate both sets of competing priorities could result in a more fragmented health sector already characterised by a proliferation of donor projects, Therefore any recommendations for future support must negotiate and trade-off these tensions to some degree. A number of options are presented for discussion between the Governments of Australia and Timor-Leste, including recommending a way forward based on a judgement of political realities and opportunities.

**Option 1: A one-year extension of the current ATLASS program with no further support to specialist services beyond mid-2012**

This option is designed to protect the sustainability of investments to date but recognises the limited contribution that ATLASS can make to significantly improving MNCH outcomes at district-level. It is proposed that the Governments of Australia and Timor-Leste should explore alternative options to influence MNCH outcomes at district-level.

An extension would result in completion of external accredited training and support to the subsequent re-entry of the Timorese trainee surgeon at UPNG, and Timorese trainee anaesthetist at Fiji School of Medicine (FSM), due to return to the National hospital at end of 2010 and end of 2011 respectively. It would also support the completion of the training of the final cohort of six nurse anaesthetists through a one year course at HIS (to be completed mid 2011) and in-service support for the initial year of posting. Whilst not an externally accredited training program, a one-year extension of ATLASS would also ensure the further skill development of a Timorese surgical trainee undergoing training in plastic and burns surgery, and another trainee in orthopaedic surgery at the National hospital.

A one-year extension of the ATLASS program would also allow transfer of funding and support arrangements for Timorese trainee surgeons in Indonesia (one trainee commenced a five-year traineeship in February 2010) and PNG (another is likely to commence four-year traineeship by mid 2010). It would also ensure further maturity of the departments of anaesthesia and surgery at the National hospital under Timorese leadership through extension of the period of mentorship from LTAs in anaesthesia and surgery (with further development of policies, procedures and protocols; and the incorporation of specialists anticipated to return from UPNG and FSM.

*Not Recommended*; this is not recommended as it ignores the preferences from the MoH for continued support in the area of specialised services (particularly short-term visits).

**Option 2: A new five-year program of specialised services with a more selective focus**

This option recognises the clear preferences of the MoH for continued support in this area. It would involve continued LTA support but reduce the number of positions from four to three. This is justified as the focus would be on supporting sustainable National Hospital functions (particularly strengthening Departments and quality assurance), and moving away from such a dominant focus on clinical service delivery. The LTA Anaesthetist could continue to support training of nurse anaesthetists but with greater attention to ensuring the Timorese counterpart could perform this function by project completion. Short-term sub-specialty visits would be continued and focused on geographically underserved areas and priority sub-specialities determined by MoH. Institutional linkages would be phased out, and funding for new trainee oversees scholarships could be invested through the HSSP-SP and managed by MoH.

*Not Recommended*: this is not recommended as it does not sufficiently address the explicit and agreed strategic priorities agreed to by Governments of Australia and Timor-Leste.

**Option 3: A new five-year program of specialised services with a transitional focus from national to district-level**

This option adopts all of the key features of Option 2, except for the focus of LTA over the five-years. The first 2.5 years would be focused on strengthening National Hospital functions while investigating options for competency-based training and supervision for district hospital-based doctors in rural/general surgery, essential obstetrics, basic anaesthesia and emergency medicine and paediatrics. At mid-point this could involve different options such as:

- Transitioning LTA support from the National Hospital to a major referral hospital;
- Using the funding for the third LTA position to fund a panel of external specialists to undertake 2-3 monthly rotations at a major referral hospital; and
- Rotating returning Timorese doctors from Cuba through the National Hospital under LTA training and supervision. (Although the MoH did not release district-based doctors under ATLASS for a similar course, the much larger numbers of returning doctors increases the likeliness that this could be feasible).

*Recommended*: this option recognises the current priorities of the MoH for continued specialised services, while also ensuring a strategy is in place to ensure a future program of support can make a greater contribution to district-level MNCH outcomes.

**Additional Recommendations**

Irrespective of which option is chosen, any future support to specialised services should incorporate the following principles:

- Promote greater accountability through establishing formal contracts between individual trainees (if continued), ATLASS and MoH and share relevant information with key MoH departments and hospital management. Individual trainee contracts should include simple capacity building plans which map out professional development needs/targets;
- Recruitment of specialist trainees and nurse anaesthetists should explicitly target female candidates;
- All future short-term specialist visits should be negotiated with MoH well in advance on planning and targeting to ensure they are demand-driven; and
- Strengthen the performance orientation through simplifying M&E systems, establishing clarity of objectives, and increasing outcomes-focused reporting. Future support should also explore opportunities to strengthen and utilise MoH information systems at national and district levels.

