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TIMOR-LESTE HEALTH IMPROVEMENT PROJECT

Annual Report



Project Year 1 and Quarter 4 Report October 2011 – September 2012

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Photos on front cover:

Photo 1: Family health promoters ready to register visitors at table 1 during SISCa in Tasifatin, Soibada sub-district, Manatuto district.

Photo 2 (bottom left): Baucau DPHO-HP facilitating the community facilitators’ training in Guruça, Quelicai sub-district.

Photo 3 (bottom right): HIP Technical Advisor supporting the facilitation of the IMCI refresher training in Viqueque.

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ACRONYMS

AAP	Annual Action Plan
<i>Aldeia</i>	Hamlet
AMTL	<i>Asosiasaun Mediku de Timor-Leste</i> (Doctors Association of Timor-Leste)
ANC	Ante-natal Care
AusAID	Australian Agency for International Development
BCC	Behavior Change Communication
BEmOC	Basic Emergency Obstetric Care
BSP	Basic Services Package
CHC	Community Health Center
CM	Community Mobilization
CMAM	Community Management of Acute Malnutrition
COP	Chief of Party
COR	Contracting Officer's Representative
DHS	District Health Service
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DMT	Decision-Making Tool
DPHO	District Public Health Officer
DTO	District Technical Officer
DTT	District Team Trainer
DTWG	District Technical Working Group
ENBC	Essential Newborn Care
FGAD	Finance, Grants & Administration Director
FP	Family Planning
FY	Financial Year
GEC	Grants Evaluation Committee
HAI	Health Alliance International
HFS	Health Facility Survey
HNTL	HealthNet Timor-Leste (local NGO)
HMIS	Health Management Information System
HIP	Health Improvement Project
HP	Health Promotion
HR	Human Resources
ICOMP	International Council on Management of Population Programs
IMCI	Integrated Management of Childhood Illness
INS	<i>Instituto Nacional da Saúde</i> (National Health Institute)
IPL	<i>Imunizasaun Proteje Labarik</i> (MCC-TPI project)
IT	Information Technology
JSI	John Snow, Inc.
LMIS	Logistics Management and Information System
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health

MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSA	Ministry of State Administration
NGO	Nongovernmental Organization
NHSCC	National Health Sector Coordination Committee
NTT	<i>Nusa Tenggara Timur</i>
ORT	Oral Rehydration Therapy
PDS	<i>Planu Dezenvolvimentu Suco (Suco Development Plan)</i>
PDSS	<i>Planu Dezenvolvimentu Suco Saúde (Suco Health Development Plan)</i>
PNDS	<i>Planu Nasional Dezenvolvimentu Suco (National Suco Development Plan)</i>
PNC	Post-natal Care
PSF	<i>Promotor Saúde Familia (Family Health Promoter)</i>
QI	Quality Improvement
QIC	Quality Improvement Collaborative
RDT	Rapid Diagnostic Test
RFA	Request for Applications
RSF	<i>Rejistu Saúde Familiar (Family Health Register)</i>
SAMES	<i>Serviço Autónomo de Medicamentos e Equipamentos de Saúde (Autonomous Services of Drugs and Health Equipments)</i>
SC	Steering Committee
SDP	Service Delivery Point
SDTWG	Sub-district Technical Working Group
SGP	Small Grant Program
SHC	<i>Sharis Haburas Comunidade (local NGO)</i>
SISCa	<i>Serviço Integrado da Saúde Comunitária (Integrated Services of Community Health)</i>
SOW	Scope of Work
<i>Suco</i>	Village
TA	Technical Advisor
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNTL	<i>Universidade Nacional de Timor-Leste (National University of Timor-Leste)</i>
USAID	U.S. Agency for International Development
WHO	World Health Organization
WG	Working Group

SECTION 1: INTRODUCTION AND SUMMARY

This document serves as the Project's Year 1 Annual Report and fourth Quarterly Progress Report covering the period from July 1, 2012 through September 30, 2012. Further detail on the quarterly activities can be found in **Annex 1**, which compiles the Weekly Reports for the period.

1.1 TL-HIP OVERVIEW

This report is submitted by John Snow, Inc. (JSI) to the United States Agency for International Development (USAID) in accordance with Contract No. AID-486-C-11-00003. JSI entered into a Contract with USAID on October 1, 2011 to implement the four year (October 2011 – September 2015) Timor-Leste “Health Improvement Project” (HIP).

The project objectives are:

1. Improved maternal, newborn and child behaviors and outcomes.
2. Improved health service delivery through Ministry of Health (MOH) service delivery sites.
3. Increased community engagement around key maternal, neonatal and child health (MNCH) and family planning (FP) issues.

The project builds upon six years of successful USAID support to the Government of Timor-Leste and the nongovernmental (NGO) sector in the areas of health systems strengthening, infectious disease prevention, nutrition, food security, MNCH and FP programming. Lessons learned from previous projects are incorporated into this narrative and work plan activities.

HIP activities are focused in the following technical areas: Maternal and Newborn Health (MNH) (40%), Child Health (10%) and FP (50%). HIP also includes technical emphasis on the concepts of Safe Motherhood and related maternal and infant nutrition in an integrated approach. The priority five districts for implementation are Oecusse, Manatuto, Ermera, Baucau and Viqueque.

The project will focus on the following population segments:

- Health providers at the district, sub-district and community levels.
- Women of reproductive age.
- Children under five years of age.

The project will ensure the following cross-cutting operational and implementation themes are integrated throughout the project strategies and activities:

- Gender Equity.
- Promotion and support of Timorese organizations.
- Coordination and collaboration with MOH.
- Youth Involvement.
- Male Involvement.
- Sector Leadership.
- Partnerships and Integration.

The implementation process ensures integrated planning with the full collaboration and buy-in from the MOH at its national, district and community levels. HIP provides technical assistance by helping to increase the capacity of the MOH and in promoting coordination and collaboration within the health sector among the MOH and donors. The MOH National Health Sector Strategic Plan 2011-2030, USAID and World Health Organization (WHO) best practices and evidence-based interventions are utilized as a part of the strategic programming. The HIP implementation process includes the sharing and dissemination of health information and lessons learned from MNCH and FP programming. The HIP plan includes strategies for the replication and scaling-up of successful USAID-funded interventions in health and for the identification and utilization of opportunities for collaboration and integration with USAID's non-health programming.

The HIP team functions as a whole and not a set of organizations with different allegiances; however some organizational skills are applied broadly in the project scope of work as follows:

JSI leads MNCH efforts, all health systems strengthening, and plays a key role in strategy development and implementation of reproductive health/family planning work including technical excellence and compliance management. JSI is responsible for overall management of the contract, including adhering to USAID regulations, financial management, project reporting, and overall accountability for the project achieving its results. JSI's project management cuts across all activities including the management of all district offices, with close collaboration from all team members.

Burnet Institute (Burnet) applies its expertise in areas including quality improvement for in-service trainings and pre-service trainings (including internships) in the technical areas of MNCH and FP for doctors, midwives and nurses.

Menzies School of Health Research (Menzies) guides HIP efforts in improving MNCH through nutrition, especially reinforcing practices that combat stunting and wasting. The Menzies team will collect and compile existing nutrition data. Menzies will also assist the MOH to develop a basic nutrition training course for health care providers at the sub-district level, pilot this course in Manatuto district, monitor, evaluate, document and disseminate the results of pilot and scale up the delivery of the course.

HIP has opted to focus its capacity-building effort on three thrusts: improve service quality; improve the quality and use of management information; strengthen community-level services and improve behaviors. Each thrust is divided into strategies, which are described in detail in the July to December 2012 work plan. Within each strategy, a number of specific tasks have been implemented and are described in this report.

To better define its capacity-building approach HIP developed a glossary of terms that can be found in **Annex 2**.

1.2 SUMMARY OF ACHIEVEMENTS

1.2.1 Summary of Quarterly Achievements

Improve service quality:

Strengthen Quality Improvement (QI) Systems

- HIP supported and participated in the MOH Working Groups on FP, maternal and child health (MCH), Immunization and Nutrition, and HIP provided updates on QI activities in HIP-supported districts.
- HIP developed a QI measurement tool to improve technical assistance to health personnel at the Community Health Centers (CHCs), health posts, and SISCas. By identifying problems, causes, and interventions, a work plan was developed to determine steps towards improved service quality.
- HIP participated in the review and planning meetings at district and sub-district levels. These meetings provided a platform for creating action plans to increase quality of services and coverage.
- HIP provided support for the orientation of midwives to the FP supportive supervision checklist. A total of 36 Service Delivery Points (SDPs) were supervised during this quarter.
- FP supportive supervision preliminary findings documented for Ermera and Manatuto; Integrated Management of Childhood Illnesses (IMCI) supportive supervision preliminary findings documented for Manatuto; and safe motherhood/Essential Newborn Care (ENBC) supportive supervision preliminary findings documented for Manatuto. Selected corrective actions were identified for the supervisee and supervisors.
- Follow up from the June 2012 Quality Improvement Collaborative (QIC) took place in Quarter 4, and 70% of the facilities at the workshop received QIC follow-up. Improvements included regular updating of the stock cards and use of requisitions forms for FP commodities.
- HIP supported the National Health Institute (INS) in the organization and facilitation of a “Training System Development” workshop. MOH and UN agency partners attended to provide support.

Support Rollout of Training Programs

- HIP, in partnership with UNFPA and the MCH Department of the MOH, identified required areas of in-service training for FP, safe motherhood, ENBC and Basic Emergency Obstetric Care (BEmOC) for health providers in HIP-supported districts. Plans are in place to collaborate on trainings.
- Four IMCI refresher trainings took place for 66 IMCI providers, mainly nurses and midwives. Identification of continued needs for supportive supervision and collaboration between IMCI and nutrition programs, among other recommendations, took place.
- The Menzies Nutrition and Food Security Approaches to Improving the Health of Women and Children short course was adapted to Timor-Leste context in the form of a five-day training curriculum and delivered to national level stakeholders in September 2012.
- Ongoing support provided to MOH and INS for the orientation and deployment of the 430 Timorese doctors who will graduate in November. In particular, HIP helped to define the terms of reference for the newly created “Working Commission for the Orientation and

Deployment of New Doctors to the *Sucos*” and also assisted the “Material and Orientation Section” at INS to determine the relevant materials and modules required for the orientation.

Improve quality and use of management information:

Strengthen Health Management Information System (HMIS) Technical Content and Management

- HIP continued to coordinate with the HMIS Cabinet regarding the development of a road map for revising the HMIS database and the development of a unified coding system for facilities. HIP will advocate for a unified coding system for the Health Facility Survey (HFS) design.
- Discussions took place with the Head of HMIS Cabinet, Health Promotion (HP) Department, and Planning Department to understand the data needs and reporting requirements from the SISCa. As a result, a draft reporting format was designed and submitted to the HMIS Cabinet for discussion and final approval.
- HIP provided financial and technical assistance to the five districts to support the MOH’s request of re-implementing the Family Health Register (RSF - *Rejistu Saúde Família*). The RSF re-implementation is finalized in Baucau, almost finalized in Manatuto, and ongoing in Ermera, Viqueque and Oecusse.
- The patient card system is under discussion with the HMIS Cabinet. A patient card format was designed and piloted in one of the CHCs.

Improve data quality

- HIP supported Manatuto and Oecusse District Public Health Officers (DPHOs)-HMIS to conduct supportive supervision using the HMIS supportive supervision checklist. Corrective actions were agreed upon.

Encourage greater use of information

- The HMIS Cabinet requested HIP’s support to ensure timeliness of monthly and quarterly reporting from the health post to CHC, CHC to District Health Services (DHS), and DHS to national level. The HIP district technical officers (DTOs)-HMIS assisted the health post staff to collect all data and transfer from the register to tally sheets, and into the HMIS report.
- HIP developed a tracking form to identify completeness and timeliness of HMIS reports that were used by DTOs-HMIS.
- HIP and MOH came up with the idea to build a filing system using a cheap wooden box designed in such way that the health worker responsible for FP can easily identify who is not coming to the health facility to get the service or commodity that she needs. A box will be piloted in Comoro CHC, and then the FP Working Group will determine its usefulness and how to go about scaling up in districts.
- A 3-day short course curriculum was developed and shared to cover Monitoring and Evaluation (M&E), including skills in compilation, analysis, interpretation, and use of HMIS data to improve program performance.

Strengthen community level services and improve behaviors:

Strengthen community-level delivery capabilities

- In order to improve the quality of services and the management of SISCAs and better streamline the role of HIP staff in supporting SISCAs, the 11-step checklist, developed in

Quarter 3 to guide district staff towards better meeting the SISCa standards, was implemented in the five districts.

- HIP supported Baucau district in the organization and facilitation of the National Family Health Promoter (*Promotor Saúde Família* – PSF) Day celebrations, in which approximately 300 PSFs participated.
- HIP, the MOH, Ministry of State Administration (MSA), WHO and Save the Children collaborated in a National Advocacy/Review Meeting for PDSS. MOH and MSA agreed to collaborate and work on a Memorandum of Understanding (MOU).

Implement Behavior Change Communication (BCC) initiatives

- HIP supported a FP Advocacy meeting held at Manatuto District Health Services (DHS). The meeting was called by the MCH Department, but HIP’s district team was actively involved in organizing the meeting and providing technical support to the presentations given by MOH.

Coordinating plans with the MOH, DHS and other service providers:

- HIP technical advisors participated in the MOH mid-year evaluation meeting for both district and national level activities.
- HIP integrated its technical support to the Planning Department of the MOH by integrating work plans in line with the Department’s annual action plan and district implementation plan.
- The HIP Steering Committee was expanded to a larger committee, the National Health Sector Coordination Committee (NHSCC), which will monitor all partners’ support to the districts.

