

**USAID/GH/HIDN/NUT  
PVO Child Survival and Health Grants Program**

**First Annual Report**

**Health Alliance International:  
Improving Maternal and Newborn Health  
in Timor-Leste**

Timor-Leste (formerly East Timor),  
Aileu, Ermera, Manatuto, Liquica, Manufahi,  
Ainaro, and Dili Districts

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## **A. Program Accomplishments**

HAI has had a strong startup year, establishing excellent collaboration with both central and district-level MOH staff, other partners, and program communities. Baseline data gathering occupied much of the first six months of the program, but the understanding gained during that period and relationships established have been instrumental in facilitating the success of our many startup activities. The other key factor has been the strong concurrence of MOH staff with our priority strategies, such as the deployment and supervision of MCH district program officers.

The main accomplishments of the program during the startup year are as follows, with further detail included in subsequent sections:

- 1) Worked with MOH to develop and support a national position for Maternal Child Health District Program Officers (MCH DPOs) in all 13 districts. The MCH DPO is HAI's key district-level counterpart for all program activities. HAI provides financial support for the position in the 4 program districts and provides ongoing supervision and technical support to the personnel in this position in the 4 program districts. HAI also supported an introductory workshop for the DPOs from all 13 districts at the commencement of their term.
- 2) Completed a detailed baseline assessment, using both qualitative and quantitative methods, of the status of maternal and newborn health services at district level and knowledge, attitudes and practices of health staff and community personnel about maternal and newborn care. The assessment included a specific focus on local traditional practices relevant to maternal and newborn care. This assessment is the most comprehensive assessment of maternal and newborn care in Timor Leste to date.
- 3) Together with MOH staff have begun development of an integrated MCH supervision tool for use at district health facilities. The antenatal care tool is regularly used by DPOs in program districts and HAI provides consistent support to this activity in order to increase the capacity of the DPOs in this area.
- 4) Supported the MOH to re-establish the national MCH working group, and participated in regular meetings in which key MCH issues of national concern are discussed and recommendations made.
- 5) Participated in a working group that reviewed the national midwifery standards.
- 6) Developed a proposal to pilot "birth-friendly facilities" in each of the program districts. This activity is a participatory activity between

- health facilities and the communities they serve and aims to increase the numbers of facility based births.
- 7) On behalf of the MOH compiled a list of key messages in maternal and newborn care for Timor-Leste.
  - 8) Compiled a list of traditional practices and beliefs in maternal and newborn care in Timor-Leste as well as an objective analysis of the potential risk of benefit or harm to the health of the mother and/or baby of each of the practices.
  - 9) Together with a national theater group developed a 45-minute drama based around the key messages for maternal and newborn care. The drama is to be shown in 3 of the 4 program districts and preliminary plans have been made for further implementation of this activity.
  - 10) In one district supported the training of a local youth theater group to conduct a street-theatre drama developed around the key messages for maternal and newborn care. The drama was performed in the district market and preliminary plans have been developed for implementation of this activity at local village level throughout the district. Local health staff facilitate the implementation.
  - 11) Held preliminary meetings with MOH to determine postpartum care policy for Timor-Leste.
  - 12) Developed and conducted training and supervision for referral hospital midwifery staff in emergency neonatal care. The training was implemented as part of the Emergency Obstetric Care course being implemented by the MOH/UNFPA.
  - 13) Together with the National Institute of Health Sciences and WHO commenced the development of training for neonatal nurses at Dili national hospital.
  - 14) Developed a pilot system for maternal death surveillance by MOH district staff, in collaboration with community leaders
  - 15) Participated in the development of a national strategy for implementation of maternity waiting homes
  - 16) Compiled a list of key messages for behavioural change in MNC
  - 17) Commenced the development of health education tools for MNC – a flip chart using photos of the NGO Share and HAI's own photos.

The project objectives and status of key activities is as follows:

Project objectives	Key Activities (as outlined in the DIP)	Status of Activities
<b>1. 90% of MOH health facilities in the program districts will have at least one staff member skilled in providing comprehensive antenatal care (specifically including counseling and communication skills)</b>	<ul style="list-style-type: none"> <li>• Select and train DPOs</li> <li>• Training needs assessment of MOH midwives</li> <li>• Develop training for midwives in antenatal care focusing on communication and counseling skills</li> <li>• Develop wall charts (training and clinical aids) for antenatal care consults</li> <li>• Conduct/evaluate training to all midwives on antenatal care/communication/counseling–<i>STARTUP DISTRICTS</i></li> <li>• Conduct and evaluate training of all midwives on antenatal care / communication/counseling–<i>EXPANSION DISTRICTS</i></li> </ul>	<p>Completed Completed</p> <p>In process</p> <p>In process</p> <p>Planned</p> <p>Planned</p>
<b>2. 90% of MOH health facilities in the program districts will have at least one staff member skilled in the key elements of essential postpartum/ newborn care including resuscitation skills</b>	<ul style="list-style-type: none"> <li>• Participate in national MNCH working group to set standards for postpartum and newborn care</li> <li>• Development of skills-focused training for midwives including a manual outlining national standards for postpartum/newborn care</li> <li>• Conduct and evaluate skills-based training for postpartum and newborn care for all midwives—<i>STARTUP DISTRICTS</i></li> <li>• Conduct and evaluate skills-based training in PP/NBC for all midwives–<i>EXPANSION DISTRICTS</i></li> </ul>	<p>Ongoing</p> <p>In process</p> <p>Planned</p> <p>Planned</p>
<b>3. 90% of MOH health facilities in the program districts will have effective systems to maintain essential supplies and materials for antenatal care</b>	<ul style="list-style-type: none"> <li>• Conduct health facility assessment</li> <li>• Participate in national MNCH working group to assist MOH to develop essential supplies and equipment list</li> <li>• Identify sources for funding of supplies / equipment not currently accounted for</li> <li>• Develop MCH DPO supervision tool for health facilities</li> </ul>	<p>Complete Ongoing</p> <p>Planned if needed</p> <p>In process</p>