# Annex 1 – Terms of Reference

**Australia Timor-Leste Program of Assistance for Specialised Services (ATLASS)**

**Independent Progress Review and Concept Note (if appropriate)**

**22 February – 4 March 2010**

## 1. Background

Australia is a key development partner supporting Timor-Leste's health sector. Its assistance accounts for a significant proportion of external financing and is delivered through a variety of programs. The recently endorsed Australia – Timor-Leste Country Strategy (2009-14) highlights health as a continued priority area, emphasising the need to focus on improving maternal and child health outcomes. A related (draft) health delivery strategy identifies Australia's role in the sector, the specific outcomes it will be targeting, and how its support will be delivered most effectively. Both strategy documents place high priority on moving away from our existing broad ranging support to the sector to a tighter focus on improving maternal and child health outcomes, particularly outside Dili.

Within this context, Australia will undertake an **independent evaluation of its support delivered through the Australia Timor-Leste Program of Assistance for Specialist Services (ATLASS)**. A 2009 report by the Program Review and Evaluation Team (PRET) also recommended the need for a **scoping mission to determine the nature of support likely to be required beyond 2011**. AusAID management has agreed this evaluation should **assess the performance of ATLASS** and pending initial evaluation findings identify **possible future options for support**.

ATLASS is a 4.75 year program (2006-2011) delivered by the Royal Australasian College of Surgeons (RACS). RACS have provided support for specialist surgical services in Timor-Leste since 2001, initially delivered through the Australia East Timor Specialist Services Project (AETSSP) 2001-2006. Both programs were initiated at the request of the Ministry of Health to address short falls in the provision of surgical services and to establish standards for clinical care.

The original goal of ATLASS was "to improve the health status and outcomes of people living in Timor-Leste with surgically treatable illness, disability or trauma". In 2008 this was revised to "**improved health outcomes for people with surgically treatable illness, disability or trauma in Timor-Leste**." The purpose or end of program outcome for which ATLASS is directly accountable is "**to improve the availability and quality of essential general and specialist surgical services for the people of Timor-Leste**." ATLASS is comprised of four components, each with a specific objective:

i. Long-term Training, Mentoring and Capacity Building
   - To strengthen general surgical, anaesthetic and peri-operative nursing capacity and clinical skills through a combination of in-country mentoring and short courses and out-of-country specialist training

ii. Short-Term Specialist Support and Planning
   - To support surgical and other clinical care through short-term specialist visits and/or outreach to regional communities by long-term Advisors

iii. Institutional Linkages Initiative
   - To provide targeted support for surgical and other clinical care and support services through strategic linkages with Australian and other overseas institutions

iv. Program Management and Mentoring
   - To manage the Program effectively and efficiently, and maintain a Program office at the National Hospital of Guido Valadares (NHGV)

## 2. Key Issues

ATLASS requires an independent evaluation as part of AusAID's quality process. The evaluation would involve an **assessment of ATLASS performance** against its stated goal and **recommendations** on - any **changes to current program approach** and **on future surgical priorities** which is aligned to the new country strategy and the (draft) health delivery strategy. Specific issues for consideration:

District-level focus on maternal and child health: the (draft) health delivery strategy indicates a transition towards greater focus on provision of basic surgical and obstetric care in districts. This is a shift from ATLASS' current focus on general surgical training delivered in Dili and short term subspecialist visits.

Results-orientation: The PRET's 2009 mission identified problems with the program's monitoring and evaluation (M&E) system. These included under reporting of achievements; inaccurate reporting against indicators / incorrect information; an absence of analysis and discussion of issues; lack of presentation of the risks that have changed during the reporting period and responses made by the program; and absence of reporting against cross cutting issues.

Partnerships: the (draft) health delivery strategy suggests negotiation of a partnership more directly been the Ministry of Health (MoH) and RACS, to promote greater ownership and ensure that this is a high priority of the GoET. In this context providing and developing surgical capacity as a priority for MoH needs to be re-visited. This should take account of revisions to the Health Sector Strategic Plan 2008-2012 and the review of the Basic Services Package (if available during evaluation period).

Sustainability: the design of ATLASS noted that it would not be possible to develop a comprehensive surgical capacity within the five years of the program. However, it will be critical to reflect on: the extent to which ATLASS has maintained an appropriate balance between capacity building and providing in-line services and the cost-effectiveness of its approach of using Australian medical specialists.[44]

## 3. Objectives

The purpose of this independent evaluation is to:

a) Review the performance of ATLASS against AusAID's quality criteria and provide recommendations for the remainder of the program's duration; and

b) Pending initial evaluation findings assess the need for future specialist surgical support beyond ATLASS, identifying possible partnerships, delivery modalities and critical risks.

## 4. Scope

### 4.1 Independent Progress Report

The Independent Progress Report (IPR) will:

***A. Assess ATLASS' performance against the evaluation criterion*** of relevance, efficiency, effectiveness, sustainability, gender equality, monitoring and evaluation and analysis and learning. The ratings will be based on the standard AusAID scale as outlined in the IPR template (see Attachment B)**.**

[44] A recent AusAID evaluation raised concerns about the cost-effectiveness of this approach. For more information, see Office of Development Effectiveness (2009) *Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands, and Vanuatu: Evaluation Report*, p26. It is also worth noting that previous PRET missions have not considered 'efficiency' criteria in their mandate.