Ensuring compliance:

- All HIP staff (except Oecusse team) completed the online FP compliance training course, a guideline on compliance with USAID’s requirements for voluntary FP activities.
- USAID’s prohibition on abortion activities was finalized.

Building the Small Grants Program:

- The Grants Evaluation Committee (GEC) was established and met to review the first four applications.
- Development of Request for Proposal (RFA) #2 is underway in collaboration with Gender, Policy and Measurement Project team for gender-related component.

Conducting monitoring and evaluation:

- HIP continues to contribute to the planning for the national HFS.
- Outline for the Knowledge, Attitudes and Practices (KAP) survey prepared and shared with relevant stakeholders.

Managing infrastructure and other assets:

- Specifications developed for the procurement of motorcycles.

1.2.2 Summary of Annual Achievements According to the Annual Monitoring Report

Please refer to **Annex 7**, the Annual Monitoring Report.

SECTION 2: BUILDING THE HEALTH SYSTEM CAPACITY IN TIMOR-LESTE

2.1 IMPROVE SERVICE QUALITY

2.1.1 Strengthen Quality Improvement (QI) Systems

a) Provision of technical assistance across the spectrum of QI

MOH Working Groups (WGs)

HIP supported and/or participated in the relevant WG meetings organized by the MOH and provided an update on the QI activities supported by HIP in the five focus districts and on the national level. See Table 1 for details of HIP's involvement.

Table 1. Working groups attended by HIP during Quarter 4

No. of WG(s)	Program	Month
1	Maternal and Child Health (MCH)	July
2	Family Planning (FP)	July and September
1	Immunization	August
1	Nutrition	September

Besides attending the WGs, HIP kept ongoing coordination with the MCH and nutrition departments for the following QI activities: supportive supervision and trainings for midwives, nurses and doctors in the area of Maternal, Neonatal and Child Health (MNCH) and FP.

As a support to the WGs and program activities, HIP also seconded a nutrition capacity-building coordinator to the Nutrition Department and is in the process of recruiting an IMCI assistant for the MCH Department.

Use of QI cycles to improve quality of service provision

During Quarter 3, a tool for QI measurements was developed to improve the DTOs technical assistance to health personnel. The tool is an Excel document with four main components: 1) problem statement (measurement of a specific indicator, see Figure 1; 2) causes of the problem; 3) interventions to fix the causes of the problem; and 4) work plan on how to best implement the interventions identified.

The DTOs fill and discuss this tool together with the health personnel at the Community Health Center (CHC), health post and SISCa (*Servisu Integradu Saude Comunitária* – Integrated Community Health Services). Involving the health staff in the process is a challenge, but their involvement is crucial in order to ensure staff ownership and an improvement in service quality over time.

Below is an example from Viqueque district, measuring improvement in the number of services provided at the seven SISCAs supported by HIP, from August to September (see Figure 1). Immunization was provided at all seven SISCAs both months; FP services increased from five to seven SISCAs; and Antenatal Care (ANC) and Postnatal Care (PNC) services increased from three SISCAs to seven. However, growth monitoring decreased from six SISCAs to five because the Family Health Promoter (*Promotor Saúde Familiar – PSF*) in charge was either absent or new to the PSF position. Those that were new to the position did not have a full orientation or understanding of their role at SISCa. Another root of this identified problem is a lack of compensation for the PSF’s services, which has become a disincentive for participation. In order to address these causes of the decrease in PSF involvement in SISCa, HIP helped the CHC leaders identify the following interventions:

- Reinforce coordination and communication between the local leaders and the PSFs.
- Support for transportation and human resources for SISCa activity.
- Coordinate and confirm schedules with the DHS.

Figure 1. Example of QI measurement for SISCa in Viqueque

INDICATOR(S)	Initial Measurement 16/08/2012	Definition	Data Source	Follow-up Measurement 12/09/2012
Indicator 1		% of scheduled SISCAs that took place and that included EPI services		
Numerator	7	Total of SISCa post where implemented EPI activities	Table 3	7
Denominator	7	Total of SISCa post in Uatucarbau	SISCa Post	7
Result	100			100
Indicator 2		% of scheduled SISCAs that took place and that included FP services		
Numerator	5	Total of SISCa post where implemented FP activities	Table 3	7
Denominator	7	total of SISCa post in Uatucarbau	SISCa Post	7
Result	71.43			100
Indicator 3		% of scheduled SISCAs that took place and that included ANC/PNC services		
Numerator	3	Total of SISCa post where implemented ANC/PNC activities	Table 3	7
Denominator	7	total of SISCa post in Uatucarbau	SISCa Post	7
Result	42.86			100
Indicator 4		% of scheduled SISCAs that took place and that included growth monitoring services		
Numerator	6	Total of SISCa post where implemented growth monitoring activities	Table 2	5
Denominator	7	total of SISCa post in Uatucarbau	SISCa Post	7
Result	85.71			71.43

Support to quarterly review and planning meetings

At the district level, HIP supported and/or participated in relevant review and planning meetings. These meeting are essential to QI work because they provide a good platform for analyzing coverage data, identifying issues/problems and their causes, and agreeing on actions to take to overcome the problems and increase quality of services and coverage. While in some districts, HIP responded to a clear request from DHS or CHCs to support the meeting, in other districts HIP encouraged its counterparts to organize such meetings. In the coming months those meetings at both district and sub-district levels will become institutionalized through the District Technical Working Groups (DTWGs) and Sub-district Technical Working Groups (SDTWGs) (see 3.1 for more details). Below are the meetings organized with HIP involvement during this Quarter 4:

- Ermera DHS 2-day safe motherhood and FP review meeting: financial and technical support (July).
- Ermera Vila CHC MCH review meeting (August).
- Baucau DHS quarterly review meeting (September).
- Oecusse DHS coordination meeting with partners on Quarter 3 results (September).
- Uatucarbau CHC (Viqueque) quarterly review meeting (July).
- Uatucarbau CHC (Viqueque) monthly review meeting (September).

United Nations Population Fund (UNFPA)-International Council on Management of Population Programs (ICOMP) workshop on operationalizing the call for elimination of unmet need for FP in Asia and Asia Pacific region:

As part of working with the MOH FP team on FP issues in a broader perspective, HIP Technical Advisor (TA) for MNCH/FP joined the Timor-Leste national team in the “UNFPA-ICOMP Workshop on Operationalizing the Call for Elimination of Unmet Need for FP in Asia and Asia Pacific Region” in Bangkok, Thailand. Issues regarding 1) challenges to access to services; 2) quality of services; 3) FP commodities security; 4) FP policies; and 5) financing for the FP programs were thoroughly discussed in the workshop. The Timor-Leste team, also composed of the MOH national director for Community Health and FP officer and UNFPA Country Representative and Deputy, identified specific interventions for the country (see **Annex 3**). The team reached a commitment for implementing the plan.

b) Facilitation of supportive supervision at the district-level

Technical assistance to supportive supervision

FP supportive supervision is one of the main activities supported by HIP under the integrated 2012 work plan with the MOH FP Unit. The arrival of HIP TA for MNCH/FP prompted this activity. However, before actually starting the support to the DPHOs-MCH for FP supportive supervision, HIP was requested by the MOH FP Unit to, whenever needed, orient the district midwives on the supportive supervision checklist, which has never been used in some districts. During Quarter 4, HIP supported three DPHOs-MCH in the orientation of their midwives to the FP checklist, with the details below (Table 2).

Table 2. Orientations to the FP supportive supervision checklist per district

Place	No. of midwives	Month
Baucau	24 (out of 36)	September
Manatuto	16 (out of 36)	August
Viqueque	23 (out of 27)	August

Aside from orienting staff to the content of the FP checklist, HIP provided assistance to DPHOs-MCH in the planning and conduct of supportive supervision in Ermera and Manatuto districts, in the technical areas of FP, IMCI and safe motherhood/ENBC. Supportive supervision visits in Baucau, Viqueque and Oecusse will be supported during the next quarter. Table 3 below shows that a total of 36 Service Delivery Points (SDPs) were supervised during Quarter 4. In Manatuto,

IMCI supportive supervision covered 15 out of 24 health facilities and safe motherhood/ENBC supervision covered Barique and Manehat health posts and Natarbora CHC. FP supportive supervision was conducted in 12 health facilities in Manatuto (Soibada, Laclubar and Natarbora CHCs and nine health posts), five CHCs (Railaco, Ermera, Letefoho, Gleno and Hatulia) and one health post (Bhakita) in Ermera (out of 20 health facilities in Ermera district).

Table 3. Number of SDPs supervised during Quarter 4

Technical area	SDPs	
	Ermera	Manatuto
IMCI	0	15
FP	6	12
Safe Motherhood/ENBC	0	3
Total	6	30

HIP will assist the DPHO-MCH in the compilation of the results during the next quarter; however, some preliminary findings can already be outlined.



Ermera DPHO-MCH conducting FP supportive supervision with HIP DTOs in one of the CHCs.

FP supportive supervision in Ermera, summary of preliminary findings:

- None of the 5 CHCs and health posts had Behavior Change Communication (BCC) materials available to provide to the FP clients.
- Only one CHC (Ermera Vila) had all FP materials and methods in a box, ready to be shown to clients in the FP service delivery room.
- Contraceptive logistics, including recording use of commodities and timely and accurate requisitions for commodities, and the state of physical inventories were good in three out of the five CHCs. On-the-job coaching was provided on this during the supportive supervision for Letefoho and Railaco CHCs.

- The new doctors posted in Ermera Vila, Letefoho and Railaco CHCs are not trained in FP counseling and clinical services.
- Midwives have not received any refresher training since their basic training several years ago. In addition they have not yet acquired the competency in Intrauterine Device insertion. Lack of in-service training has many other negative impacts on quality of counseling, FP care and the ability to provide services according to MOH service delivery guidelines.
- Railaco and Letefoho CHCs lack light and space to ensure privacy in the FP service room. Moreover, the hand washing space is too far from the service delivery room. Immediate feedback was provided to the CHC managers.
- Gleno CHC does not have any proper waste disposal mechanism.

For each of problems identified, HIP, the DPHO-MCH and health facilities staff agreed on corrective actions to be taken by both the supervisee and the supervisor. The next round of supportive supervision will assess whether those actions were taken or not.

Selected corrective actions discussed during supportive supervision:

Supervisee:

- Request BCC materials and commodities from the DHS on a more systematic, routine basis.
- Railaco and Letefoho CHCs health staff to improve clients' privacy set up.
- Railaco and Letefoho CHCs health staff to improve logistics.

Supervisor:

- Conduct refresher training to midwives and follow up after training to ensure acquisition of competencies.
- Liaise with INS regarding training of new doctors.
- Provide BCC materials after having received the request from health facilities.
- Conduct supportive supervision visits on a regular basis.

FP supportive supervision in Manatuto, summary of preliminary findings:

- None of the 12 health facilities had BCC materials available to provide to the FP clients.
- The Decision-Making Tools (DMT), the MOH counseling flipchart for FP, is not properly used by midwives.
- Four health posts (Manelima, Manehat, Barique and Aimeta Laran) do not prepare the Logistics and Management Information System (LMIS) reports on a monthly basis.
- The FP counseling book is not available in Aimeta Laran health post.
- Almost all health workers from health posts are not recording correctly the update on the client status card.
- Basic furnishings for proper commodity management, such as cabinets for keeping medicines and commodities, are lacking in some health posts.
- Infection control equipment not available in Barique, Manehat and Aimeta Laran health posts.

Selected corrective actions discussed during supportive supervision:

Supervisee:

- Request BCC materials and commodities from the DHS on a more systematic, routine basis.
- Create consistency in the completion of registration and client cards.

Supervisor:

- Link with National level to organize refresher training on LMIS and FP counseling.
- Organize orientation on the DMT for FP.

IMCI supportive supervision in Manatuto, summary of preliminary findings:

- IMCI is not systematically applied to all sick children under 5.
- Oral Rehydration Therapy (ORT) corners not consistently set up because the petty cash allocated to health facilities is not sufficient for buying water and materials.
- Most health posts do not have chairs or a table for consultation.
- Most health facilities face stock out of some essential drugs and equipment.



Manatuto DPHO-MCH observing an IMCI consultation during supportive supervision.

Selected corrective actions discussed during supportive supervision:

Supervisee:

- Follow the IMCI protocol for each consultation.
- Request BCC materials and IMCI drugs from the DHS on a more systematic basis.

Supervisor:

- Coordinate with national level for refresher training.¹

¹ As described below under 2.1.2, HIP supported the MOH to conduct IMCI refresher trainings in three districts. Manatuto refresher training will be conducted in November 2012.



Ermera DPHO-MCH checking the IMCI case recording form during a supportive supervision visit.

Supported by HIP, Manatuto DPHO-MCH has been very proactive in conducting regular supportive supervision in the health facilities, which contributed to improving quality of care in a concrete, visible manner. The supervision visits allowed regular mentoring and on-the-job training for IMCI providers, who, despite the problems identified above, have gradually improved their skills in assessing, classifying and treating sick children according to the IMCI protocol. On-the-job training included, for example, how to request IMCI drugs to the CHC and DHS, how to properly fill in the case recording form, how to classify diseases from the assessment and how to provide the right treatment according to the classification.

Safe motherhood/ENBC supportive supervision in Manatuto, summary of preliminary findings:

- Most health facilities supervised had a private room for consultation.
- Most midwives had been trained on safe motherhood (83%) and Emergency Obstetric Care (EmOC) (67%), but none were trained on ENBC.
- All health facilities showed high scores for infection prevention.
- Only one third of health facilities had the drugs and equipment for labor, delivery and ENBC.
- Supportive supervision on safe motherhood/ENBC rarely conducted.