<p><b>4. 90% of MOH health facilities in the program districts will have effective systems to maintain essential supplies and materials for postpartum/newborn care</b></p>	<ul style="list-style-type: none"> <li>• Conduct health facility assessment</li> <li>• Participate in national MNCH working group to assist MOH to identify essential supplies and equipment</li> <li>• Develop MCH DPO supervision tool for health facilities</li> <li>• Identify sources for funding of supplies/equipment not currently accounted for</li> </ul>	<p>Complete Ongoing</p> <p>In process</p> <p>Planned if needed</p>
<p><b>5. Percent of women with children age 0-23 months who received one or more antenatal care visits during their last pregnancy in program districts will increase from an estimated 50% to 70%</b></p>	<ul style="list-style-type: none"> <li>• Conduct qualitative investigation related to culturally-determined beliefs and practices re: pregnancy</li> <li>• Train community-based groups (including women’s groups, NGOs, Peace Corps volunteers) in promoting <i>ANC–STARTUP DISTRICTS</i></li> <li>• Train community-based groups (including women’s groups, NGOs, Peace Corps volunteers) in promoting <i>ANC–EXPANSION DISTRICTS</i></li> <li>• Disseminate print materials, develop drama and broadcast programs for community promotion of ANC</li> <li>• Develop community based systems for identification of pregnant women / notification to health facility staff</li> <li>• Increasing accessibility of antenatal care by working with DHMT and facility managers to overcome current obstacles (especially provision of antenatal care at mobile clinics)</li> </ul>	<p>Complete</p> <p>Planned</p> <p>Planned</p> <p>In process</p> <p>Planned</p> <p>In process</p>
<p><b>6. Percent of women with children age 0-23 months who received at least two tetanus toxoid injections during their last pregnancy in the program districts will increase from 48% to 70%</b></p>	<ul style="list-style-type: none"> <li>• Conduct qualitative investigation related to culturally-determined beliefs and practices re: pregnancy</li> <li>• Training of community-based groups (including women’s groups, NGOs, Peace Corps volunteers) on need for tetanus immunization as part of <i>ANC–STARTUP DISTRICTS</i></li> <li>• Training of community-based groups (including women’s groups, NGOs, Peace Corps volunteers) on need for tetanus immunization as part of <i>ANC–</i></li> </ul>	<p>Complete</p> <p>Planned</p> <p>Planned</p>

	<p><i>EXPANSION DISTRICTS</i></p> <ul style="list-style-type: none"> <li>Disseminate print materials for community promotion of safe delivery practices</li> <li>Develop drama and broadcast programs that includes community promotion of tetanus toxoid immunization</li> </ul>	<p>In process</p> <p>In process</p>
<p><b>7. Percent of women with children age 0-23 months whose last delivery was assisted by a skilled birth attendant in program districts will increase from 16% to 30%</b></p>	<ul style="list-style-type: none"> <li>Conduct qualitative investigation related to culturally-determined beliefs and practices re: birth</li> <li>Train community-based groups (including women's groups, NGOs, Peace Corps volunteers) in safe birth promotion–<i>STARTUP DISTRICTS</i></li> <li>Train community-based groups (including women's groups, NGOs, Peace Corps volunteers) in safe birth promotion–<i>EXPANSION DISTRICTS</i></li> <li>Disseminate print materials for community promotion of safe delivery practices</li> <li>Develop drama and broadcast programs for community promotion of safe delivery practices</li> <li>OR activities to test strategies to increase access to trained birth attendants (birth-friendly health facilities, waiting homes)</li> <li>Meetings with community leaders to promote and develop birth plans and emergency transport plans</li> <li>Active participation in MNCH working group</li> </ul>	<p>Complete</p> <p>Planned</p> <p>Planned</p> <p>In process</p> <p>In process</p> <p>Planned</p> <p>Planned</p> <p>Ongoing</p>
<p><b>8. Percent of women with children age 0-23 months who received a vitamin A dose in the first two months after their last delivery will increase from 28% to 60%</b></p>	<ul style="list-style-type: none"> <li>Training of midwives in program districts in integrated postpartum care, including vitamin A supplementation</li> <li>Community education on value for mother and newborn of postpartum visit, including Vitamin A supplementation–<i>START UP DISTRICTS</i></li> <li>Community education on value for</li> </ul>	<p>Planned</p> <p>Planned</p> <p>Planned</p>

	<p>mother and newborn of postpartum visit, including Vitamin A supplementation – <i>EXPANSION DISTRICTS</i></p> <ul style="list-style-type: none"> <li>• Disseminate print materials for community promotion of vitamin A as a component of integrated postpartum care</li> <li>• OR to improve postpartum care coverage (e.g. buddy system for accompany mother to HF, promote <i>face matan</i> ceremony as opportunity for PPC, train CHW to assist home based delivery of PPC)</li> <li>• Increasing accessibility of postpartum care by working with DHMT and facility managers to overcome current obstacles (eg trial home visits)</li> <li>• Actively participate in MCH working group to lead policy development for national standards of, and for increasing coverage of, comprehensive integrated postpartum care (including vitamin A for postpartum mothers and hepatitis B vaccination for newborns)</li> </ul>	<p>In process</p> <p>Planned</p> <p>Planned</p> <p>Ongoing</p>
<p><b>9. Percent of infants aged 0-5 months who are exclusively breastfed will increase from 29% to 45%</b></p>	<ul style="list-style-type: none"> <li>• Work with existing community-based groups trained in breastfeeding promotion to expand coverage of activities</li> <li>• Dissemination of IEC materials for breastfeeding promotion</li> <li>• See activities for objective #10</li> </ul>	<p>In process</p> <p>Planned</p>
<p><b>10. 50% of mothers of children under one year in the program districts will know at least 3 signs of serious newborn illness</b></p>	<ul style="list-style-type: none"> <li>• Conduct qualitative investigation related to culturally-determined beliefs and practices re: postpartum/newborn care including breastfeeding</li> <li>• Together with MCH working group develop a standard set of “danger signs” for newborn illness for use in health education in Timor-Leste</li> <li>• Develop and disseminate written IEC materials for community-based</li> </ul>	<p>Complete</p> <p>In-process</p> <p>In-process</p>