Efficiency

- How efficient are short-term visiting teams and outreach to districts by long-term Advisors?
    - How does ATLASS compare to other models of providing specialist services, such as agreements with other countries to provide surgical services out of country (e.g. Indonesia) or use of specialists from other countries within the region?
- How well are ATLASS activities coordinated with other key players (such as the Cuban medical mission, UNTL and Institute for Health Sciences) in the health sector?
- Is the current delivery modality the most appropriate and efficient partnership option?

Effectiveness & Sustainability

- To what extent has ATLASS capacity building interventions resulted in sustained improvements in the capacity and clinical skills of medical trainees?
    - Which approaches were most effective and sustainable?
- To what extent has ATLASS support to surgical and clinical care led to sustainable health outcomes?

Monitoring & Evaluation

- To what extent has ATLASS designed, resourced and implemented an appropriate monitoring and evaluation system?
    - Does the design of ATLASS demonstrate a robust program logic and clearly defined end-of-program outcomes?
    - Are performance measures appropriate and is data routinely collected, analysed and used to inform decision-making (including the proposed Beneficiaries Study?
    - What is the quality of program reports?

***B. Assess ATLASS' relevance and fit with the priorities in the new country strategy.***

- To what extent are the objectives and approaches of ATLASS directly relevant to the priorities identified in the Australia – Timor-Leste Country Strategy (2009-14) and related (draft) health delivery strategy?
    - How well is ATLASS positioned to make an effective contribution to improving maternal and child health outcomes (through expanding access to basic surgery and obstetric care) at the district-level?
- To what extent is specialist medical support a priority for MoH?
    - To what extent were major activities funded under Institutional Linkages Initiative relevant and have they led to sustainable linkages?

***C. Provide recommendations for changes to ATLASS' current approach, if required, given implications of the findings above – i.e. changes to: current focus, existing management arrangements and the sustainability of services provided.***

***D. Comment on future support.*** The IPR should also include clear recommendations on whether further support to improving surgical services is aligned to country strategy priorities and make an effective contribution to improving maternal and child health in East Timor.

If the IPR recommends an ongoing need to support surgical services, beyond the ATLASS program, a concept note should be developed. The decision to develop a concept note will be

made by Jemal Sharah (Counsellor, Dili) and the Evaluation Management Team by Week 1 of the In-Country Mission.

### 4.1 Concept Note

The scope of the concept note will be to discuss whether future medical specialist support is a priority and identify future partnership options. Key evaluation questions include:

- What is the nature of future support proposed and how would it effectively contribute to improving maternal and child health outcomes particularly at the district-levels?
- What are the most appropriate and efficient partnership options and delivery modalities? What the key risks involved with each approach?
- What would be an appropriate and effective role for PRET?

## 5. Duration and Phasing

The independent evaluation of ATLASS will take around 4 weeks in total, with an in-country mission planned for 22 February to 4 March 2010. During this period, the following will be completed:

| **Dates (2010)** | **Activities** | **Location** | **Maximum No. of Days** | | |
|---|---|---|---|---|---|
| | | | Team Leader | M&E Specialist | AusAID Post |
| 8-12/02 | Document Review | Australia | 2 | 2 | |
| 8-12/02 | Telecon Briefings with AusAID (including Health Adviser) | Australia | 0.5 | 0.5 | |
| 8-12/02 | Consultations with RACS | Australia | 0.5 | 0.5 | |
| 12/02 | Submit Evaluation Plan | Australia | 0.5 | 2 | |
| 22/02 | Briefing with AusAID Mission | Dili | 0.5 | 0.5 | 0.5 |
| 22/02-3/03 | Consult with key representatives of the MoH, NHGV, the Institute of Health Science, UNTL and the other medical missions | Dili | 4 | 2 | 4 |
| 22-26/02 | Consultations with RACS and trainees | Dili | 0.5 | 0.5 | 0.5 |
| 23-26/02 | Visit to referral hospital(s) and clinics | Districts (tbc) | 2 | 2 | 2 |
| 1-3/03 | Appraisal of M&E System | Australia | | 2 | |
| 4-5/03 | Prepare and present an | Dili | 2 | 1 | 0.5 |

| | | | | | |
|---|---|---|---|---|---|
| | Aide Memoire | | | | |
| 12/03 | Submit draft IPR and Concept Note to AusAID | Australia | 2 | 2 | |
| 24/03 | Peer review of Concept Note | Australia | 0.5 | 0.5 | |
| 07/04 | Submit final IPR and Concept Note to AusAID | Australia | 1 | 1 | |
| Total | | | 16 | 16.5 | 7.5 |

## 6. Team Composition

The review team will comprise of: Professor Peter Deutschmann, team leader and medical specialist and Aedan Whyatt, AusAID M&E specialist. Participation and input to the evaluation will include relevant Ministry of Health staff, Armandina Gusmão Amaral, AusAID Activity Manager (in Dili) and Natalie McKelleher, Second Secretary, Dili Post.