Selected corrective actions discussed during supportive supervision:

Supervisee:

- Request drugs and materials/equipment on a more systematic, routine basis.

Supervisor:

- Organize training for ENBC for all midwives and new doctors in Manatuto district.
- Organize refresher training on safe motherhood for all midwives in Manatuto district (and training for new doctors).
- Conduct supportive supervision on a more regular basis.

c) Introduction of Quality Improvement Collaborative (QIC)

QIC follow-up

The last day of the three-day QIC workshop conducted in June 2012, which focused on improving the quality of LMIS, also addressed the coaching part of the QIC. This “coaching” session was provided to part of the Ermera District Health Management Team (DHMT), including the DPHO-MCH and HIP team (Ermera team and DTOs-QI from other districts). This session prepared the DHMT and HIP on how to follow up on the QIC facilities in implementing the improvements they identified for better LMIS after they attended the QIC workshop.

The DPHO-MCH took advantage of the FP supportive supervision visits to the CHCs and health posts to provide the follow-up required for the QIC. Seventy percent (70%) of the facilities participating in the QIC were visited and received QIC follow-up. The improvements noted in QIC facilities include:

- In general, the stock cards were regularly updated.
- The use of requisition forms for FP commodities (instead of only using a simple sheet of paper) increased.

Nevertheless, below are some findings that require more support:

- Inventories of physical stock are not conducted regularly in order to cross-check with the balance on stock cards.
- Despite the regular stock cards update, there are still stock outs in a few facilities because: 1) not all midwives are consistent in filling the cards and 2) midwives are not paying attention to the amount of commodity left in the stock card, even when it becomes very low.
- Health posts requisitions for FP methods are not included in the CHC ones, but instead, they are sent directly to the DHS.
- Some midwives still need re-orientation on how to know their average consumption and how to calculate and predict the amount of each FP methods they require on a monthly basis.
- None of the CHCs shared the information/knowledge acquired during the QIC workshop on LMIS to their non-participating health posts, mainly due to the lack of regular follow-up from the DHS.

The team was not able to do the LMIS follow-up in two CHCs because the midwives responsible were not present. During the follow-up visits to 70% of sites, necessary coaching/mentoring was provided and discussions on how to improve were held based on the observations identified.

Selected corrective actions discussed during QIC follow up visit:

Supervisee:

- Conduct physical inventory in order to cross-check with the records from the stock cards.
- Use the principle of a stock minimum so that requests can be made with ample time.
- Health posts to follow protocol for requisitions.
- Monthly requisitions according to stock maximum and stock on hand.

Supervisor:

- Include the health posts that did not receive the information in the next feedback workshop.

d) Capacity-building to INS to organize, deliver and follow-up training

HIP, with the technical assistance of partner Burnet Institute, has been supporting the National Health Institute (*Instituto Nacional da Saúde – INS*) to organize, deliver and follow-up trainings since Quarter 2. By conducting an organizational development capacity building assessment, assisting to develop its M&E framework, training 17 MOH midwives in FP counseling and clinical skills, and organizing a visit to *Nusa Tenggara Timur* (NTT) provincial training center in Kupang, Indonesia (all in Quarter 3), HIP supported INS in the organization and facilitation of a “Training System Development” workshop. The workshop was attended by MOH and partners supporting INS, such as UN agencies, donors and non-governmental organizations (NGOs). The workshop resulted in a common understanding of INS needs and in an agreement on working together to define MOH needs.



Head of MCH Department providing input on MOH needs in terms of trainings provided by the INS.

Burnet later facilitated an INS assessment to identify training needs for the INS trainers and training needs for health professionals (doctors, nurses and midwives). Continued technical assistance from Burnet in the following quarter will further determine how the training will be organized and delivered.

HIP and INS worked on developing a MOU defining both organizations' responsibilities. It will be signed by the Executive Director of the INS and HIP's Chief of Party (COP) during the next quarter.

2.1.2 Support Rollout of Training Programs

a) Support to the rollout of in-service training

In-service trainings for FP, safe motherhood, ENBC and Basic Emergency Obstetric Care (BEmOC)

During Quarter 4, HIP regularly met with UNFPA and the MCH Department of the MOH to plan and collaborate on in-service training on FP, safe motherhood, ENBC and BEmOC for the health providers working in HIP-supported districts. In this regard:

- An inventory was completed to identify training needs for the midwives and nurses for basic and refresher trainings in the area of MNCH and FP.
- A list of midwives needing basic and refresher trainings in the area of MNCH and FP was compiled. The MOH and INS have agreed to collaborate to conduct the trainings.
- A verbal agreement was reached between the FP Unit of MOH, the INS, HIP and UNFPA to conduct three waves of FP trainings before the end of December 2012.
- A verbal agreement between the same parties was reached to collaborate on a BEmOC training strategy, including standardized training of a national team of trainers in Indonesia, a training of trainers in Dili, and several rounds of training during 2013.

Other Related Activities

HIP supported the Manatuto DPHO-MCH and the Soibada CHC manager in conducting an orientation on the DMT for FP to the sub-district midwives based in CHC and health posts.

b) Support to the rollout of refresher training

IMCI refresher training

The first national IMCI refresher trainings were conducted between 2008 and early 2009. The training focused on the technical updates deriving from the World Health Organization (WHO) recommendations on IMCI treatment protocol. Recently, there have been additional changes in the use of malaria Rapid Diagnostic Test (RDT) and the incorporation of the Community Management of Acute Malnutrition (CMAM) into the IMCI treatment protocol. These changes required another national IMCI refresher training.

In close coordination with MCH and Nutrition Departments, along with the DPHOs-MCH and nutrition from the five focus districts, HIP provided support (financial, material and facilitation) to four refresher trainings. The two-day refresher trainings were provided to 66 IMCI providers (18 in Baucau; 9 in Oecusse; 16 in Ermera and 23 in Viqueque), mainly consisting of nurses and

midwives. The methodologies used were: brief PowerPoint presentation, IMCI chart booklet review, and case study using IMCI case recording form and discussions. The training started with a pre-test and ended with a post-test and a quick self-assessment by each participating facility using the IMCI supportive supervision checklist to identify issues influencing the implementation of IMCI treatment protocol. The findings and recommendations from the refresher trainings are as follows:

- The motivation to implement the IMCI protocol is high because it is a very systematic way of attending sick children; however, the lack of regular support from CHC management, DHS and national level (in terms of responding to issues such as lack of drugs and equipment) risks compromising health staff motivation.
- In addition to the refresher training, supportive supervision needs to be conducted regularly and strengthened to ensure proper implementation of the IMCI protocol.
- IMCI and nutrition providers should continue working together, especially in attending malnourished sick children.
- There is a need to update the Health Management Information System (HMIS) form for IMCI (this will be one of the agenda items in the next MCH WG meeting).
- Availability of essential drugs and equipment remains an important challenge (i.e., zinc stock out in *Serviço Autónomo de Medicamentos e Equipamentos de Saúde (SAMES)* (Autonomous Services of Drugs and Health Equipments)).

c) Support to the rollout of a nutrition short course

Development of a Timor-Leste short course curriculum

The Menzies 20-day Nutrition and Food Security Approaches to Improving the Health of Women and Children short course was adapted to Timor-Leste context in the form of a five-day training curriculum. It was delivered to national level stakeholders in September 2012.

Negotiations are currently taking place for finalizing the content of this five-day training to be used to develop a curriculum for future in-service training in nutrition at INS. With support from the MOH Nutrition Department, Health Promotion Department and the INS, this course will be further adapted for use in Manatuto district.

d) Support to the rollout of training for newly graduated service providers

By the end of November 2012, 430 Timorese doctors will graduate from the National University of Timor-Leste (UNTL). They will follow a 2-week orientation course in December and will be deployed to 211 health posts and some of the 67 CHCs in February under a civil servant contract. HIP has started to provide support in two different areas: 1) support to the doctors' orientation and 2) advocacy for the set up of a management and technical structure for the doctors' support. In November, an assessment of the doctors' needs and planning for in-service trainings will be conducted.

HIP provided ongoing support to the MOH and INS for the deployment of the new doctors. Starting from August 2012, HIP strongly advocated to the MOH Human Resource (HR)

Directorate and several stakeholders (such as WHO, UNTL and the *Asosiasaun Mediku de Timor-Leste*, the Timor-Leste Doctors Association – AMTL) for the formation of a high level Commission in charge of managing the upcoming deployment of the doctors. When the Vice-Minister of Health requested the quick formation of the “Working Commission for the Orientation and Deployment of New Doctors to the *Sucos*,” HIP supported MOH in the revision of the Terms of References (TOR). HIP was also appointed as the main partner organization to support INS in the management of the “Material and Orientation Section,” in charge of developing the orientation package for the new doctors.

HIP supported the INS in organizing the “Material and Orientation Section” meetings, which resulted in an agreement on the materials to be taught during the orientation and in a clear delegation of responsibilities among key MOH managers for the development of the modules. Table 4 below provides details on the materials agreed upon, the main responsible entities and support from partner organizations to develop seven orientation modules.

Table 4. Orientation package and responsible entities

No.	Materials	Responsibility		Support
		Main	Others	
1	TOR for doctors	HR	INS and AMTL	WHO, UNICEF, USAID and HIP
2	Public Function	HR	INS and Public Function Commission	Public Function
3	Career regime	HR	INS and Public Function Commission	Public Function
4	Ethics	AMLT	INS, Quality Control Cabinet and UNTL	UNFPA and WHO
5	National Health Policy and Health System	Health Policy Cabinet	INS	WHO, USAID and AusAID
6	BSP and SISCa	Community Health Directorate	INS	UNFPA, UNICEF, WHO, HIP, USAID and AusAID
7	Public Health Management (global vision of health, supervision and monitoring)	Planning Department	INS, HMIS, Health Policy Cabinet, Community Health Directorate and UNTL	WHO, USAID and HIP

In constant coordination with the INS, HIP supported the MOH in developing the following materials: TOR for doctors placed at CHC and health post level (currently being revised by AMTL); National Health Policy and Health System; Basic Services Package (BSP) and SISCa; and Public Health Management.

During the next quarter and with support from Burnet, HIP will help MOH to conduct an assessment of the doctors’ needs in terms of in-service training. UNTL Medicine School

curriculum and internship program will be reviewed and a training plan will be developed according to the gaps identified in comparison to the doctors' TOR.

While the majority of those gaps are unknown or not documented at this stage, the need for a management and technical structure able to provide supportive supervision is already apparent. HIP already developed a concept for the placement of the first batch of UNTL graduated doctors (2011) at all levels of the health system for trainings (INS-based) and technical/management (MOH and DHS-based). In this scenario, doctors at INS would be intensively trained as trainers and would provide trainings to their peers working at CHC and health post levels, in addition to conducting regular supportive supervision. The ones placed at the national Community Health Directorate and DHS (in the role of "DPHO-doctor" or "district medical officer") would work on program design, implementation and monitoring. They would have a management, mentoring and supervisory role for the CHC and health post doctors.

2.2 IMPROVE QUALITY AND USE OF MANAGEMENT INFORMATION

2.2.1 Strengthen HMIS Technical Content and Management

a) Health Facilities' IT Capabilities, Road Map for Creating a HMIS Database Design and Unified Coding System for Facilities

HMIS database

The expansion of the use of the HMIS database developed mid-2011 did not take place as planned due to the health facilities' poor Information Technology (IT) capabilities. HIP met with Catalpa, a company specialized in IT and based in Timor-Leste, for possible collaboration on a health facility assessment regarding IT capacities of the health facilities and the development of a road map for revising the HMIS database. Unfortunately, these interventions were not received as a priority by the head of the HMIS Cabinet currently busy revising the seventeen official formats.

HIP team initiated discussion with the HMIS Cabinet on introducing numerical codes for all health facilities and SISCAs using a mix of p-codes and facility codes. The codes will be helpful in separating data for each facility including SISCAs. A standard coding guideline will be developed and shared with the HMIS Cabinet during the HFS design and implementation.

b) Assessment of information needs at *suco* and SISCAs levels

Revision of the HMIS data collection forms

Along with the head of HMIS Cabinet, field visits were organized to assess *suco* (village) and SISCAs level information needs at various health facilities in Dili. Discussions were also organized with the head of HP Department and Planning Department to understand the data needs and reporting requirement from SISCAs. Following the assessment, discussion and

meetings, a draft reporting format was designed for reporting from SISCAs and submitted to the HMIS Cabinet for discussion and final approval.