	<p>promotion of newborn care including breastfeeding promotion</p> <ul style="list-style-type: none"> <li>• Conduct skills-based training for postpartum and newborn care for all midwives in focus districts</li> </ul>	Planned
	<ul style="list-style-type: none"> <li>• Training of community-based groups (including women’s groups, NGOs, Peace Corps volunteers) about newborn care and signs of illness– <i>START UP DISTRICTS</i></li> </ul>	Planned
	<ul style="list-style-type: none"> <li>• Training of community-based groups (including women’s groups, NGOs, Peace Corps volunteers) about newborn care and signs of illness– <i>EXPANSION DISTRICTS</i></li> </ul>	Planned

**B. Main factors impeding progress toward achieving overall goals and objectives**

❖ ***Factors in health services arm of program strategy.***

HAI’s prime operating principal is to support the MCH and Health Promotion departments of the MOH to strengthen their activities. By definition HAI’s progress is reliant on genuine collaboration and commitment from MOH MCH counterparts, both at central and at district level (DHMT and the MCH-DPO). This relationship, although strong, is hindered by the following:

- i. **The multiple demands and competing priorities that are constantly faced by a very limited number of staff in the MCH department:** The department of MCH is HAI’s key counterpart in the MOH. The department is small, with only one person assigned to reproductive health and one to child health. Neonatal health is a responsibility of each of these personnel. These same two personnel however are responsible for the broader agendas of maternal health and child health respectively. They must also meet the demands of numerous other agencies, donors and organizations. This seriously limits the availability of the MCH staff for regular meetings and for full active participation in program activities of any individual agency or organization. Schedules are overbooked and priorities sometimes appear unexpectedly, meaning that scheduled meetings are often cancelled at “the last minute” and postponed; inevitably program activity processes are delayed. In addition MCH staff not infrequently travel abroad to attend meetings or related activities. A clear example of this problem of competing priorities and a limited staff is that of the

recently launched supplementary feeding program of the World Food Program. All staff of the MCH department have been completely occupied with this new program over the recent month, essentially making them unavailable for other, routine, MCH activities. Other recent examples include 2 national immunization days (NID) and the recent dengue haemorrhagic fever outbreak (December 2004 – March 2005) which had a similar effect on the health promotion department.

As HAI is committed to coordinating with the MOH, HAI has elected to demonstrate this commitment by not proceeding with major program activities until a reciprocal commitment from the MCH department is secured. HAI strongly believes that this is the only acceptable way to operate in order to maximize the likelihood of sustainability of activities; it also acts to ensure capacity building at every step. On occasions where there has been less active participation from the MCH department than HAI has felt necessary HAI has made sure to provide personal feedback as well as wider feedback in the form of presentations and/or written reports or updates about the activities. HAI is constantly working on cementing a solid relationship with both the MCH and the health promotion (HP) departments. At times this has meant participating and collaborating in activities that have fallen outside the immediate program schedule – e.g., assisting transport for the national immunization days. In other activities, such as reestablishing the MCH working group, HAI has facilitated their implementation by coordinating logistics on behalf of the MCH department.

- ii. **Turnover of key staff and unfilled positions in MCH department and DHMT:** Government MCH and HP staff numbers are further limited or compromised by ongoing turnover in key personnel and by a slow recruitment process, leaving key positions unfilled for sometimes lengthy periods of time. During the past year both the head of the MCH department and her head, the director of service delivery, as well as the head of the HP department were moved to other positions in the health sector; all three positions remain filled with temporary heads at present. At district level, the head of the district of Ermera has, until very recently, also been unfilled. To compound things further the MCH-DPO in Ermera district was on maternity leave for 3 months until August. These realities not only reduce availability of staff but also affect efficiency and leadership of program implementation.

HAI cannot directly address these fundamental government processes. In the district of Ermera HAI elected to wait until the MCH-DPO returned from leave before attempting to fully implement routine health system

activities eg supervision. In Ermera district more attention was given to building relationships with other community implementing partners.

- iii. **Restructuring of system for health training in Timor-Leste:** Over this past year the system for health trainings has been reorganized. The training centre, formerly "NCHET", was restructured into an Institute for Health Sciences. This brings with it a new administrative sector and protocol for implementing trainings. This process, which naturally took many months to finalize, has delayed the implementation of scheduled health staff trainings.

HAI has addressed this issue by accommodating it into the program schedule. Priority trainings (postpartum care and counseling for midwives) have been preliminarily discussed with IHS staff and HAI are aware of the new requirements for this procedure. The counseling training in particular was scheduled to start in the last quarter of 2005. This has now been pushed back as a consequence of these adjustments (see timeline). Now that the process of the IHS has been finalized HAI anticipates that further steps in developing these trainings will proceed according to schedule.