Dili Post will organise the meeting schedule, provide background information on the project implementation process, content and oversight to the review team through regular feedback during the evaluation process.

The review team will collectively have the following skills and qualifications:

- Expertise in medical specialties (surgery)
- Demonstrated knowledge of health service delivery in East Timor
- Understanding of priorities within East Timor's development cooperation program
- Knowledge of tertiary health services in East Timor
- Expertise in monitoring and evaluation and design

## 7. Reporting requirements

The team leader will be responsible for the following written outputs:

- An Aide Memoire on the initial findings of the IPR to be presented and discussed with AusAID Dili Post (including Minister Counsellor), followed by presentations with MoH and RACS at the end of the in-country visit;
- A draft IPR of no more than ten pages (excluding annexes), and if continuation of support in surgery is assessed as appropriate and a priority for the MoH, a concept note of no more than five pages, will be submitted to AusAID by 12 March 2010. Both reports should include an executive summary, analysis of the findings, and conclusions and recommendations. AusAID may share the IPR with, and seek feedback from, MoH and other key stakeholders as appropriate;
- The final IPR, and if appropriate, the concept note, will be submitted within ten working days of receipt of collated comments on the draft report from AusAID.

The M&E specialist will be responsible for the following written outputs:

- Developing an evaluation methodology in advance of the in-country mission, to be submitted to the AusAID Evaluation Management Team by 12 February 2010. The evaluation methodology should include: a statement of the general approach being proposed; evaluation questions to be answered; proposed methods for sampling, collecting and analysing data for evaluation questions; identification of the respondents or documents that will provide the information; and allocation of specific areas of responsibility for the evaluation team both during the data collection and reporting phase.

- Undertaking a written assessment of the program's M&E system, directly informing the IPR and potentially the concept note.

The AusAID Evaluation Management Team (Natalie McKelleher, Armandina Amaral and Kavitha Kasynathan) will be responsible for developing the Terms of Reference (TORs), AusAID management response and a learning and dissemination plan. The AusAID evaluation delegate (Jemal Sharah) will work directly with them to approve these processes and ensure the quality of the evaluation report. The Minister Counsellor will be responsible for approving the final IPR (including management response) for public release, and learning and dissemination plan.

## 8. List of Key Documents

The following documents should be provided to the evaluation team in advance on the in-country mission by the evaluation manager:

- ATLASS Program Design Document (PDD)
- Project Scope of Services (Contract Amendment 1)
- Six-Monthly Progress Reports (from 2006 – current)
- Program Management Committee Minutes
- PRET Mission Reports
- Australia – Timor-Leste Country Strategy (2009-2014)
- AusAID (draft) Health Delivery Strategy
- ATLASS Quality-at-Implementation Reports
- AusAID policies on Health, Gender, Disability and Child Protection
- ODE (2009) Australian Aid to Health Service Delivery in Papua New Guinea, Solomon Islands, and Vanuatu: Evaluation Report
- Service Delivery Evaluation Solomon Islands, Vanuatu, PNG
- Other relevant documents including those relating to the Sector Wide Approach, the Timor-Leste Health Sector Strategic Plan and the Hospital Services Package

# Annex 2 – Evaluation Plan

## Independent Evaluation of Australia Timor-Leste Program of Assistance to Specialist Services (ATLASS)

### 1. Overview of ATLASS

ATLASS is a 4.75 year program (2006-2011) delivered by the Royal Australasian College of Surgeons (RACS). RACS have provided support for specialist surgical services in Timor-Leste since 2001, initially delivered through the Australia East Timor Specialist Services Project (AETSSP) 2001-2006. Both programs were initiated at the request of the Ministry of Health to address short falls in the provision of surgical services and to establish standards for clinical care.

The original goal of ATLASS was "to improve the health status and outcomes of people living in Timor-Leste with surgically treatable illness, disability or trauma". In 2008 this was revised to "improved health outcomes for people with surgically treatable illness, disability or trauma in Timor-Leste." The purpose or end of program outcome for which ATLASS is directly accountable is "to improve the availability and quality of essential general and specialist surgical services for the people of Timor-Leste." ATLASS is comprised of four components, each with a specific objective:

- Long-term Training, Mentoring and Capacity Building: to strengthen general surgical, anaesthetic and peri-operative nursing capacity and clinical skills through a combination of in-country mentoring and short courses and out-of-country specialist training
- Short-Term Specialist Support and Planning: to support surgical and other clinical care through short-term specialist visits and/or outreach to regional communities by long-term Advisors
- Institutional Linkages Initiative: to provide targeted support for surgical and other clinical care and support services through strategic linkages with Australian and other overseas institutions
- Program Management and Mentoring: to manage the Program effectively and efficiently, and maintain a Program office at the National Hospital of Guido Valadares (NHGV)

### 2. Objectives and Approach of the Independent Progress Report (IPR)

The objectives of the IPR are three-fold:

- To assess the performance of ATLASS against AusAID's quality criteria;
- To provide recommendations to improve implementation progress for the remainder of the program; and
- To assess if AusAID-funded future specialised surgical support is justified.[45]

The approach proposed for this IPR is a goal- or objectives-based evaluation, where performance is assessed against the stated objectives in the program design. As the IPR is a formative (i.e. mid-term) evaluation, it relies predominantly on existing data and stakeholder perceptions for evaluating performance. Within these constraints the approach focuses on assessing the extent to which ATLASS components have attained or are likely to attain its objectives.