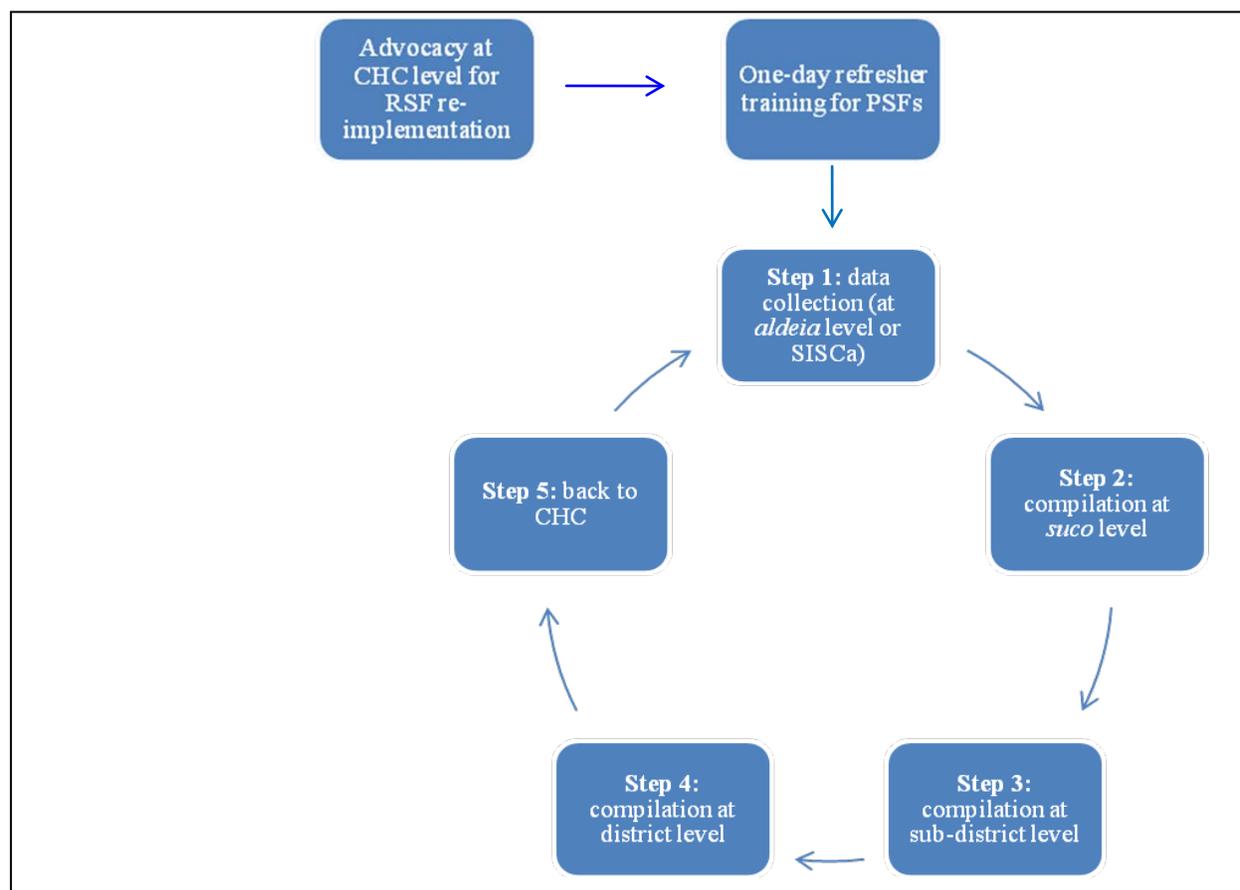
Designing a HMIS system for the newly trained doctors was also discussed with the team (mentioned above). The team concluded that once the roles and responsibilities of these doctors are finalized they can work on designing an appropriate information system to capture data on service delivery.

c) Ensure RSF data is regularly collected and updated

Re-implementation of the RSF

During Quarter 4, HIP provided intensive financial and technical assistance to the five districts in order to boost the re-implementation of the Family Health Register (RSF – *Rejistu Saúde Família*), a register capturing real-time information on births, deaths, pregnant women, newborns, under-fives and on priority diseases. The normal cycle for RSF implementation includes the following five steps (see Figure 2):

1. Data collection at *aldeia* (hamlet) level (or at SISCa), done by the PSFs using the paper-based RSF data collection format.
2. Compilation and tabulation at *suco* level, done by the PSFs, by transferring the data from the data collection tool to the tally sheet to the paper-based RSF reporting format for *suco*.
3. Compilation of RSF data to the sub-district reporting format, done by the CHC HMIS focal point. This task is computerized in the CHCs equipped with a computer using the new RSF database where it has been socialized. In the CHCs where there is no computer or where electricity is unreliable, the health staff is completing the paper-based format by hand.
4. Compilation at DHS level by the DPHO-HMIS.
5. The report goes back to the CHC for denominator use and tracking of target populations.

Figure 2. RSF update and feedback cycle


Because the RSF had not been updated for several years, MOH requested all districts to re-implement the RSF. That is why two steps were added in the beginning of the process: an advocacy meeting at CHC level for all community leaders and PSFs and a one-day refresher training for PSFs to do the data collection and compilation at *suco* level. Based on the needs of the district and focus sub-districts, HIP's technical assistance included either all or only some of the steps outlined in Figure 2. Below is further detail of the technical assistance provided by HIP.

Table 5. RSF re-implementation status per district, with focus sub-districts details

Steps	Districts and focus sub-districts status				
	Baucau	Ermera	Manatuto	Oecusse	Viqueque
Advocacy to community leaders at CHC level	- Quelicai: done - Other CHCs: done (*)	- Ermera Vila and Letefoho: done - Other CHCs: done (*)	- Laclubar and Soibada: done - Other CHCs: done (*)	Advocacy done at DHS level with all community leaders (*)	- Lacluta and Uatukarbau: done - Other CHCs: done (*)
Refresher training to PSFs	- Quelicai: done - Other CHCs: done (*)	- Ermera Vila and Letefoho: done - Other CHCs: done (*)	- Laclubar and Soibada: done - Other CHCs: done (*)	- Oesilo: done - Baqui: done - Other CHCs: done (*)	- Lacluta and Uatukarbau: done - Other CHCs: done (*)

Steps	Districts and focus sub-districts status				
	Baucau	Ermera	Manatuto	Oecusse	Viqueque
1. Data collection	- Quelicai: done - Other CHCs: done (*)	- Ermera Vila: done - Letefoho: on-going - Other CHCs: on-going (*)	- Laclubar: done - Soibada: done - Other CHCs: done (*)	- Oesilo: done - Baqui: on-going - Other CHCs: done (*)	- Lacluta: done - Uatukarbau: on-going - Other CHCs: on-going (*)
2. <i>Suco</i> compilation	- Quelicai: done - Other CHCs: done (*)	- Ermera Vila: done - Letefoho: on-going - Other CHCs: on-going (*)	- Laclubar: done - Soibada: done - Other CHCs: done (*)	- Oesilo: done - Baqui: on-going - Other CHCs: done (*)	- Lacluta: done - Uatukarbau: on-going - Other CHCs: on-going (*)
3. CHC compilation	- Quelicai: done - Other CHCs: done (*)	- Ermera Vila: done and sent to DHS	- Laclubar: done - Soibada: done - Other CHCs: done (*)	- Oesilo: on-going - Other CHCs: done and sent to DHS (*)	- Lacluta: on-going
4. DHS compilation	- Done (*) - Data sent to HMIS Cabinet	- Not yet	- Done	- Not yet	- Not yet
5. Back to CHC/use	- All CHCs: done by HMIS Cabinet	- Not yet	- The data will be brought back to CHCs by HMIS Cabinet	- Not yet	- Not yet
Database socialization and installation	- DHS: done (*) - Quelicai and other CHCs: installation failed (technical problem in the software)	- Not yet	- DHS: next quarter - Laclubar: next quarter - Soibada: next quarter	- DHS: done (*) - Oesilo: no computer - Baqui: no computer - Other CHCs: no computer	- DHS: done (*) - Lacluta: computer to be checked - Uatukarbau: no computer

(*) Activity supported by DHS or CHC (not directly supported by HIP).

A quick analysis of Table 5 shows that the RSF re-implementation is finalized in Baucau, almost finalized in Manatuto (waiting for the HMIS Cabinet to return the data to the CHCs and community) and on-going in the three remaining districts. In Ermera, Viqueque and Oecusse, the HIP team managed to support Ermera Vila, Lacluta and Oesilo sub-districts in starting and/or finalizing *suco* level compilation; HIP will strengthen its support to Letefoho, Uatukarbau and Baqui sub-districts, where data collection has not yet been completed.

At the district level, only two districts have completed the entire re-implementation across *sucos*/SISCAs. The HIP team is encouraging the health staff to use the RSF at SISCAs in order to ensure that all women and children under five receive the quality services provided by the CHC and health post staff.

d) Advocacy for separate collection of SISCa Data

Currently an average of 442 SISCAs is organized every month across the country providing preventive and curative services in rural and remote areas. The HMIS should be designed to capture performance data of these SISCAs. Service delivery data on number and types of patients, seen at a SISCa and other types of service providers, will be helpful for planning the next SISCa and the optimal utilization of resources. Currently, the SISCa performance data is aggregated with the total CHC data and not recorded and reported separately. As described above, support was provided to the HMIS Cabinet in drafting a reporting format for SISCa. The format is being finalized and piloted in a few SISCAs.

A patient card system is currently being discussed with the HMIS Cabinet. A patient card format has been designed and is being piloted in one of the CHCs. The system will be tested and expanded.

2.2.2 Improve Data Quality**a) Adaptation of the HMIS supportive supervision tools to provide stronger HMIS oversight**Technical assistance to HMIS supportive supervision

Using the MOH HMIS supportive supervision checklist, HIP had focused its effort on HMIS supportive supervision during Quarter 3. It had provided valuable information on the performance of the HMIS system and highlighted issues related to data quality and use of data. During Quarter 4, HIP supported Manatuto and Oecusse DPHOs-HMIS to conduct supportive supervision, respectively in two CHCs in Manatuto (Soibada and Laclubar) and three health posts in Oecusse (Pune, Tumin and Nibin, from Oesilo sub-district). Similar findings and corrective actions were found and agreed upon in the conducted supportive supervisions of Quarter 4 as in Quarter 3.

2.2.3 Encourage Greater Use of Information**a) Assistance to districts to improve information reporting**Technical assistance to reporting and the reports' timeliness and completeness

The HMIS Cabinet specifically requested HIP's support to ensure timeliness of monthly and quarterly reporting from the health post to CHC (by the 3rd of each month), from CHC to DHS (by the 6th of each month) and from DHS to national level (by the 10th of each month). From the 1st to the 3rd of each month, HIP DTO-HMIS assist the health post staff to collect all data and transfer them from registers to tally sheets and into the 17 pages of the HMIS report. DTOs-HMIS also support the data verification, analysis, cross-check and validation at CHC level and district level. Ideally the first two weeks of each month should be dedicated to this task for ensuring timeliness and completeness of HMIS reporting, as requested by the national level HMIS Cabinet.

During Quarter 4, HIP tried to assess timeliness and completeness of reports from health post to national levels (see Table 6 for results). Data is considered *timely* when it is up-to-date and when the information is available on time (indicator calculation: number of timely reports / number of expected reports x 100). Completeness means that an information system from which the results are derived is appropriately inclusive: it represents the complete list of eligible persons or units and not just a fraction of the list (indicator calculation: number of complete reports / number of expected reports x 100). HIP developed a tracking form, which was used by DTOs-HMIS, to identify completeness and timeliness of HMIS reports and to measure the indicators in Table 6.

Table 6. Percentage of timeliness and completeness of reports compiled by health facilities during the period of January to September 2012

District	Indicator	
	Timeliness	Completeness
Ermera	- All CHCs (average): 89%	- All CHCs (average): 100%
Manatuto	- Soibada CHC: 78% - Laclubar CHC: 67% - Other CHCs: 78%	- All health facilities (average): 100%
Oecusse	- DHS: 100% - Oesilo CHC: 89% (with health posts between 56 and 89%) - Baqui CHC: 56% (with health posts between 67 and 89%) - Passabe CHC: 56% (100% for the last 4 months) - Nitibe CHC: 67%	
Viqueque	- Lacluta CHC: 89% - Uatucarbau CHC: 89% (health posts are above 67%) - Other CHCs: between 67 and 89%	- Lacluta CHC: 100% - Uatucarbau CHC: 100%

The assessment results show that timeliness is usually good at the health posts because they generally start their data reporting at the end of the month. In the focus sub-districts in particular, HIP has provided intensive assistance in conducting the HMIS days. The timeliness at CHCs varies between 56 and 89%. Very often the reason given by CHCs (and observed by HIP) is the lack of transport to bring the reports from one level to the other.

Improving data quality – an example for FP

Data quality was another important issue found in Quarter 3 supportive supervision activities. Identified problem areas included the mismatch between general registers, program registers and HMIS reports; misunderstanding of some indicators (such as FP continuous users); drop-outs not captured; and stock out of FP client cards.

An important problem found during supportive supervision was the difficulty in identifying the number of FP clients who were dropping out of the program, especially for those using injections and pills. The main reason appeared to be an inappropriate filing system for the FP client cards, which did not facilitate a good follow-up or easy identification of drop outs. Based on observations through supportive supervision and other health facility-based activities, HIP and MOH came up with the idea to build a filing system using a cheap wooden box designed in such way that the health worker responsible for FP can easily identify who is not coming to the health facility to get the service or commodity that she needs. HIP supported the LMIS officer of MOH to facilitate a brainstorming session and a simulated trial of the FP client card filing system box. All members of the FP WG and three midwives from Becora, Lanud and Becora CHCs expressed their willingness to implement this system. The FP WG members agreed to pilot the box in Comoro CHC. After the pilot phase, the FP WG will discuss and determine its usefulness and then decide how to go about scaling up in districts. The pilot process will be monitored by a national team composed of the FP Unit, Health Alliance International (HAI), HIP and Dili DHS during the next quarter.

Support to LMIS training

HIP provided technical assistance to the FP Unit for the organization of a LMIS training in Baucau. Assistance also included the development of training materials, pre- and post-test questions, post-training evaluation forms and the facilitation of the training.

b) Training of facilities to interpret, use and share performance data

M&E training and disaggregation of *suco* level data

HIP noticed that its district team, DHS, and CHC staff lacked knowledge and skills that were required for effective monitoring of district health services. This observation was discussed with DHS officials and agreed to provide training to all DHS staff, CHC managers, and HIP team in the district. A short course curriculum for three days training and necessary teaching learning materials were developed and shared (see Table 7). The main objective of the training was to enable DHS and HIP participants to compile, analyze, interpret and use HMIS data to improve program performance.