- iv. **Limited capacity of district health team staff:** HAI's prime counterpart in the district health team is the DPO-MCH, although HAI also works closely with the head of the DHMT in each district, as well as with the DPO for health promotion. In two of HAI's program districts, Liquica and (until very recently) Ermera, the head of the DHMT has a non-health background. This has hampered progress of activities in these districts in comparison to the other districts where the leadership is much stronger. With the recent appointment of a senior health person to the position of DHMT head in Ermera it is anticipated that progress in program activities in that district will begin to proceed at a faster rate.

The DPO-MCH is a recent addition to the DHMT. The position was added to the official DHMT structure in January of this year, prompted by the launch of the HAI program. Recognizing the very limited district capacity in MCH, HAI had specifically included appointing an MCH-DPO in the program strategy. The DPOs are all midwives with no previous experience in management, administration or supervision. Thus they are unable initially to function independently in their new role. For the most part, the DHMT heads also do not have sufficient experience to single-handedly provide the necessary training and supervision that is required.

HAI has specifically addressed this issue in two ways. Firstly, HAI's approach to district based activities is very participatory. At each step of implementation of district activities (baseline assessments, feedback, planning for implementation, implementation of individual activities) HAI has arranged formal meetings with all members of the DHMT, as well as other district partners in MCH. The DHMT has been actively involved in each step of the program cycle and, as a consequence has a solid understanding of HAI's strategic approach; they have responded very favorably to this approach to collaboration. Secondly, HAI has complete commitment to technically supporting the newly appointed DPO-MCH in their new role in the program districts. Specifically this is done through an initial orientation and training workshop, regular meetings, monthly reports, acting as a liaison point with central MOH when required, and providing frequent and ongoing support for supervision visits to health facilities. There is no other agency that provides them with this support, nor does central MOH have sufficient staff to fulfill this role. In this way HAI's work is unique and the DPOs in the HAI program district are expected to acquire capacity much more quickly than in the other program districts where the DPOs are currently for the most part left to their own resources.

- v. **Poor collaboration/coordination of all stakeholders in health at district level, including with the DHMT:** Progress towards health gains is often limited if there is poor coordination and collaboration between partners, including between the public and private sectors. This is particularly so in Timor-Leste where there are limited personnel, both in numbers and in capacity, in the public sector. At the commencement of the HAI program there was no organized means of achieving this at central level and only one program district, Aileu, was holding regular "NGO coordination" meetings.

In order to address this, and to simultaneously assist HAI's work towards achieving its own program objectives, HAI has facilitated coordination and collaboration at both central and district level. Centrally HAI precipitated and facilitated the re-institution of the MCH working group, renamed the MNCH (maternal, neonatal and child health working group) meetings, and at district level HAI has held several meetings for district based stakeholders in MCH, bringing together both private and public sectors.

- vi. **Process of district civil administrative structure:** Timor-Leste has recently held elections to formerly appoint the first post-Independence district civil administration structure (chefes sucos and aldeias). Implementation of this important community based network is crucial to

the success of certain HAI program activities, particularly those relying on community based information reporting systems such as that of the maternal and newborn death audit.

HAI has acknowledged that this process is integral to the death audit activity and elected to delay full implementation of the death audit project until elections were completed (see timeline).

❖ ***Factors impeding progress in community education arm:***

- i. **MOH process of developing a policy framework for training for Community Health Workers (CHWs):** This year the MOH department of health promotion began a process of developing a policy framework for a national system of community health workers (CHWs). The process is still underway. As an adjunct to this process they expressed a clear reticence for any organization to independently develop curriculums or systems for CHWs. This decision has recently been reviewed as it has been realized that it will take longer than initially anticipated for the MOH to finalize and implement their CHW policy framework.

HAI respected the MOH's requests with regards to this process. In order to support the MOH process, HAI contributed as an active participant in the working group that is developing the CHW policy framework. Secondly, HAI elected not to initiate any training activities for CHWs until there was a "go-ahead" from the MOH. In the interim however HAI has begun developing some training materials in maternal/newborn health for future use by CHWs. HAI has also established contacts with specific CHW groups supported by other community-based NGOs in Aileu and Ermera districts who are interested to work together with HAI in maternal/newborn care when the program is ready. With the recent revision of MOH policy on CHWs, HAI has also now made more definite plans to incorporate CHW trainings in at least one site in each of the program districts, as part of the "Birth Friendly Health Facility" pilot project.

- ii. **Limited capacity of district health team staff:** see above. The limited capacity of the DHMT members also impacts on community health education/promotion activities. Being aware of this, HAI attempts to ensure that the DPO-HP is also included in all community based activities.

- iii. **Poor collaboration/coordination of stakeholders in health at district level, including with the DHMT:** above also applies to community level activities.

### **C. Technical Assistance**

Technical assistance may be required for implementation of some of the training activities scheduled for 2006, such as the training of midwives in communication skills. At this point, however, this is not certain – it will depend upon the decisions that are reached about implementation, such as choice of language, and such as training and course materials. It is expected that this will be clearer at the end of the next quarter. Other technical assistance that may be needed can most likely be met by local or regional resource persons.

### **D. Modifications to Cooperative Agreement**

No modification to the Cooperative Agreement is required.

### **E. Sustainability**

Long-term sustainability is the hallmark of HAI's efforts in Timor-Leste. Each of the program districts is staffed with a newly appointed MCH District Program Officer (DPO) who is part of the District Health Management Team (DHMT) and coordinates all district level MCH activities, conducts community health promotion and supervises all district midwives. HAI provides salary support for these positions in the program districts. However when the project ends the MOH is committed to covering their salaries directly, and is already doing so in the remaining nine districts of the country. Two HAI program assistants provide ongoing support to the MCH DPOs in the program districts and training has been provided by HAI and MOH to all DPOs in the 13 districts around the country. At the end of the grant cycle the new body of work of the MCH DPOs will be embedded in the DHMT structure and the DPOs will be fully trained to carry on the work.