[45] If so, a separate concept note will be commissioned identifying possible partnerships, delivery modalities and critical risks.

The evaluation design was developed in consultation with AusAID stakeholders only. Time constraints limited opportunities for a more collaborative approach with ATLASS and Ministry of Health stakeholders.

## 3. Utilisation of Findings

Approaches that will be adopted for this IPR are:

- Identify intended primary users of this evaluation. The needs of the AusAID East Timor management team are to utilise an evidence-based report to make decisions regarding future specialised support to Timor-Leste. The needs of the ATLASS implementation team relate specifically to improving implementation performance of the Program for its duration.
- Ensure that participating key stakeholders responsible for implementing ATLASS have the opportunity to discuss the findings of the evaluation team, and feasibility of recommendations before the final report is submitted;
- The same stakeholder representatives and broader AusAID stakeholders (such as the Health and HIV Thematic Group and Pacific Health team) will be given the opportunity to comment on the draft report submitted to AusAID by the evaluation team;
- The final report will be written with a brief executive summary of key findings and recommendations for a wide audience;
- AusAID will provide a management response to the IPR's findings and recommendations and develop a learning and dissemination plan.

## 4. IPR Design – Information requirements

This section describes the information required during this review, and methods employed to collect that information. A more detailed list of information required, or evaluation questions can be found in Annex 1.

This review will gather information on:

- Relevance: assess whether specialised surgical services is a continuing priority for the Governments of Australia and Timor-Leste, and if so, whether ATLASS is the most appropriate project to fulfil this role;
- Efficiency: assess whether the program management has met AusAID's quality standards for program implementation, will deliver the expected outputs and outcomes, and represents value-for-money;
- Effectiveness and Sustainability: assess whether ATLASS has attained or is likely to attain its objectives, and whether sufficient factors are in place to ensure the continued practice of new capacities/linkages;
- Monitoring and Evaluation: assess whether ATLASS has designed, implemented and resourced an appropriate monitoring and evaluation system;
- Gender Equality: assess whether gender equality is incorporated into design and implementation arrangements and if outcomes are equally benefiting men and women, boys and girls;
- Lessons Learned: assess whether the Program has adequately incorporated lessons from similar programs, and from its own experience, to improve implementation;
- Partnership Options: identify possible alternative partnership options and modalities, including an assessment of critical opportunities/risks.

## 5. Scope and Sampling

### *5.1 Scope and Flexibility of IPR Design*

The scope of the review presented here is relatively limited, with 8 days available for interviews in Timor-Leste and 3 days in Australia.

Information collection will be conducted in three phases. The first phase is a preliminary documentation review followed by a series of interviews in Canberra and Melbourne. Phase two will involve a series of interviews in Timor-Leste, undertaken over two separate missions. The final phase will be a more comprehensive documentation review in Australia. There will be 7 broad groups of respondents for this review.

Phase 1: Australia

*Group 1*: Royal Australasian College of Surgeons (RACS) in Melbourne

*Group 2*: AusAID Health stakeholders – Health and HIV Thematic Group and Pacific Health Team

Phase 2: Timor-Leste

*Group 3*: AusAID activity managers and senior management

*Group 4*: ATLASS implementation team

*Group 5*: Ministry of Health stakeholders

*Group 6*: Participants in capacity building interventions

*Group 7*: Additional stakeholders, such as other donors and key health sector development partners

### *5.2 Sampling*

Purposive (i.e. non-random) sampling was applied to select the district referral hospitals for closer review. The criteria for selection of these were a) examples of high and low quality referral hospitals and b) what was logistically feasible within the in-country field mission. Maliana (high quality) and Suai (low quality) referral hospitals were identified on this basis. However, due to unexpected circumstances the evaluation team were only able to visit Maliana.

## 6. Methods

The evaluation is a desk review of documentation, supplemented by in-depth interviews using qualitative questioning techniques seeking the perceptions of relevant stakeholders described in the seven groups above. Multiple perspectives strengthen confidence in the findings where primary data is not available. Although reliability and validity of findings will be weaker than if a formal outcome evaluation with the collection of primary data was carried out, this is well beyond the resources available to AusAID for this IPR. Many of the findings will be based on a combination of stakeholder perceptions and the professional judgment of the IPR team.