Table 7. Content and methodology of the training

Content	Key points	Methodology
M&E framework	<ul style="list-style-type: none"> - Definition - Framework - Indicators 	PPP discussion
Catchment areas and target populations for district and various sub-districts	<ul style="list-style-type: none"> - Definition of catchment area - Target population for various services - Calculation of target population for various services 	Discussion, individual and group exercises
Compilation of data by month, and by SDP for a selected indicator	<ul style="list-style-type: none"> - Quality - Coverage 	Group or individual exercise
Data Analysis, interpretation, and use	<ul style="list-style-type: none"> - Performance rating - Problem identification - Recommendation and planning 	Group discussion
Presentation discussion	<ul style="list-style-type: none"> - Observation - Interpretation - Action plan 	Group work
Socialization of <i>suco</i> data disaggregation tools	<ul style="list-style-type: none"> - Presentation - Discussion 	Plenary/ group work



Ermera Vila CHC Manager commenting on an indicator illustrated by HIP M&E Officer on the flipchart.

Step by step activities:

- A. Identify an important health indicator.
- B. Identify numerator and denominator data for the indicator.
- C. Identify data sources for both numerator and denominator.
- D. Complete worksheet with numerator and denominator data by month for various SDPs.
- E. Identify strengths.
- F. Identify weaknesses.
- G. Identify and recommend locally viable action to address the weakness and organize into a time bound work-plan.
- H. Repeat the step A-G for each indicator.

During Quarter 4, the training was conducted in two districts (see Table 8).

Table 8. Details per Training

District	Date	Total participants	No. of participating CHCs
Baucau	August 15-17	21	5
Oecusse	September 12-14	29	3

In Baucau, the MOH M&E officer participated in the training; an MOH HMIS officer participated in Oecusse. The training was well received by participants and each obtained a copy of the presentations for their future use.

The first two hours of the workshop were allocated for background and introduction. During this two hour session, the discussion focused on maternal, infant, and child mortality rates/ratio for Timor-Leste and corresponding numbers for each respective district. Discussion continued about the causes of these deaths and the interventions that can prevent those causes or treat conditions.

Participants of the workshop also discussed catchment area, catchment population, and target groups for various services. The formula for deriving service specific target populations was reviewed. The administrative map of the district – showing sub-district and *suco* boundaries and location of CHC – served as a guide to distinguish the areas that are not accessible to CHC.

The above introductory session was followed by a session on the monitoring of program performance. For this, each CHC was expected to bring the HMIS monthly data that they had received from various health posts as well as the data generated from CHC during January to June 2012. Participants were grouped for each CHC. The groups then plotted performance in the monthly data worksheet. A comparison was drawn between the monthly performance against target population and expected users.

Variation in coverage between different facilities demonstrated that the key service utilization data must be disaggregated by *suco*. On the third day, participants were oriented on *suco* data disaggregation tools (developed by the HMIS Cabinet and customized by HIP for its focus districts).

Below is the *suco* data disaggregation tool socialization status during Quarter 4:

- Conducted in three HIP focus districts, Baucau, Oecusse and Ermera.
- The next districts will be Manatuto and Viqueque.
- During the next quarter, HIP will assist its focus CHCs to field test the tool, focusing on one or two indicators.

2.3 STRENGTHEN COMMUNITY-LEVEL SERVICES AND IMPROVE BEHAVIORS

2.3.1 Strengthen Community-level Delivery Capabilities

a) Development/dissemination/monitoring of standards for conducting SISCas

As a part of HIP's efforts to improve the quality of services and the management of SISCAs, the role of HIP staff in supporting SISCAs had been clarified during Quarter 3. A checklist of 11 steps was developed for district staff to follow in the future in order to support better the CHCs in meeting the SISCa standards (see Annex 4). The list was socialized with all district staff and implemented. The implementation results will be discussed during the next quarter. Besides the 11-step checklist, HIP staff kept using the MOH monitoring checklist to assess the functioning of SISCAs (see Table 9 below for the list of SISCAs supported by HIP and scores obtained).



Quelicaí health staff and HIP team preparing for SISCAs in Guruça.

Table 9. SISCas supported by HIP during Quarter 4

Districts	Sub-districts	Sucos	SISCa posts	Scores (*)
Baucau	Quelicai	Kulugia	Guruça	B
		Lelalai	Watagia	B
		Adukele	Adukele	C
		Waiaka	Waiaka	B
		Namanei	Namanei	C
		Lasorulai Leten	Lasorulai Leten	B
		Lasorulai Kraik	Lasorulai Kraik	C
		Abu	Abu	B
		Maluro	Maluro	C
		Saraida	Saraida	B
Manatuto	Laclubar	Manelima	Lafulau	A
		Orlalan	Pualaka	B
		Sananain	Sananain	B
		Funar	Funar	B
		Fatumakerek	Tasi Fatin	A
		Maun Fahe Kiik	Maun Fahe Kiik	A
	Soibada	Manlala	Manlala	B
		Salau	Salau	A
		Leohat	Leohat	A
Viqueque	Lacluta	Lalini	Lalini	B
		Uma tolu	Aitara,	A
			Dasi Loe	A
		Dilor	Rade Uman	B
	Uatukarbau	Bahatata	Bahatata	B
		Afloicai	Afloicai	A
			Lia-Oli Hoo	B
		Loi-Ulu	Loi-Ulu	A
		Irabere	Irabin Leten	A
			Irabin Kraik	B
Uani-Uman	Uani-Uman	A		
Ermera	Ermera	Urahau	Caetorloa	B
		Lisapat	Namnaro	B
		Fatubessi	Bugria	B
		Mauubu	Mauubu	B
		Ponilala	Sakok	A
	Letefoho	Assi	Hauptu	A
		Leimea Sorin Balu	Leimea Sorin Balu	B
		Lakau	Lakau	B
		Catrai Leten	Raebou	B
		Catrai Kraik	Hatuqueu	B

Districts	Sub-districts	Sucos	SISCa posts	Scores (*)
Oecusse	Oesilo	Bobometo	Nonquican	B
		Usitasae	Lis As	B
		Usitaquino	Nibin	B
	Pante Makasar	Naimeco	Oe-lulan	B
		Lifau	Lifau	B
		Lalisuc	Usapibela	B
		Costa	Cutete	B
		Cunha	Cunha	B

(*) The scores are from the MOH SISCa monitoring checklist



Health staff, assisted by PSF, conducting HP to mothers on complementary feeding in SISCa Tasifatin, Soibada sub-district.



Baucau DPHO-HP facilitating a night event in Guruça

During Quarter 4, HIP continued its communication activities at SISCAs and, as requested by all focus CHCs, the “night events.” Night events are organized in remote places the night before SISCa and use HP films and discussion guides for sharing health information. Table 10 lists the 56 night events organized during Quarter 3.

Table 10. Night events supported by HIP during Quarter 4

Districts	Sub-districts	Sucos	Topic delivered (No. Participants)	No. Sessions
Manatuto	Laclubar	Manelima	Pregnancy and delivery	1
		Fatimakerek	Pregnancy and delivery	1
		Pualaka	Pregnancy and delivery	1
		Sananain	Pregnancy and delivery	1
		Funar	Pregnancy and delivery	1
	Soibada	Manlala	Child spacing	1
		Leohaot	Child spacing	1
		Salau	Child spacing	1
		Tasi fatin	Child spacing	1
		Maun Fahe kiik	Child spacing	1
Total sessions conducted				10

Districts	Sub-districts	Sucos	Topic delivered (No. Participants)	No. Sessions
Baucau	Quelicaí	Guruca	Child spacing, safe motherhood	2
		Lelalai	Child spacing, PSF role	1
	Total session conducted			3
Viqueque	Lacluta	Luhan Rai Kuak	FP, nutrition, hygiene, diarrhea (110, 123 and 107)	3
		Aitara	FP, nutrition (109)	1
		Dasi-Loe	FP, nutrition, hygiene, diarrhea (109, 89 and 89)	3
		Nuntetuk	FP, nutrition (91)	1
		Sumaco	Breastfeeding, child health (25 and 35)	2
	Uatucarbau	Bahatata	FP, nutrition, diarrhea (102)	1
		Afloicaí	FP, nutrition, diarrhea (112, 122 and 119)	3
		Loi-Ulu	FP, nutrition, diarrhea (109 and 89)	2
		Uani-Uma	Nutrition (35)	1
	Total session conducted			17
Ermera	Ermera Vila	Mauubu	FP, nutrition and ANC (94)	1
	Letefoho	Catrai Leten	FP, nutrition and ANC (66)	1
	Total session conducted			2
TOTAL				32

b) Development of guidelines for improving PSF operations and management

PSF guidelines

The recruitment of a consultant to facilitate the PSF guidelines revision started during Quarter 4. Despite several advertisements, HIP and the MOH have not yet been able to identify a professional with the required expertise. Efforts will continue during the next quarter.

PSF Day celebrations

While waiting for the revision of the PSF guidelines, HIP continued its on-going support to the PSF program, at both national and district levels. During Quarter 4, HIP supported Baucau district in the organization and facilitation of the National PSF Day celebrations. Approximately 300 PSFs participated in the activities. Group discussions resulted in recommendations for the PSF program, which will be discussed with the HP Department of the MOH.

While the commemorations of the “PSF Day” occurs every year at the national level, this year everyone in the country focused its attention on Baucau, one of the only districts taking the initiative to celebrate this important day for volunteerism outside Dili. This year the Baucau DHS and Administrator’s Office decided to recognize all PSFs from the district for their dedicated volunteerism to support their communities’ health. The month before the event, Baucau DHS organized the agencies working on HP programs, namely: HIP, World Vision, UNWFP, Alola Foundation, *Imunizasaun Proteje Labarik* (IPL), and several local NGOs. The DHS held several meetings and distributed roles and responsibilities in order to plan for a successful celebration. This occasion also showed how agencies are keen to work hand-in-hand

to support the DHS. Thus, the two-day celebration was conducted on the 26 and 27 September in Baucau Sport Hall.

The first day's agenda included group discussions per sub-district. HIP stood beside Quelicai group to assist the PSFs in answering three questions prepared by the organizing committee. The PSFs from Quelicai took advantage of this exercise to define their support to SISCa according to their understanding. They also shared their feeling regarding their work and came up with recommendations for the Government's attention. The second day's agenda was a quiz involving the six sub-districts. Quelicai won the second place as a result of the PSFs' strong efforts in responding to the committee's questions. This event really helped to re-motivate the PSFs to continue their work to serve the community for the improvement of health at the household level. HIP committed to conducting a training on maternal, neonatal and child health for all PSFs in Quelicai before the end of the year.

c) Training of PSFs with 'Mai Ita Koko' training module

PSF trainings

The "Mai Ita Koko" training module was developed in 2009 by the MOH, supported by HAI and funded by USAID. The District Team Trainers (DTTs) will train the PSFs in conducting home visits and discussions with pregnant women, husbands and grandmothers, using photo cards (kept by the PSFs) and an "action poster," which uses the same photos and is left at the household. The photo cards and the poster are used in the course of three different home visits, each focusing on a different phase for the woman:

- The first set of cards focuses on two key messages: 1) get the first ANC in the first trimester of pregnancy; and 2) make a birth plan.
- The second set of cards focuses on three key messages: 1) deliver with the assistance of a midwife in the health facility; 2) deliver with the assistance of a midwife in the home; and 3) give colostrum to the newborn.
- The third set of cards focuses on three key messages: 1) get post-natal consultation at the health facility maximum three days after delivery; 2) call the midwife to provide post-natal consultation maximum three days after delivery; and 3) space your children with at least three year intervals.

The training module and photo cards are under revision and should be finalized by the end of October. HIP is planning to support the training of Baucau DTTs in November, followed by one training for 69 PSFs in Quelicai. While waiting for the final module, Baucau DTO-HP already initiated meetings with the DPHO-HP and other partners to cover all PSFs with the training in Baucau.

d) Adaptation and implementation of a PDSS model for use by *sucos*
Implementation of PDSS
Table 11. PDSS implementation status per district

District	Sub-district	Suco
Baucau	Quelicai – Conducted advocacy at CHC level (Q2)	Lelalai - Conducted advocacy with <i>suco</i> council (Q2) - Selected community facilitators (Q3) - Conducted facilitators training (Q3) - Conducted community health assessment (Q3) - Conducted data validation (Q3) - Developed PDSS (Q3)
		Guruça - Conducted advocacy with <i>suco</i> council (Q3) - Selected community facilitators (Q3) - Conducted facilitators training (Q4) - Conducted community health assessment (Q4) - Conducted data validation (Q4)
Ermera	Letefoho – To start in FY2	<i>Suco</i> to be identified
Manatuto	Soibada – To start in FY2	<i>Suco</i> to be identified
	Laclubar – Conducted advocacy at CHC level (Q4)	Manelima - Conducted advocacy with <i>suco</i> council (Q4) - Selected community facilitators (Q4) - Conducted facilitators training (Q4) - Conducted community health assessment (Q4)
Oecusse	Oesilo – Conducted advocacy at CHC level (Q3)	<i>Suco</i> to be identified
Viqueque	Lacluta – Conducted advocacy at CHC level (Q3)	Uma Tolu - Conducted advocacy with <i>suco</i> council (Q4)
	Uatucarbau – To start in FY2	<i>Suco</i> to be identified



Manatuto DTO-HP showing an example of how to conduct a focus group discussion with mothers to community facilitators in Manelima, Laclubar sub-district.

Advocacy at CHC level

During Quarter 4, CHC-level advocacy was held in Laclubar (Manatuto). The objective of this activity was to advocate to *suco* heads the need to improve their community's health and what they can do to contribute through their PDS. One of the strongest advocacy tools used was the presentation of *suco*-level health data prepared by the CHC, which included health coverage rates for every *suco*.