A significant number of HAI activities involve assisting the MOH to increase the skills of health facility staff and enhance the quality of services. Inherent within these types of activities are improving local capacities that endure beyond the life of the grant. For example, HAI staff have either completed or have planned the following capacity building activities: training in emergency neonatal care for midwives, training for midwives in communication and counseling skills, training for nurses at the national hospital in neonatal care, piloting a system for maternal death surveillance, and development of a plan for piloting birth-friendly facilities. Additionally,

as a new nation the Timor-Leste MOH is in the process of developing national health policy and strategies. HAI staff have played a key role in the re-establishment of the MNCH (Maternal, Newborn and Child Health) working group, which is actively involved in the development of national policy and strategies in the area of MNC/MCH. The capacity building and the policy development activities undertaken as part of this grant will continue to provide positive impact for health long after the grant cycle ends.

HAI has actively sought out additional sources of funding to support activities/products not supported by the original Child Survival proposal. These include a USAID mission grant that is funding the rehabilitation of a mostly destroyed building that will become the joint offices of HAI, TAIS (BASICS3 and ImmunizationBASICS), the MCH unit of the MOH, and Dili District health staff. At the end of the grant it will continue as MOH office space. Additionally, HAI has interested funders (UNICEF and AusAID) who plan to support the production of a set of culturally relevant audiovisual films/video training modules on MNC, which will improve capacity of health facility staff to promote healthy behaviors in communities for years to come.

HAI's policy of close collaboration with the MOH at either district or central levels is a key element of our sustainability strategy. As a result, we are careful to roll out interventions at a pace that does not exceed the pace of the MOH's capacity and commitment. In addition, at the district level we are careful to include both the DHMT and community partners in all planning efforts. For example, the deployment of community volunteers to provide health education and support at the household level is a recent strategy of the MOH Health Promotion department, with plans to start implementation in late 2005 or early 2006. HAI and UNICEF are two of the key partners who will assist in the implementation of this strategy in three shared districts. HAI has been involved in the development of the plan relevant to MNC, has identified potential collaborating groups in program districts, and is developing relevant materials for this effort. We will ensure that all planning and training regarding volunteers is consistent with the MOH strategy, as the best way to ensure sustainability of this effort.

## **F. Response to DIP review comments**

All recommendations raised following submission of the DRAFT DIP in April 2005 were satisfactorily responded to in the final DIP submitted in June 2005. No other issues were raised at the DIP consultation.

## **G. Indicators Reporting Table: *Not Applicable***

## H. Program management

No particular problems have been encountered to date with program management. The following describes our management system.

### i. Financial management system

Program advisors and their counterparts prepare detailed budgets for each major program activity. As expenditures are requested, key program staff for each activity assign the appropriate cost category (based on the detailed budgets) to that request. All program expenditure is approved by HAI Country Director/Program Manager. The program field accountant summarizes and sends financial documents monthly to HQ where the HQ accountant monitors the categories assigned for accuracy and prepares detailed and summary reports from the information sent. Counterpart staff are involved with the process of budget preparation, monitoring, and reporting to the extent that they are available, as costing and financial management is a valuable area of skills acquisition for staff at all levels.

Tracking costs. The HQ accountant and her assistant maintain detailed records of the types of individual costs incurred. In addition to tracking by intervention at the field level, the categories monitored include office costs such as communication, payroll, benefits, travel, supplies, equipment, contracted services, evaluation, and training costs. Summaries are shared regularly with all pertinent staff. Program budgets are developed by HAI program staff and their counterparts. Because workshops and other discrete activities are conducted jointly with MOH or other staff, HAI counterparts in those institutions are expected to jointly plan, manage and account for the expenditures for those activities.

### ii. Human resources

There are no substantive changes in the management and staffing plan from the Detailed Implementation Plan. The job title for Training Advisor was changed to MCH Technical Advisor when it became clear that there was ample training expertise among both Timorese and international advisors, but technical expertise particularly in postpartum and newborn care was needed. Dr. Ingrid Bucens, the program's Technical Advisor, is a neonatologist with MPH training and over two years previous work experience in Timor-Leste. Dr. Bucens speaks Tetum and was involved in the original development of the Timor-Leste proposal.

The main HQ technical backstop is the HAI Deputy Director, Mary Anne Mercer, assisted by Susan Thompson, who also supports HAI's community health promotion project in Venilale. Headquarters staff provide direct support to field staff by means of field visits 2-3 times yearly; regular telephone and email contacts; review of program reports; coordination with US-based staff of partner organizations, particularly BASICS3 project; sending technical materials and documents; and assistance with the selection, orientation, and supervision of consultants, student, student volunteers, and other resource persons. Additional headquarter support for financial and human resource management is provided by the Office Manager, Accountant and an Accountant Assistant.

At the field level, the program is directed by the CS Program Manager, Nadine Hoekman, who also serves as HAI country coordinator in Timor-Leste. The program manager reports directly to the Deputy Director at headquarters, and works in close collaboration with the MCH Head of the MOH, who has overall responsibility for maternal and child health programming. The technical approaches of the project are coordinated by the MCH Technical Advisor, Ingrid Bucens, working as a counterpart to the MOH's MCH Program Officer. Community health activities are coordinated by the Health Promotion Coordinator, Dr. Teda Littik, whose MOH counterpart is the national Health Promotion Head. Each of the program districts is staffed with a newly appointed MCH District Program Officer (DPO) supported by HAI who works with the DHMTs to coordinate all district level MCH activities. The Health Promotion Coordinator is responsible for overseeing the health promotion activities of the DPOs. All program staff plan activities jointly with their respective MOH counterparts. Assisting the HP Coordinator are two HAI program assistants. Other staff who support the program at the Dili office are an administrator/office manager, an accounting assistant, and various support staff. All program staff report to the CS program manager; support staff report to the administrator/office manager, who in turn reports to the program manager.