## 7. Responsibility for data collection and reporting

The Team Leader and Health Specialist is responsible for collecting, analysing and reporting data relating to the Program's performance against relevance, effectiveness, efficiency, sustainability, gender equality and lessons learned criteria; and for recommendations and development of a concept note.

The Monitoring and Evaluation Specialist is responsible for collecting, analysing and reporting data directly related to monitoring and evaluation criteria, and for recommendations to improve the performance orientation of the Program.

## 8. Evaluation Questions and Methods

| REF | EVALUATION QUESTION | METHOD | DOCUMENTS/RESPONDENT |
|---|---|---|---|
| **1. Relevance** | | | |
| 1.1 | Are specialist services a priority for the Government of Timor-Leste? | Document Review<br><br>Interviews | Basic Services Package<br>Health Sector Strategic Plan<br>Ministry of Health staff |
| 1.2 | What are Australia's priorities for health sector engagement in Timor-Leste in 2009-2014?<br>- Are specialised surgical services a continuing priority for the Australian assistance to Timor-Leste? | Document Review<br><br>Interview | Australia Timor-Leste Country Strategy 2009-2014<br>Health delivery Strategy<br>Child Protection, Gender and Disability Policies<br>AusAID Health Program staff |
| 1.3 | Are the objectives/components of ATLASS relevant to the current context?<br>- Are there other health sector needs that are of greater priority to the Government's of Australia and Timor-Leste (opportunity cost)? | Document Review<br><br>Interview | Strengthening human Resources for Health in Timor-Leste<br>ATLASS Contract Amendment<br>AusAID Health Program staff<br>Ministry of Health staff |
| 1.4 | What consequences would result from discontinuing ATLASS in its current form? | Interview | Ministry of Health staff<br>ATLASS LTA<br>ATLASS Trainees |
| 1.4 | To what extent can ATLASS directly contribute to:<br>- Maternal and child health outcomes?<br>- District-level health service delivery? | Document Review<br><br>Interviews | Progress Reports & Monitoring Matrix<br>LTA Logbooks<br>ATLASS LTA<br>Maliana Referral Hospital staff |
| 1.5 | Has ATLASS targeted priority needs not addressed by other development partners?<br>- If not, how did it seek to harmonise its assistance? | Interviews | ATLASS LTA<br>Head of Surgery Department, National Hospital<br>Ministry of Health staff<br>AusAID Health Program staff<br>National Coordinator, Cuban Medical Brigade<br>Health Specialist, World Bank<br>UNFPA Representative<br>US Mercy Ship Pre-Deployment Site Team |

| REF | EVALUATION QUESTION | METHOD | DOCUMENTS/RESPONDENT |
|---|---|---|---|
| **2. Efficiency** | | | |
| 2.1 | Has implementation progress been adequate?<br>- If any, what were major delays? How did they impact on program effectiveness? | Document Review<br><br><br><br><br>Interviews | Progress Reports<br>Monitoring Matrix<br>Program Management Committee Minutes<br>Quality-at-Implementation Reports<br>PRET Reports<br>AusAID Health Program Staff<br>ATLASS LTA<br>Ministry of Health staff<br>Maliana Referral Hospital staff |
| 2.2 | Has the implementation of ATLASS made effective use of time and resources to achieving outcomes?<br>- Have there been any financial variations and if so, was value for money considered?<br>- Has management of ATLASS been responsive to changing needs? If not, why not?<br>- Has ATLASS had sufficient and appropriate staffing resources? | Document Review<br><br><br><br><br>Interviews | Progress Reports<br>Monitoring Matrix<br>Program Management Committee Minutes<br>Quality-at-Implementation Reports<br>PRET Reports<br>AusAID Health Program Staff<br>ATLASS LTA<br>Ministry of Health staff<br>Maliana Referral Hospital staff |
| 2.3 | How cost-effective is the ATLASS model of providing specialist surgical services?<br>- How does ATLASS compare to other models of providing specialist services, such as agreements with other countries to provide surgical services out of country (e.g. Indonesia) or use of specialists from other countries within the region? | Document Review<br><br>Interviews | Design Document<br>Progress Reports (Expenditure Breakdown)<br>AusAID Health Program staff<br>Ministry of Health staff |