Advocacy at *suco* level and subsequent PDSS creation activities in Guruça (Quelicaí, Baucau), Manelima (Laclubar, Manatuto) and Uma Tolu (Lacluta, Viqueque)

As shown in Table 11, HIP successfully advocated to Manelima and Uma Tolu *suco* councils about the need to develop and implement a PDSS. In Manelima and Guruça, community facilitators were selected and trained to conduct a short community health problems perception and health seeking assessment in the form of focus group discussions with mothers. From the results validated by the *suco* council, an action plan will be developed in the beginning of PY2.

e) Strengthening of MOH/MSA contacts on coordinating community policies

On August 24, MOH and Ministry of State Administration (MSA), technically and financially supported by HIP, WHO and Save the Children, organized the National Advocacy/Review Meeting for PDSS. The objectives of the meeting were: 1) to share lessons learned from existing PDSS and 2) to reinforce the cooperation between MSA and MOH through integrated health programs in the National *Suco* Development Plan program (PNDS – *Planu Nasional Dezenvolvimentu Suco*). One hundred and twenty-three persons participated in the meeting, including MSA, MOH and DHS representatives, district and sub-district administrator, *suco* heads and partners from UN agencies, donors and NGOs. Presentations included an overview of the PDSS process by the MOH national director of community health, an overview on the acceleration of community development by the MSA national director of *suco* administration, and PDSS concrete results by three *suco* heads from Poetete (Ermera), Cairui (Manatuto) and Holarua (Manufahi). During the second part of the workshop, the participants broke into four groups in order to agree on recommendations for the future strengthening of the PDSS program.

The main recommendation from the workshop was to speed up the process of finalizing the MOU between MOH and MSA, specifically between the National Directorate of Community Health (MOH) and the National Directorate of *Suco* Administration (MSA). Both directorates should also take the lead at district, sub-district and *suco* levels to ensure the PDSS is implemented in anticipation of the PNDS funding. Another recommendation was an appeal to MOH and MSA to increase the number of PSFs to three per *aldeia* (currently there is only one).

2.3.2 Implement BCC Initiatives

a) Identification and organization of community leaders for advocacy

FP advocacy activities

Whereas BCC and Community Mobilization (CM) involve a direct approach to individuals and families, advocacy uses influential intermediaries to engage with individuals and families and persuade them of the value of BCC. Advocacy has been proven effective in situations where there is a sufficient stock of respected influential ‘leaders’ who can be encouraged to take the time to participate actively. HIP supported a FP Advocacy meeting held at Manatuto DHS. The meeting was called by the MCH Department, but HIP’s district team was actively involved in organizing the meeting, i.e., inviting providers and community stakeholders from the sub-districts, arranging for food and allowances and providing technical support to the presentations given by MOH. MOH participants were the head of MCH Department, FP Unit officers, Manatuto DHS director and DPHO-MCH, CHC managers and midwives. Stakeholders from the MSA were the targeted audience and were represented by the district administrator, some sub-district administrators, *suco* heads and *suco* councils’ representatives. Other participants included other community leaders, Church representatives and NGOs.



Police, suco heads, women’s representatives and health staff from Laclubar participating in the sub-district FP advocacy meeting.



Manatuto DPHO-MCH displaying FP methods during the district advocacy meeting.

The meeting was divided into three parts. After introductory speeches by representatives of MOH and DHS, the head of MCH Department delivered her presentation on the importance of child spacing and the use of proper FP methods that impact family, child education and nutrition. She also conveyed the importance of proper counseling and the involvement of all levels of stakeholders to better implement and achieve success in the program. Then the FP Unit officer

presented the policy and strategy regarding FP by the MOH and the FP statement from the Bishop. Open discussion continued in the advocacy meeting, generating several important points. First, the Bishops now understand FP as a very important program for Timor-Leste; therefore, FP advocacy should be initiated within the Church by the priests. Second, the audience suggested proper counseling on different methods of contraceptives, such as being clear on side effects or on the fact that FP does not affect sexuality, so that new misconceptions do not evolve. Finally, some of the audience strongly suggested that the FP program continues targeting only married couples.

The participants suggested that this type of advocacy meeting should be conducted at sub-district level too, so participation from the *sucos* and community can be increased. HIP therefore supported Laclubar CHC to conduct a similar advocacy meeting at the sub-district, where all relevant stakeholders participated.

During the next quarter HIP will develop its BCC strategy encompassing an action plan for advocacy activities at district, sub-district and *suco* levels.

SECTION 3: INTERNAL HIP MANAGEMENT

3.1 COORDINATING PLANS WITH MOH, DHS AND OTHER PARTNERS

a) Support to DHS planning sessions, National Health Sector Coordination Committee (NHSCC) and District Technical Working Groups (DTWGs)

MOH Mid-Year Evaluation Meeting

All HIP TAs participated in the MOH mid-year evaluation meeting for both district and national levels activities. The meeting, organized by the Planning Department of MOH, marked the beginning of a series of planning meetings for the 2013 work plan exercises.

DHS 2013 work planning sessions

During Quarter 4, HIP strengthened its relationship with the Planning Department of MOH for the district 2013 work planning exercises. The DHS uses the district annual action plan (AAP) and district implementation plan (DIP) formats for the general objective of “ensuring the implementation of basic services package in the community in relation to the Millennium Development Goals (MDGs)”. The AAP is composed of activities, sub-activities, expected results, result indicators, costs and timeline per quarter, into which HIP integrated its technical support.

National Health Sector Coordination Committee and District and Sub-district Technical Working Groups

At national level the HIP Steering Committee, which was conceived to monitor the progress of HIP with MOH counterparts and key partners, was expanded by the Minister of Health to a larger committee, the National Health Sector Coordination Committee (NHSCC). The NHSCC will not only monitor HIP, but also all partners’ support to the districts. At district level and sub-district level, the set-up of two additional types of committee, respectively the DTWGs and SDTWGs were also requested by the Minister. In May 2012, intensive work with MOH and partners to develop the three committees’ TORs started. These were finalized in July and signed in August by the MOH director general (DG), accompanied by a letter requesting all DHS directors and partners to establish those committees in the districts. The first NHSCC took place in August, attended by the new Minister of Health and the two new Vice-Ministers.

At district level, HIP agreed with the Planning Department and Health Policy Cabinet to set up a model in Manatuto district, where the DTWG will coordinate implementation of district level activities by the DHS and all other partners. It will include a representative from the district administrator’s office and support the planning process at district level. The SDTWGs will coordinate implementation of sub-district level activities by the CHC and partners, and they will be embedded in an existing structured meeting, such as the CHC management meetings or the micro-planning meetings. Additionally, the SDTWGs will be supported by relevant implementing partners working at the sub-district level. As mentioned above, some CHCs and partners have supported the establishment of a health section inside the *suco* council. Through community needs assessments and analysis of CHCs *suco* level data, the *suco* councils developed a PDSS. The PDSS

ensures that the health component of the PDS addresses the community needs in terms of health and, at the same time, addresses the diseases burden identified by the CHC coverage data.

In 2013, the Multi-Donor Trust Fund (MDTF)/AusAID/European Union (EU)-funded National Health Sector Strategic Plan-Support Project will be recruiting district support advisors, who will have a high degree of responsibility in assisting DHS during the planning process. They will assist the DHMT to develop activity-based AAPs and DIPs that reflect priority areas for health service delivery improvement.

(Annex 5 illustrates this dynamic for planning with an intersectoral component from *suco* to national level with support from the different committees/WGs).

3.2 ENSURING COMPLIANCE

a) Ensuring compliance with the USAID voluntary FP requirements

The principles of voluntarism and informed choice clearly and strongly guide USAID's FP program. These principles are spelled out in program guidelines and in legislative and policy requirements that govern the use of US FP assistance. It is USAID's intent that all FP service delivery programs provide a broad range of family planning methods and services and that information on where such methods and services may be obtained be widely available. USAID is committed to ensuring that women and couples have access to voluntary FP services and are free to make informed decisions about their reproductive lives, including the opportunity to choose voluntarily whether to use FP or a specific FP method to help plan their own families. Since the enactment of legislation in 1973, recipients of US FP assistance have been legally prohibited from supporting abortion as a method of FP using US funds. The following actions were taken during Quarter 4 to ensure compliance:

- All HIP staff (except Oecusse team) completed the online FP compliance training course in the period of August to September 2012.
- A guideline on compliance with USAID's requirements for voluntary FP activities and USAID's prohibition on abortion related activities was finalized.
- Checklists to follow up HIP and MOH staffs' compliance with USAID rules while providing FP services (during SS, at SISCa, during training) are developed and will be implemented starting during the next quarter for continuous monitoring on compliance.

3.3 BUILDING THE SMALL GRANTS PROGRAM

a) Process of SGP bids and grant awards

In July 2012 advertising was broadcast on national television over three weeks, and brochures were distributed by hand and email to all potential local NGOs in Timor-Leste seeking proposals for Request for Applications (RFA) #1. A total of four grant proposals were received. The GEC for RFA#1 was established and comprised of four members, namely:

- USAID Contracting Officer's Representative (COR).
- HIP Finance, Grants and Administration (FGAD) Director.
- HIP Grants Manager.
- HIP TA-HP.

On August 14, 2012 the GEC reviewed all four applications and only two were shortlisted for further assessment. The two shortlisted applicants were HealthNet Timor-Leste (HNTL) and *Sharis Haburas Comunidade* (SHC). Meetings were subsequently held with the two potential candidates to seek clarifications on their Scope of Work (SOW) and budget proposals and to conduct a Pre-Award Assessment. In September 2012 HIP received one new grant application in its second-round of submissions for RFA#1, but it was deemed not worthy of further consideration by GEC. Similarly both HNTL and SHC submitted revised applications in September to address potential cost reductions and clarifications to their SOW.

SHC's revised proposal did not adequately address their intended SOW and inherent cost inefficiencies, so it was subsequently rejected. The remaining HNTL proposal only covers work in four sub-districts, two in Oecusse and two in Manatuto, with a total budget of \$182,688 over a one year period. The cost effectiveness of covering only four sub-districts was in question and a final decision on the HNTL proposal will be determined after further assessment and discussion with GEC members.

Having completed two rounds of solicitations for proposals under RFA#1 it has become increasingly clear there are significant limitations in the capacity and geographical coverage available solely from local NGOs in Timor-Leste.

Work commenced in September 2012 on the development of RFA#2, which will focus on the need to identify and address opportunities for improving health through influence on gender-related health situations, activities and barriers.

3.4 CONDUCTING MONITORING AND EVALUATION

a) HIP's M&E Plan

As discussed with USAID during the Results Framework Workshop in April 2012, and as documented in the July–December 2012 work plan, HIP will continue to work with USAID to assign annual targets in line with the annual work plan and the needs of a capacity-building project and evidence-based interventions in the pathway to care. **Annex 6** illustrates the Indicator Matrix from the July–December 2012 work plan, assigning contribution and attribution per indicator. **Annex 7** demonstrates the Annual Monitoring Report for the period of October 2011 – September 2012, as required by the approved M&E Plan.

b) Facilitation of a national Health Facility Survey (HFS)

The MOH has issued to JSI a sole sourced RFP for conducting the national HFS as well as redesigning the BSP and logistics management system. Several meetings have been organized with key stakeholders to determine their needs and expectations. The MOH is in the process of setting

up a Steering Committee (SC) to facilitate and oversee the design and implementation of the survey. The SC is expected to assign an individual to coordinate the communication between the SC and JSI team.

HIP developed a survey design, plan and data collection instruments as per its baseline data needs for its focused districts. With expansion of the survey to all health facilities nationwide, the survey design, plan and data collection instruments needed significant modification. Within the MOH structure, each department and unit has unique data needs. The key development partners also have various concerns to be addressed through the survey. Therefore, the survey design, plan and data collection instruments are being finalized through an intensive consultative process, while also taking into full consideration international norms and standards. The consultation process has begun and will be continuing in the next quarter.

There will be three kinds of reports generated from the survey data: 1) national summary report with comparative district data; 2) district summary report with comparative facility data; and 3) health facility profile containing most of the data collected through the survey. The preceding two will be available in print, and the third will be made available electronically. The content of the summary reports will be agreed before commissioning the survey.

c) Conduct of a baseline Knowledge, Attitudes and Practices (KAP) survey

An outline for the KAP survey was prepared and shared with relevant stakeholders. The literature review is in progress and expected to be completed during the next quarter. All other activities will commence in the last quarter, and the survey will be conducted during the first quarter of 2013.

3.5 MANAGING INFRASTRUCTURE AND OTHER ASSETS

a) HIP Quarter 4 Financial Status



² Note that there is a one-month lag in official financial reporting of field office expenses due to processing time, so the cumulative expenditures to-date include home office expenses through September 2012, and field office expenses through August 2012.

Contract Line Item Description	USAID APPROVED BUDGET	EXPENSES THROUGH SEPT. 2012
[REDACTED]	[REDACTED]	[REDACTED]

Although the actual expenditure under all CLINs remain within budget (see above), there exist some significant variances from budgeted line items for direct labor and sub-contracts following Marie Stopes International’s decision to withdraw from participation in HIP. Similarly, expenditure in the Small Grants Program remains largely unutilized following difficulties in identifying suitably qualified local NGOs possessing the resources and capacity to manage grants in HIP’s focus districts.