### **iii. Communication system and team development**

Headquarter staff and field staff are in regular communication via email and telephone regarding program planning and activities, program financial accounting, and human resource management. During this busy first program year, activity reports from field staff have been primarily via weekly emails and as needed telephone calls. Due to many competing priorities for staff time, regular written reporting has been challenging during the first program year. However, beginning in the second program year a more formal reporting system is being implemented with

field staff responsible for monthly activity reports to headquarters. Quarterly reports documenting progress against work plans will also be prepared for headquarters and key partners MOH, TAIS and USAID mission in an effort to keep collaborating partners apprised of program activities and achievements. Headquarters staff conduct monitoring and supervisory field visits to Timor-Leste two to three times a year.

HAI field staff have worked tirelessly during the first program year to coordinate and collaborate with MOH partners at every step. This has resulted in very positive working relationships with key counterparts within the MOH. Currently, HAI offices are located in remodeled former shipping containers on the grounds of the MOH which, although cramped, has greatly facilitated communication with MOH staff. The new joint office space will be ready to move into toward the end of 2005.

#### **iv. Local partner relationships**

HAI's primary partner is the MOH, including the departments of MCH and HP. During this first year HAI has worked towards cementing a strong supportive and collaborative relationship with the MOH, particularly with the MCH department. HAI believes that these efforts have paid off; HAI is clearly recognized and respected by the MOH as the lead agency in maternal/neonatal/postpartum health and, more broadly, as a key partner in MCH. Additionally, HAI has developed credibility by strictly adhering to their principal of working through government staff and policy. Supporting evidence includes:

- HAI is regularly invited to all MCH activities including mid-level policy meetings
- HAI is viewed as a technical resource for MNH
- Following the HAI baseline assessment studies, HAI is recognized by the MOH as having particular knowledge about the traditional practices and beliefs about MNH in Timor-Leste
- HAI commonly functions as a co-organizer of fundamental MOH MCH activities – e.g., the MNCH working group meetings
- HAI is recognized by the MOH as having a strong field presence in the public sector and for our unique role in supporting the new MCH-DPOs. In this way HAI differs from other agencies with similarly close working relations at central level (e.g., UN agencies) who do not have such a presence in the field. Again, this adds to HAI's credibility.

HAI's unique style of operating, supporting the government counterparts, is also clearly recognized by the DHMT and the DPOs themselves. This has been openly stated on numerous occasions.

## **v. PVO coordination/collaboration in country**

Although the HAI's primary counterpart is the MOH/DHMT at central and district levels respectively, HAI relies on partnering with other implementing agencies, particularly for district based work where HAI has no permanent staff presence. HAI links with other agencies and organizations to implement specific activities, but HAI also assures that the relationship is triangulated, ensuring the DHMT (or, importantly the DPO-MCH and the DPO-HP) are part of "the loop". In this way HAI assists with improved collaboration between other partners and the district health team, which clearly has broader benefits.

In each program district HAI has sought out interested partners. HAI's main nongovernmental partner in Timor-Leste is TAIS, the joint project of BASICS3 and ImmunizationBASICS, described in Section I, below. As only one other organization is currently working in neonatal/postpartum health at district level (Alola Foundation's mother support groups), it is little surprise that in general others are enthusiastic to partner with HAI. Specific examples of this partnering include:

- Work with Peace Corps, Bibi Bulak (a national drama group), the national youth group and the DHMT in Liquica district to develop a street drama in MNC.
- Work with SHARE in Ermera to develop health promotion materials in postpartum/neonatal care.
- Firm commitments for collaboration from Cooperativa Café Timor (a private clinic supported by the coffee cooperative in Ermera district) and Uma Ita Nian (a church clinic in Aileu district).

At central level HAI has also actively sought to develop partner relationships with other agencies and organizations. This has been developed both within and outside of the MNCH working group. Specific examples include:

- Working with UNFPA in emergency neonatal care trainings for referral facilities
- Working with Alola Foundation and Unicef to develop a "Mother-Baby pack" for families who deliver babies in health facilities.
- Working with WHO to develop training for neonatal care in hospitals
- Working with Bibi Bulak to develop a drama in MNC to be performed in the program districts

## **vi. Other relevant management systems**

HAI is currently developing a web-based system for dissemination and archiving of program reports for its field projects. The system will be

easily accessible by field staff and will provide an opportunity for expanded sharing of documents between field and headquarters. The system is part of an 'internal links' section of a new and expanded HAI web site.

#### **vii. Financial audit**

A financial audit of HAI was conducted in 2005 with no findings or questioned costs reported. Additionally, due to rapid organizational growth the past two years, HAI headquarters hired a human resource consultant in 2005 to audit and make recommendations for changes in HR policy and procedure. This resulted in modifications in HAI's policies related to contracts for new personnel, termination clauses, etc. An additional response to the human resource consultation was to hire new staff at headquarters to handle all issues related to international benefits and allowances.

HAI staff and board of directors has begun the development of a new strategic plan, which will be completed by early 2006. A key element of the plan is expected to be a strategy for further dissemination of lessons learned in our field projects as well as broader health advocacy activities.

### **I. Mission Collaboration**

HAI is one of USAID's two key central-level mechanisms for health assistance in Timor-Leste, the other being TAIS, described below. HQ staff were consulted in the development of the mission's strategic plan, and the mission has made every effort to assure us that our activities in Timor-Leste are an integral aspect of USAID support there.