| REF | EVALUATION QUESTION | METHOD | DOCUMENTS/RESPONDENT |
|---|---|---|---|
| **3. Effectiveness and Sustainability** | | | |
| 3.1 | What intended/unintended outcomes are already evident?<br>- Basis for perceptions?<br>- What are the strengths and weaknesses with respect to achieving outcomes; or factors affecting the outcomes? Which approaches are most effective and sustainable? | Document Review<br><br><br>Interview | Progress Reports<br>Monitoring Matrix<br>PRET Reports<br>ATLASS LTA<br>ATLASS trainees<br>Ministry of Health staff |
| 3.2 | What development outcomes do you currently anticipate by the end-of-project? | Document Review<br><br><br>Interviews | Progress Reports<br>Monitoring Matrix<br>PRET Reports<br>ATLASS LTA<br>ATLASS trainees |
| 3.3 | Do beneficiaries and stakeholders have sufficient ownership, capacity and resources to maintain ATLASS outcomes after project completion in 2011? | Document Review<br><br>Interviews | Progress Reports<br>Program Management Committee Minutes<br>ATLASS LTA<br>ATLASS trainees<br>Ministry of Health staff<br>AusAID Health Program staff |
| 3.4 | Are there any actions that can be taken now that will increase the likelihood that ATLASS outcomes will be sustainable?<br>- Are there any areas of the activity that are clearly not sustainable? What actions should be taken to address this? | Interviews | ATLASS LTA<br>ATLASS trainees<br>Ministry of Health staff<br>AusAID Health Program staff |

| REF | EVALUATION QUESTION | METHOD | DOCUMENTS/RESPONDENT |
|---|---|---|---|
| **4. Monitoring and Evaluation (M&E)** | | | |
| 4.1 | Does the design of ATLASS demonstrate a robust program logic and clearly defined end-of-program outcomes? | Document Review | ATLASS Design Document<br>Monitoring Matrix<br>PRET Reports (including revised program logic) |
| 4.2 | Do M&E arrangements provide timely and meaningful information in support of management, accountability and lessons-learned needs?<br>- Is M&E focused on priority information needs and not overly complex?<br>- Are performance measures appropriate and is data routinely collected and analysed?<br>- What is the quality of progress reports?<br>- Is data sex-disaggregated to measure the outcomes of ATLASS on men, women, girls and boys? | Document Review<br><br><br><br>Interviews | Progress Reports<br>Monitoring Matrix<br>PRET Reports<br>Quality-at-Implementation Reports<br>AusAID Health Program Staff<br>ATLASS LTA<br>ATLASS Program Manager |
| 4.3 | Does evidence (or professional judgement) exist to show that objectives are on track to be achieved by 2011, and to what extent changes will be sustained? | Document Review<br><br><br>Interviews | Monitoring Matrix<br>Progress Reports<br>PRET Reports<br>ATLASS LTA<br>ATLASS Trainees<br>Ministry of Health staff |
| 4.4 | Is monitoring and evaluation adequately resourced? | Document Review<br>Interview | ATLASS Budget<br>ATLASS Project Manager |

| REF | EVALUATION QUESTION | METHOD | DOCUMENTS/RESPONDENT |
|---|---|---|---|
| **5. Gender Equality** | | | |
| 5.1 | Was ATLASS designed to provide equal participation and benefits for women and men, boys and girls? | Document Review | ATLASS Design Document |
| 5.2 | Is ATLASS promoting equal participation and benefits for women and men, boys and girls?<br>- Is ATLASS promoting more equal access by women and men to the benefits of its activities, and more broadly to resources, services and skills?<br>- Is the activity promoting equality of decision-making between women and men? | Document Review<br><br><br><br>Interview | Monitoring Matrix<br>Progress Reports<br>Short-term Visits Masterfile Spreadsheet<br>LTA Logbooks<br>ATLASS LTA |
| **6. Learning and Analysis** | | | |
| 6.1 | How well was the design based on previous learning and analysis? | Document Review | Design Document, ATLASS<br>External Project Review, AETSSP<br>Activity Completion Report, AETSSP |
| 6.2 | How well was learning from implementation and previous reviews (self-assessment and independent) integrated into the activity? | Document Review | Progress Reports<br>PRET Reports<br>External Project Review, AETSSP<br>Activity Completion Report, AETSSP<br>Design Document, Strengthening Access to Specialised Clinical Services in the Pacific<br>ODE Evaluation of Australian Aid to Health Service Delivery<br>Design Document, Program of Partnership and Support for Health Worker Education and Training and Specialised Services in PNG<br>Review of the PNG Tertiary Health Services Project and Options for Future Support<br>External Project Review of Provision of a Range of Tertiary Health Care Services to Pacific Island Countries |

# Annex 3 – Stakeholders Consulted

| Name | Title | Organisation |
|---|---|---|
| Beth Slatyer | Health Adviser, Health and HIV Thematic Group | AusAID |
| Lucy Phillips | Health Resource Facility Manager, Health and HIV Thematic Group | AusAID |
| Timothy Gill | Manager, Health Unit, Pacific Human Development | AusAID |
| Katherine Ruiz-Avila | Director, East Timor Section | AusAID |
| Kavitha Kasynathan | Health Sectoral Analyst, East Timor Section | AusAID |
| Miriam Smith | Pre-Posting (2nd Secretary Health and Education) East Timor Section | AusAID |
| Jemal Sharah | Counsellor, Dili Post | AusAID |
| Natalie Mckelleher | 2nd Secretary, Health and Education, Dili Post | AusAID |
| Armandina Amaral | Program Officer, Health, Dili Post | AusAID |
| David Scott | ATLASS Project Director, International Projects | Royal Australasian College of Surgeons |
| Daliah Moss | Director, External Affairs | Royal Australasian College of Surgeons |
| Lito De Silva | Operations and International Projects Manager | Royal Australasian College of Surgeons |
| Natalie Stephens | Program Officer, International Projects | Royal Australasian College of Surgeons |
| Kate Moss | Program Officer, International Projects | Royal Australasian College of Surgeons |
| Eric Vreede | Anaesthetist, Team Leader | ATLASS |
| Anthony | Physician, Emergency Department | ATLASS |
| Karen Moss | ATLASS Program Officer | ATLASS |