Every effort has been made to manage HIP’s budget in the most cost effective manner for the best use of US government funds. Given the need to directly hire human resources, which were originally budgeted for sub-contracts, and the urgent need to increase local transportation resources for district activities, JSI is reviewing its budgeted line items to determine whether a budget re-alignment is warranted within the contract ceiling.

b) Increase Transport Resources at District Offices

Given the need to provide motorcycles for the remaining three-year life of HIP, it will be most cost effective to purchase second-hand or new bikes rather than renting. Enquiries were made into the availability of used motorcycles from other USAID projects and it was determined that no second-hand bikes are currently available in Timor-Leste. Subsequently the decision was made to procure new bikes.

Detailed specifications for the required motorcycles were developed. After determining that the cost of procuring, maintaining and operating 12 motorcycles would not exceed the total budgeted non-expendable equipment and vehicle maintenance expenditures, quotations were sought from vendors. An evaluation of vendor quotations and a request was prepared for submission to USAID during the start of the next quarter for the approval to purchase 12 motorcycles. The purchase and delivery of motorcycles and the development of project policies and procedures and staff orientation in the use of such motor vehicles will be initiated subject to USAID approval to this request.

ANNEXES

Annex 1

Quarter 4 July – September Weekly Updates

Annex 2

Glossary of Terms

Glossary of Terms

Term	Definition	Implications for HIP
Capacity building	“A process that improves the ability of a person, group, organization or system to meet its objectives or perform better.” [USAID]	This is our Mission – to build capacity for MOH, DHSs, PSFs, local grantees, and the HIP staff.
Coaching	Conduct of a one-on-one developmental discussion aimed at providing feedback on the coached person’s strengths and weaknesses and improving their performance and/or specific skills. The discussion is advisory and non-directive. It is generally short-term and focuses on specific issues where performance improvement is mutually seen as necessary. [Chartered Institute of Personnel and Development]	We need to teach coaching skills as part of our improvement to supportive supervision.
Leadership	“Management is doing things right; leadership is doing the right things” [Peter Drucker]. Technically, leadership has been defined as ‘a process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task’ [M Chemers, An Integrative Theory of Leadership]. There are many different styles of leadership – e.g., authoritarian, participative, free rein, self-interested, group – which all offer pros and cons, and there are competing theories as to whether leadership is innate or can be taught/learned.	There is no ‘right’ model of leadership. Our job is to ensure that DHS leaders are successful in getting things done, which may involve either coaching or mentoring them and possibly softening extreme examples of different styles.
Mentoring	Similar to coaching except that the relationship is less formal, longer term and aims at broader concerns like career, personal development and preparing the mentee for new roles. Whereas a coach is often a peer, a mentor is usually senior and has greater experience than the person being mentored. [Chartered Institute of Personnel and Development]	Most of our effort goes into specific coaching; mentoring will be very occasional – for more senior DHS representatives who need it, and for those on staff seeking professional development from a senior staff member.
Mission	The mission statement defines why an organization exists. It should be very brief (i.e., one sentence), and it rarely changes over the organization’s planning timeframe.	We have built a mission statement into our Sept. – Dec. 2012 work plan. This probably will not change over HIP’s life.
Service delivery	The act of interfacing with a client to provide a specific service of health benefit to the client. Organizations can deliver services directly (e.g., a USAID contractor actually manages clinics) or can provide technical assistance to improve the delivery of services provided by others (e.g., HIP helps CHCs to serve the CHCs’ clients better).	HIP does not deliver services. We provide technical assistance to help MOH, DHSs and PSFs deliver their services more effectively and efficiently.
Strategy	A collection of planned tasks that will be undertaken in pursuit of a given thrust. The thrust defines the goal that the strategy is aiming to achieve. Strategies connect planned thrusts (above) to planned tasks (below).	We have identified 9 strategies in our Sept. – Dec. 2012 work plan – dovetailed into 3 thrusts.
Supportive Supervision	Supportive supervision (SS) is an effective means to improve quality of care in a holistic approach and ensure health providers implement what they learn through training. SS visits can include direct mentorship on technical, logistical, planning	Providing SS at health facilities, with supervision results analyzed and acted upon locally, will be a core

	and managerial best practices (as per BSP standards), debriefing, mini-training and facilitation of liaison with the central level.	HIP-MOH joint activity which will complement all other capacity development activities.
Systems strengthening	<p>“Simply defined, health systems strengthening involves identifying issues that interfere with provision of services and introducing systems changes that result in sustainable improvements.” [FHI 360] Thus systems strengthening lies behind service delivery and can focus on supply-side problems (e.g., service providers’ skills, shortage of drugs), demand-side problems (e.g., encouraging clients to come to clinics, client preventive behaviours in the home) or problems which affect both supply and demand (e.g., poor information, lack of financing).</p> <p>More recently, WHO defined the six building blocks of a health system as a way to design more effective strategies for strengthening health systems to meet the needs of the population:</p> <ul style="list-style-type: none"> • Health services must be efficient, effective, and accessible. • A number of well-trained staff should be available. • Health information systems should generate useful data on health determinants and health system performance. • Access to medicines, vaccines, and medical technologies must be equitable. • Health financing systems must raise adequate funds for health, ensuring that people can access affordable services. • Leadership must guarantee effective oversight, regulation, and accountability. 	We are focusing on one supply-side system (quality improvement), one demand-side (behavior change) and one which affects both supply and demand (management information).
Thrust	One of the broad pathways which an organization will follow towards achieving its vision. It should be phrased so that the goal being pursued is clear. A ‘thrust’ is a collective noun for a number of strategies within it. Most organizations can cope with only a few thrusts (i.e., 2-3).	HIP is pursuing three thrusts: raising service quality, strengthening quality/use of information, and improving community-level services/behaviors.
Vision	Characterization of what an organization wants to look like and have achieved by the end of its planning timeframe. A vision must be associated with a timeframe. The vision statement should set reasonable and measurable stretch targets for the organization. It can be multi-paragraph but not longer than a page. A good test of whether the vision is specific enough is if the thrusts to be pursued in achieving the vision are capable of being extracted from the vision brainstorming.	We have built a 2015 vision statement into our Sept. – Dec. 2012 plan. All staff need to be able to recognize it and act to support it.

Annex 3
Action Plan

Action Plan

This action plan was agreed upon during the UNFPA-ICOMP “Workshop on Operationalizing the Call for Elimination of Unmet Need for FP in Asia and Asia Pacific Region” in Bangkok, Thailand:

Key priorities	Groups requiring special focus	Strategies or suggested actions to address these challenges	Possible technical support/capacity building
Review and update FP policy and strategy	Rarely anything is mentioned about young people’s adolescent reproductive Health needs in FP strategy	<ol style="list-style-type: none"> 1. Collaboration between MOH and MOE to have a curriculum on information and education on sexual and reproductive Health 2. Include Church in this process 3. Learn from good example from other countries regarding programs on reproductive adolescent health 	MOH, USAID/HIP, UNFPA
Capacity building	New doctors and new midwives	<ol style="list-style-type: none"> 1. Update FP curriculum 2. Plan for training on FP counseling and clinical skills 	MOH, UNFPA,USAID/HIP and WHO
BCC/ IEC material is not user friendly	Community	<ol style="list-style-type: none"> 1. Revise IEC materials 2. Improve the BCC strategy 3. Increase radio messaging to reach those out of school 	MOH, UNFPA,USAID/HIP and WHO
Allocate more of the budget for FP program Advocacy/community sensitization	New MOH	<ol style="list-style-type: none"> 1. Advocate for the new health minister 2. Allocate budget for advocacy 3. Spread advocacy efforts from national to community level 4. Include the Church in this process 5. Use of Champions (ex: president family) 	MOH, UNFPA,USAID/HIP
Supportive supervision and continuous monitoring and improvement of LMIS to improve quality of services	Health providers and health facilities	<ol style="list-style-type: none"> 1. Develop a system for SS and feedback to improve quality of services 2. Train on LMIS 	MOH, UNFPA,USAID/HIP

Annex 4

Checklist for HIP's role at SISCa

Checklist for HIP's role at SISCa

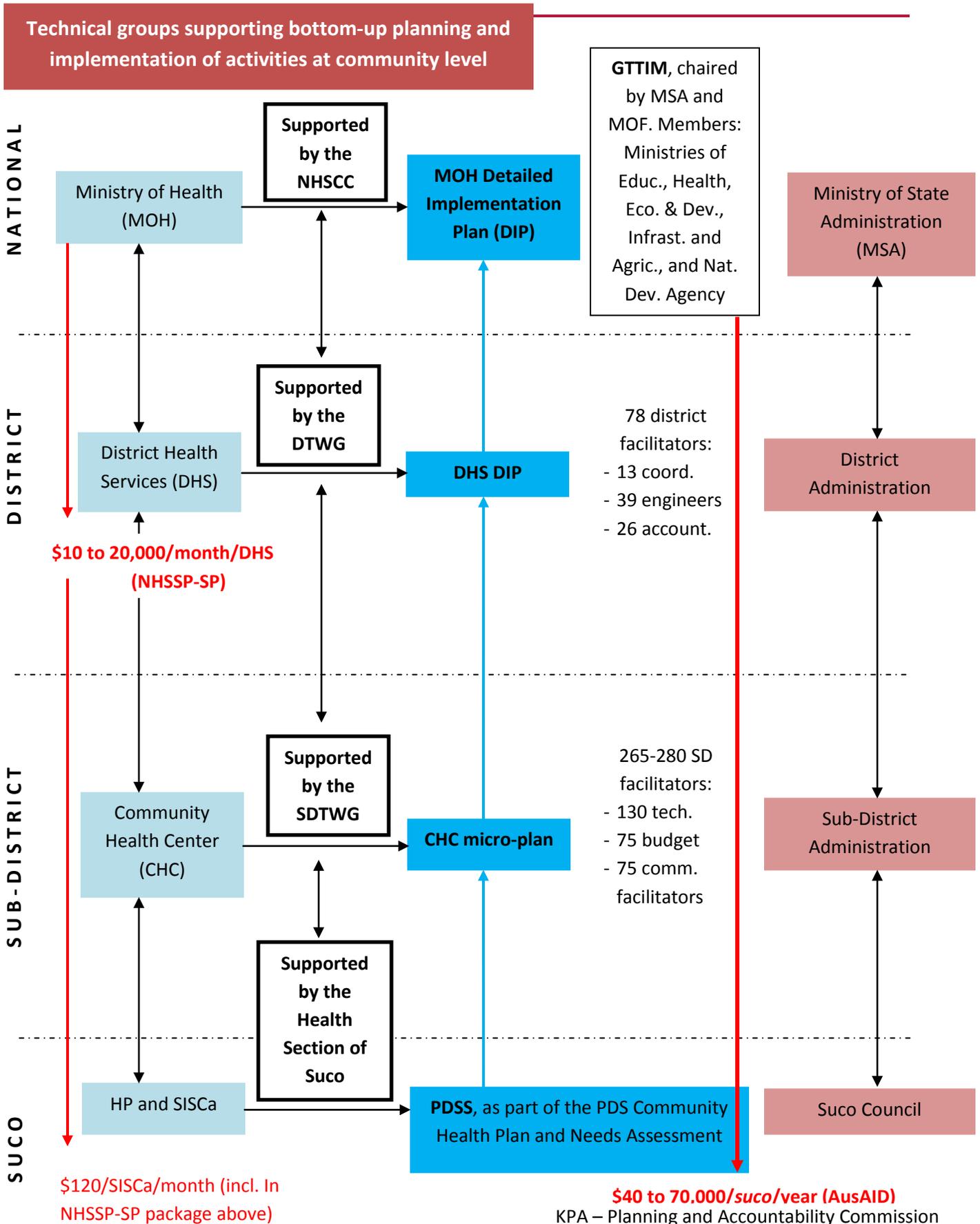
1. Obtain the quarterly SISCa schedule from CHCs in priority sub-districts, review the proposed sites and plan either HIP or small grant program (SGP) staff and vehicle assignments. Communicate any planned requirements to SGP partners as needed, so HIP and SGP monthly plans are well-coordinated.
2. Liaise with DHS to agree upon which SISCAs will be attended by a DHS staff member for supportive supervision, so HIP and DHS monthly plans are well-coordinated.
3. Liaise with *suco* heads to agree on the number of clients each SISCa will target quarterly. Include this information in the PDSS.
4. Liaise with CHCs in HIP priority sub-districts weekly to confirm which of the scheduled SISCAs will take place and confirm HIP/SGP and DHS staff and vehicle assignments.

If SGP partners not involved...

5. Collect and transport CHC staff (and any DHS staff) to SISCAs on the appointed day, if HIP is designated to provide transport, collecting health post staff en route if feasible and necessary. Verify that CHC's staff has all the necessary equipment and supplies before departure.
6. Assist CHC staff, health post staff, PSFs and the *suco* (and possibly *aldeia*) head to ensure that the SISCa site is appropriately prepared and ready for client arrivals.
7. Assign HIP staff to SISCa tables to provide supportive supervision, if DHS staff are not involved, or to provide substitute staffing for the table if there are no CHC/health post/PSF staff available. On supportive supervision, give particular attention to rational drug use at Table 5.
8. Work with PSFs at conclusion of the SISCa to ensure that SISCa register books are compared with RSF household-level registers, missing clients are identified and PSFs prepare monthly plans for household follow-up.
9. Ensure PSFs are aware of the next monthly HP topic, and hand over any new promotional materials to be used for community group meetings as part of their monthly plan before the next SISCa.
10. Ensure PSFs and *suco* head are aware of the next scheduled date for SISCa at this site.
11. Transport CHC and any health post staff back to their home facilities.