HAI has had several meetings with USAID Mission in Timor Leste to apprise Mission staff of project activities. Headquarters staff meet with mission staff at every field visit. Copies of routine reports (baseline assessments, Detailed Implementation Plan, annual reports and evaluations) are submitted to mission staff. Because the US Ambassador in Timor-Leste is very interested in health programs in the country, HAI has met with him twice to provide updates on the program. In response to requests for more regular and detailed updating on the program by USAID, HAI will in addition provide progress reports to mission staff every quarter during the remainder of the program.

A new key partner of HAI is the USAID Mission-funded BASICS3 and ImmunizationBASICS programs in Timor-Leste. These two programs, currently in the early stages of implementation, have merged

administratively for country operation as the TAIS (Timor-Leste Asistencia Integra do Saude) project. HAI and TAIS both have as their goals to improve health in Timor-Leste by working with government structures to improve the quality of health services and to promote community awareness and appropriate care-seeking for health problems. TAIS focuses on the health of the child and HAI on maternal and newborn health; the groups have an overlapping interest in the health of the newborn. The convergence of our two groups in Timor-Leste offers an ideal opportunity to provide coordinated technical support to the MOH in the full spectrum of maternal and child health.

Current plans for collaboration include shared office space, frequent communication around common issues and approaches and working together with the MOH to develop national policy on postpartum and newborn care. In addition, as we are able to document successes in our initial program districts, TAIS and HAI will discuss possible mechanisms for the most rapid and effective approaches to scaling up our respective programs nationwide. One possibility for active TAIS-HAI collaboration will be in the implementation of TAIS's newly developed plan for continuous quality improvement at the district level (CCQI). The TAIS plan will bring staff of the DHMT and heads of health centers together for a regular planning/implementation/evaluation process that is as applicable to maternal/newborn care services as it is to child health care.

HAI was awarded a USAID Mission grant to rehabilitate a largely destroyed building, which will become the shared office space of HAI, TAIS, the MCH unit of the MOH, and the Dili District health team, greatly facilitating communication and collaboration among these key partners.

HAI is also supporting and collaborating with the private health clinic system Cooperativa Café Timor (CCT). The USAID Mission supports CCT to operate health clinics in the coffee growing areas of the country (two of HAI's program districts). CCT will begin implementing a new program in maternal and child health in January 2006. HAI was consulted by CCT for technical input into the program design. HAI has been requested to provide ongoing technical support to the program following the commencement of implementation. Given HAI's main implementing partner at district level is the DHMT and government clinic staff, this collaboration is an excellent opportunity to explore private-public sector partnership in the two overlapping districts, Ermera and Liquisa. Currently, the HAI health promotion team provides supervision visits and consultation to midwives working at CCT clinics.

## J. Timeline

A timeline of activities for the coming year (year 2 of program implementation) is seen in Annex A. The variations from the original program timeline are marked in bold; the reasons for the variations here are listed in the order that they appear in the timeline. There are no major changes.

- Policy input: HAI has been part of a small working group to revise and update the national standards for midwifery practice in Timor-Leste. The process is nearing completion but will roll-over into program year 2.
- Development of the integrated supervision tool for MCH is well underway; it will be completed Q1 of program year 2 as indicated in the timeline.
- Development of systems for collecting information about maternal and neonatal deaths: This has been pushed back a further quarter. The process for this commenced as scheduled in Q4 of year 1. It is anticipated however that this will take longer than planned to implement fully due to the time needed to secure high level policy commitment to the activity, as well as the delays that were encountered because of ongoing elections of personnel for a new district system of civil administration (chefes of sucos and aldeias).
- Development of health promotion materials for MNC is ongoing; it is anticipated to extend through to Q3.
- Working with school HP staff has been pushed back as the school health curriculum is not yet ready to incorporate MCH messages; the relevant staff at MOH level are aware of HAI's commitment to this activity.
- In year 1 HAI was very involved with the development of a national strategy for maternal waiting homes. HAI will continue to assist in the implementation of the MWH pilots in program districts.
- Planning for the birth-friendly health facilities were begun in year 1, and the project is now ready for implementation in all 4 program districts. The concept has now been expanded to be linked to other related HAI community activities – namely CHW training, systems for improved health service delivery, emergency transport systems, promoting skilled birth attendance and developing community based systems for collection of information. The rationale behind this is that the activity is most likely to be effective if it is strengthened and linked by these inter-related activities.
- Implementation of the counseling/communications training for midwives has been delayed by the restructuring of the system for implementation of trainings, as explained in section B above. This also

applies to the slight delay in the implementation of training for newborn care at referral hospitals.

- District based drama in MNC was developed for Liquica district in the 3<sup>rd</sup> and 4<sup>th</sup> quarters of year 1. It is planned that we will replicate the project in other program districts during year 2.

## **K. Success Stories**

HAI is currently beginning the second year of a new program. Although there are a number of initiatives that already appear to benefit national programs, we will report on them next year after suitable evaluations have been conducted. We respond here, however, to the additional areas suggested for inclusion into the report.

### **❖ Contributions to Scale:**

Section E of this report details many of the ways in which HAI's approach to health support in Timor-Leste is influencing national policy in critical areas. Our work at the central level MOH means that we take part in a wide range of discussions on both policy and procedures that will affect the health system of the entire country. For example, by initiating the appointment of district program officers for MCH in all districts, we have strengthened, at the national level, the district capacity to carry out the policies and processes that are set at the central level.

HAI is on schedule to reach, by project end, districts containing approximately half of Timor-Leste's population with sustainable improvements in maternal and newborn care services and community behaviors. The USAID mission funded project TAIS (BASICS3/ ImmunizationBASICS) is also working in other selected districts (only one of which overlaps with HAI's) to ensure improved services and behaviors related to child health. We have met with TAIS staff to discuss various possible approaches to scaling up our respective program interventions in districts covered by the other's program. Although it is too early to determine a workable strategy to address this issue, discussions are ongoing.