| Name | Title | Organisation |
|---|---|---|
| Nilton Tilman | Surgical Trainee | ATLASS |
| Joao Ximenes | Surgical Trainee | ATLASS |
| Alito Soares | Surgical Trainee | ATLASS |
| Abel Monteiro | Nurse Anaesthetist (ATLASS trained) | Maliana Referral Hospital |
| Jose Pere Para | Nurse Anaesthetist (ATLASS trained) | Maliana Referral Hospital |
| Romualdo da Cunha | Nurse Anaesthetist (ATLASS trained) | Maliana Referral Hospital |
| Dr Vitorino Bere Talo | Director of Maliana Referral Hospital | Maliana Referral Hospital |
| Dr Odilia Moniz | Clinical Director of Maliana Hospital | Maliana Referral Hospital |
| Girish Naidu | Ophthalmologist | East Timor Eye Program |
| Dr Odete Belo | Director of External Funding | Ministry of Health |
| Ana Magno | Director, for Hospital and Referral Services | Ministry of Health |
| Jaime Sarmento | Adviser for MoH | Ministry of Health |
| Francisco Soares | Acting Director-General | Ministry of Health |
| Dr Odete Viegas | Executive Director of the National Hospital | Ministry of Health |
| Dr Terlinda Barros | Clinical Director of the National Hospital | Ministry of Health |
| Dr Mendes Pinto | Head of Surgery Department | National Hospital |
| Erling Larsson | Health Policy Advisor | Ministry of Health |
| Diamantino de Jesus | Director of Human Resources | Ministry of Health |
| Dr Osvaldo Castellanos Rabanal | Coordinator for Cuban Medical Brigade | Cuban Medical Brigade |
| Dr Agusto | National Adviser Coordinator | Cuban Medical Brigade |

| Name | Title | Organisation |
|---|---|---|
| Dr Emilia | Dean for Faculty of Medicine, UNTL | Cuban Medical Brigade |
| Dr Daisy | Cuban Medical at Centro and Manatuto Community Health Centre | Cuban Medical Brigade |
| Tanya Wells-Brown | Health Specialist | World Bank |
| Jeremias Gomes | Health Program Assistant | World Bank |
| Various | Pre-deployment Site Survey Team | US Mercy Ship |
| Dr Maria do Ceo Sarmento | HR/Academic Focal point, MoH | HNGV |
| Dr Pornchai Suchita | UNFPA Representative | UNFPA |
| Dr Domingas Bernardo | UNFPA Deputy Representative | UNFPA |

# Annex 4 – Documents Reviewed

*ATLASS Documentation*

Program Year 4 Implementation Plan (July 2009 – June 2010)

Six Monthly Report (July – December 2009)

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Surgery Long-Term Adviser, Log Book

Specialist Short-term Visits, Statistics Masterfile

Expenditure Breakdown for LTA, Short-term visits, and Institutional Linkages and Extra-budgetary Support

Program Monitoring Matrix

Risk Management Matrix

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University of New South Wales, Strengthening Human Resources for Health in Timor-Leste: Progress, Challenges and Ways Forward, Mission Report, July 2009

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AusAID Health Delivery Strategy, Draft, February 2010

AusAID, Child Protection Policy, January 2009

AusAID, Development for All: Towards a Disability-Inclusive Australian Aid Program 2009-2014

AusAID, Gender Equality in Australia's Aid Program – Why and How, March 2007

*PNG/Pacific Approaches to Specialised Service Provision*

Design Document, Strengthening Access to Specialised Clinical Services in the Pacific 2010-2014, January 2010

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Office of Development Effectiveness, Working Paper 1: Papua New Guinea Country Report, June 2009

Office of Development Effectiveness, Working Paper 2: Solomon Islands Country Report, June 2009

Office of Development Effectiveness, Working Paper 3: Vanuatu Country Report, June 2009

Program Design Document, Program of Partnership and Support for Health Worker Education and Training and Specialised Services in PNG, June 2008

Review of the PNG Tertiary Health Services Project and Options for Future Support Models, April 2007

External Project Review, Provision of a Range of Tertiary Health Care Services to Pacific Island Countries (The Pacific Islands Project): Evaluation of Phase III and Review of Options for Supporting the Provision of Tertiary Health Care in Pacific Island Countries, December 2006