Annex 5

Planning Process from *Suco* to National Level with Required Intersectoral Support



KPA – Planning and Accountability Commission
 EIP – Project Implementation Team
 Kader – volunteer
 EO&M – operation and maintenance

Annex 6

Indicator Matrix, July – December 2012

Indicator Matrix, July – December 2012

THRUST	STRATEGY	TASK	INDICATORS CONTRIBUTED TO (See List of Indicators below)	INDICATORS ATTRIBUTED TO (See List of Indicators below)
T1: Improve Service Quality	S1: Strengthen QI systems	1. Provide TA across the spectrum of QI	1-8, 9, 11-13, 19-20, 22, 24-25, 29	
		2. Facilitate supportive supervision at the district-level	1-7, 9, 11-13, 19-20, 22, 24-25, 29	
		3. Introduce Quality Improvement Collaborative	1-8, 9, 11-13, 19-20, 22, 24-25, 29	
		4. Support INS's capacity to organize, deliver and follow-up training	1-7, 9, 11-13, 20, 22, 24-25, 29	
	S2: Support rollout of training programs	5. Support roll-out of in-service training		14-18, 23, 26
		6. Support roll-out of refresher training	1-7, 9, 11-13, 22, 25, 29	14-18, 23, 26
		7. Support roll-out of a nutrition short course		23
		8. Support roll-out of training for newly-graduated service providers		14-18, 23, 26
T2: Improve Quality/Use of Management Information	S1: Strengthen HMIS technical content and management	9. Audit DHS and health facilities' IT capabilities		17
		10. Assess information needs at <i>suco</i> and SISCa levels		17
		11. Develop a roadmap for creating a HMIS database design		17
		12. Develop a unified coding system for facilities, including SISCas		16-17
		13. Ensure RSF data is regularly collected and updated		16-17
		14. Advocate for separate collection of SISCa data		16, 17
	S2: Improve data quality	15. Adapt supportive supervision tools to provide stronger HMIS oversight	20	16, 17
	S3: Encourage greater use of information	16. Assist districts to improve information reporting	11, 19, 25, 27	16-17
17. Promote and train facilities to interpret, use and share performance data		11, 19, 25, 27	16-17	
T3: Strengthen Community-level Services and Improve Behaviors	S1: Strengthen community-level delivery capabilities	18. Develop/disseminate/monitor standards for conducting SISCas	1-8, 10-13, 21, 24-25, 27-29	
		19. Develop guidelines for improving PSF operations and management	10, 21	
		20. Train PSFs with <i>Mai Ita Koko</i> Training Module	10, 21	
		21. Adapt and implement a PDSS model for use by <i>sucos</i>	10, 21	

		22. Strengthen MOH/MAE contacts on coordinating community policies	21	
	S2: Strengthen BC management and systems	23. Facilitate HP quarterly meetings at MOH	28	
		24. Develop a HIP communication strategy coordinated with national priorities	28	
	S3: Develop BC materials	25. Assess existing materials and re-print those tested as effective	11-13, 28	
	S4: Implement BC initiatives	26. Identify and organize community leaders for advocacy	11-13, 21, 28	

List of Indicators

Indicator #	Indicator Description*	Source	
		JSI Contract (October 2011)	Draft M&E Plan (21 March 2012)
1	Maternal mortality ratio	X	X
2	Infant mortality rate	X	X
3	Under-5 mortality rate	X	X
4	CPR (modern methods)	X	X
5	CYPs	X	X
6	% of births attended by skilled provider	X	X
7	% of under-5 children at appropriate weight-for-age	X	X
8	% of <6 month children who are exclusively breastfed	X	X
9	% of health facilities meeting BSP standards	X	X
10	% of SISCAs functioning according to the national standards (as per MOH target)	X	X
11	No of cases of child pneumonia treated with antibiotics by trained facility or community health workers		X
12	No of children <12-months of age receiving DPT3		X
13	No of children under-5 years of age who received Vitamin A		X
14	No of medical and para-medical practitioners trained in evidence-based clinical guidelines		X
15	No of people trained in MNH		X
16	No of people trained in M&E		X
17	No of people trained in strategic information management		X
18	No of trained providers who have completed competency checks for all FP methods		X
19	% facilities without FP/MNCH stockouts of essential commodities		X
20	No of supervision visits conducted to SDP		X
21	No of <i>sucos</i> and communities involved in the management of SISCa/health care		X
22	No of women receiving AMTSL		X
23	No of people trained in CH and nutrition		X
24	No of cases of children reached by USG-supported nutrition programs		X
25	No of child diarrhoea cases treated		X
26	No of people trained in FP/RH		X
27	No of counselling visits for FP/RH		X
28	No of people who have seen/heard a specific USG-supported FP/RH message		X
29	No of USG-assisted service delivery points providing FP counselling or services		X

*all refer to HIP-assisted districts or resulting from HIP's assistance efforts only

Annex 7

Annual Monitoring Report: October 2011 – September 2012

Annual Monitoring Report: October 2011 – September 2012

ID	Indicator	2011 Actual	2012 Target	Baseline Value (per approved M&E Plan)	Jan – Sep 2012 (9 months)	Estimated for Oct 2011 – Sep 2012	% achieved	Baucau	Ermera	Manatuto	Oecusse	Viqueque
Cross Cutting												
8	Percent of health facilities in HIP supported districts meeting Basic Service Package standards ¹	NA	NA	TBD								
9	Percent of SISCa functioning according to established standards ²	NA	NA	TBD								
10	Number of supervision visits conducted to SDP	231	560	231	664	664	119%	259	248	157	165	156
11	Number of people trained in monitoring and evaluation with USG assistance	927	750	927	741	741	99%	299	109	-	80	110
	<i>Number of women</i>	NA	NA	NA	308			115	47	-	37	30
	<i>Number of men</i>	NA	NA	NA	433			184	62	-	43	80
12	Number of people trained in strategic information management with USG assistance	1,169	1,250	1169	1,200	1,200	96%	528	123	52	83	206
	<i>Number of women</i>			NA	464			178	53	27	37	59
	<i>Number of men</i>			NA	736			350	70	25	46	147
14	Number of <i>Sucos</i> and communities in USAID supported areas involved in the management of health care services	TBD	TBD	TBD	674	674	100%	283	150	10	63	40
Maternal and Child Health												
15	Number of women receiving AMTSL through USG supported program	TBD	TBD	NA	Not available							

¹ Data on this indicator will be available through the National Health Facility Survey to be conducted in 2013.

² Data on this indicator will be available through the National Health Facility Survey to be conducted in 2013.

ID	Indicator	2011 Actual	2012 Target	Baseline Value (per approved M&E Plan)	Jan – Sep 2012 (9 months)	Estimated for Oct 2011 – Sep 2012	% achieved	Baucau	Ermera	Manatuto	Oecusse	Viqueque
16	Number of people trained in maternal/newborn health through USG-supported programs	4,117	4,000	NA	3722	3722	93% ³	914	1,042	280	742	481
	<i>Number of women</i>	<i>2,038</i>	<i>2,000</i>	<i>NA</i>	<i>1794</i>			<i>443</i>	<i>512</i>	<i>171</i>	<i>324</i>	<i>223</i>
	<i>Number of men</i>	<i>2,079</i>	<i>2,000</i>	<i>NA</i>	<i>1928</i>			<i>471</i>	<i>530</i>	<i>109</i>	<i>418</i>	<i>258</i>
17	Number of people trained in child health and nutrition through USG-supported health care programs	984	1,500	NA	1,374	1,374	92%	316	323	30	293	149
	<i>Number of women</i>	<i>551</i>	<i>1,000</i>	<i>NA</i>	<i>570</i>			<i>143</i>	<i>111</i>	<i>23</i>	<i>103</i>	<i>69</i>
	<i>Number of men</i>	<i>433</i>	<i>500</i>	<i>NA</i>	<i>804</i>			<i>173</i>	<i>212</i>	<i>7</i>	<i>190</i>	<i>80</i>
18	Number of cases of children reached by USG-supported nutrition programs	15,492	38,000	NA	61,410	81,880	215% ⁴	27,512	17,460	24,787	9,599	14,177
19	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs	15,492	22,800	NA ⁵	4,799	6,399	28% ⁶	2,521	1,161	548	280	1,888
20	Number of children less than 12 months of age who received DPT3 from USG-supported programs	28,000	10,500	NA	8,523	11,364	108%	3,652	3,225	1,183	1,565	1,739
21	Number of child diarrhea cases treated in USAID-assisted programs	26,000	92,400	NA	4,073	5,431	6% ⁷	1,481	571	748	1,544	1,087

³ This includes the training of health service providers, PSFs, high risk pregnant women and her spouse.

⁴ Recipient of growth monitoring services inclusive, but children receiving vitamin A are not included; see Indicator 22 below.

⁵ Indicator 19 has the same “Actual 2011” as indicator 18 but different data sources per the approved M&E Plan. The validity and source of these “Actual 2011” data require additional confirmation.

⁶ This data from HMIS shows that few cases were diagnosed as pneumonia and severe pneumonia and treated by antibiotics. Total number of pneumonia and severe pneumonia cases reported for the whole country in 2011 was 14,378. For the 38% population in HIP districts, 6,399 cases look slightly underreported.

⁷ This data collected through HMIS shows few diarrhea cases were seen and treated at health facilities. Total diarrhea cases reported for the whole country in 2011 were 16,139. For the 38% of the population in HIP districts, 6,399 cases appear to be underreported. With HIP’s ongoing support for strengthening HMIS data, HIP’s capture of actual cases is expected to improve for 2013.

ID	Indicator	2011 Actual	2012 Target	Baseline Value (per approved M&E Plan)	Jan – Sep 2012 (9 months)	Estimated for Oct 2011 – Sep 2012	% achieved	Baucau	Ermera	Manatuto	Oecusse	Viqueque
22	Number of children under 5 years of age who received vitamin A from USG-supported programs ⁸	36,688	46,200	NA ⁹	33,346	44,462	96%	10,267	12,402	5,597	7,051	9,145
23	Number of medical and para-medical practitioners trained in evidence-based clinical guidelines	874	1,040	NA	689	689	66%/100% ¹⁰	151	198	21	85	91
	<i>Number of women</i>			NA	302			68	88	18	22	27
	<i>Number of men</i>			NA	387			83	110	3	63	64
	Family Planning and Reproductive Health											
24	Couple-years of protection (CYP) in USG-supported programs (disaggregated by district)	24,809	22,000	TBD ¹¹	13,929	18,572	84% ¹²	5,000	5,561	1,468	3,799	2,744
25	Number of people trained in FP/RH with USG funds	1,455	2,000	1455	1,996	1,996	100%	414	359	250	375	124
	<i>Number of women</i>	803	600	803	836			155	132	146	125	56
	<i>Number of men</i>	544	1,400	544	1,160			259	227	104	250	68

⁸ The HMIS collects data on the number of vitamin A doses that are distributed, not on the number of children receiving them. Since young children under 1 year of age (21% of under 5 population) receive one dose and children older than 1 (79% of under 5 population) receive two doses, the data has been accordingly adjusted to reflect the estimated number of children who received vitamin A.

⁹ The statistical basis of the “Baseline Value” is in question and therefore remains TBD until the results of the HFS are available.

¹⁰ Curriculum for training newly graduated medical doctors and midwives is being finalized. Training will be conducted in 2013.

¹¹ The statistical basis of the “Baseline Value” has not yet been established and therefore remains TBD.

¹² The factors affecting FP performance, among others, are: a) severe human resource limitations including difficulty with recruiting Timorese midwives that make improved access to and quality of FP care difficult to achieve, especially this year. Future project years will have significant improvement given HIP’s strategy to address human resource shortages and provider needs; b) contraceptive supply chain issues including stock-outs; c) HMIS limitations: the HMIS does not capture the data on all contraceptives distributed from all service delivery points. With HIP’s support to strengthen the HMIS and USAID’s upcoming investment in DELIVER, reliability of contraceptive supply chain data will be improved by the end of each project year (2013, 2014); d) infrastructure issues including lack of privacy, lack of equipment for long-acting methods and related infection prevention, etc.; e) some HIP districts have long-standing, unmet need for training or refresher training for midwives providing FP and these compound access and quality issues. All of the above will be addressed by HIP over the next years except for (d), which is partially beyond JSI’s manageable interest due to limitations within the HIP contract (procurement of clinical equipment and renovations, for example).

ID	Indicator	2011 Actual	2012 Target	Baseline Value (per approved M&E Plan)	Jan – Sep 2012 (9 months)	Estimated for Oct 2011 – Sep 2012	% achieved	Baucau	Ermera	Manatuto	Oecusse	Viqueque
26	Number of counseling visits for Family Planning/Reproductive Health as a result of USG assistance	57,852	94,800	TBD	45470	60627	64% ¹³	3,667	4,271	4,924	8,664	5,636
	<i>Number of Women</i>	49,414	37607 ¹⁴	NA								
	<i>Number of men</i>	2,504	57,193	NA								
27	Number of people that have seen or heard a specific USG supported FP/RH message	3,867	25,000	TBD ¹⁵	25,554	34,072	136% ¹⁶	4,619	4,009	5,424	13,797	6,223
28	Number of USG-assisted service delivery points providing FP counseling or services	215	280	TBD	179	179	64% ¹⁷	47	34	33	28	34
29	Number of trained providers who have completed competency checks for all methods ¹⁸	215	320	TBD	Data not available							

¹³ FP counseling data is collected through routine HMIS.

¹⁴ Counseling data not disaggregated by gender in current HMIS reporting.

¹⁵ The baseline value will be determined by the Health Facilities Survey.

¹⁶ People attending SISCa and evening health promotion events are included in this figure.

¹⁷ 100% health facilities (123) in HIP districts and 100% (56) SISCa in HIP focus area are providing FP counseling or counseling and services.

¹⁸ Tools and guidelines are being updated. Competency checks will be completed beginning in Project Year 2.