### **❖ Civil Society Development:**

As noted in Section B, HAI's district-level efforts require close collaboration with and strengthening of district health management teams. Although only one year into our project, we have already noted increased skills and confidence of the MCH District Program Officers (members of the DHMTs) in supervision of MCH midwives.

HAI is also involved in strengthening the abilities of local artists to use their skills to deliver health messages in an entertaining way. We are working with a local professional drama group, Bibi Bulak, to develop, field test, and evaluate an entertaining show that incorporates key messages on maternal and newborn care. That group is also in the process of training a district-based health promotion group, *Juventude Haburas Saude*, street-theater skills and the development of a maternal and newborn health drama for performance in rural areas. Throughout this process we have sought to promote cooperation and coordination between this group and the District Health Team. We hope that supporting *Juventude Haburas Saude* will not only assist in the dissemination of MNC health messages to target areas but will also develop the public health skills of such local groups, and strengthen the linkages between independent and government health systems at the district level.

We are assessing the success of these efforts in transmitting messages clearly and accurately via pre- and post-test audience interviews. Success, if documented, may encourage other health organizations, such as TAIS and Unicef, to undertake similar projects with Bibi Bulak as well as with local theater groups that are currently being formed.

#### ❖ **Innovative approaches:**

Up to the present time, health promotion efforts in Timor-Leste have been mainly limited to development of written materials (mainly posters) with didactic and non-interactive “teaching” by health staff. However, this is a country where half the population is non-literate and not accustomed to learning via didactic approaches, and where culturally-based beliefs and values are still very strong. HAI is taking the lead in supporting innovative and interactive approaches that address and include local cultural realities and, we believe, are more likely to result in improved understanding and acceptance by the predominantly rural population. Examples of current efforts are the support of the Bibi Bulak theater group to present a program with maternal and newborn care messages at district capitals; the development of a district-based drama group for the same purpose; the development of pilot birth-friendly facilities; and plans to support a locally-produced film for use in community education and midwife training on maternal and newborn care. All show HAI’s strong commitment to including and addressing local cultural realities in our health promotion work.

### ❖ **Equity:**

One of the program populations of greatest concern to HAI staff are families living far from the health care, transportation, or communication infrastructure. These families are also typically the most immersed in local cultural traditions that do not value biomedical health services. Mothers and infants from these families are at great risk for morbidity and mortality because of very high levels of poverty as well as great difficulty in accessing health services. We are in discussions with the MOH on various approaches to assuring better access to maternal and newborn care for these populations through such methods as providing incentives for midwives to conduct home visits for deliveries, postpartum and newborn care; training of community members as CHWs; and modifying selected district facilities to serve as birth-friendly health facilities for women who for culturally-based reasons will not utilize the standard biomedical units for their deliveries.

Additionally, while most health promotion activities occur in Timor-Leste's most commonly spoken language, *Tetun*, in some very rural areas this language is not widely spoken. In an attempt to address this issue, the district based street-theater group we support targets very rural areas for maternal and newborn health promotion, and performs in the local language.

### ❖ **Visibility and Recognition:**

HAI field staff have attended two international meetings during this past year in which problems of maternal/newborn health in Timor-Leste and the HAI approach to addressing these problems was discussed. Both the program manager and MCH technical advisor attended a meeting on community-based postpartum care in Bangladesh in April, and the technical advisor presented a paper on the state of newborn health in Timor-Leste at the meeting of the Perinatal Society of Australia and New Zealand in Australia in May. The technical advisor also presented a paper on "The State of Timor-Leste's Newborns" at the first conference of the East Timorese Medical Association in Dili in August this year. The program manager and headquarters backstop made three presentations on our work at the DIP reviews/mini-university meetings at Johns Hopkins University in June. Finally, HAI's experiences with the Timor-Leste CSH grant have been presented at various classes and student forums at the University of Washington School of Public Health this past year.

Annex A.

Activity					
		Q1	Q2	Q3	Q4
<b>CENTRAL LEVEL</b>					
1	Active member of MNCH working group	X	X	X	X
2	Policy input – maternal malaria, TBAs, waiting homes, PPC / NBC, Hep B vax, MTCT HIV/AIDS, <b>midwifery standards</b>	X	X	X	X
3	Complete development of integrated supervision tool for MCH for health facilities	<b>X</b>			
4	Support development of systems for collecting information re: maternal and neonatal deaths	X	X	<b>X</b>	
5	Review and discuss cultural practices relevant to MNC and use of that information in refining health services	X	X	X	
6	Review available HP materials for MNC. Assist development of materials to address current gaps (esp. PPC / NBC)	X	X	<b>X</b>	
7	Produce and disseminate film on MNC for use in HP activities nation wide	X	X	X	
8	With school HP staff, identify HP messages to be included in school curriculum.		X	<b>X</b>	
<b>HEALTH SYSTEM LEVEL Districts / Health facilities</b>					
9	Quarterly meetings for MCH-DPOs (1-day each)	X	X	X	X
10	Supervision / technical support for MCH-DPOs	X	X	X	X
11	Ensure essential equipment for MNC available at HF through MCH-DPO supervision tool	X	X	X	X
12	Training of MCH-DPOs re: death audits (maternal and newborn)	X	X	X	X
13	Assist in implementation of strategy for maternal waiting homes	<b>X</b>	<b>X</b>		
14	Pilot birth-friendly health facility in conjunction with community	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
15	Develop and conduct communication and counseling skills training for midwives	X	X	X	<b>X</b>
16	Training of referral facility staff in newborn care (EMOC / newborn resuscitation and training for neonatology nurses)	X	<b>X</b>		
17	Develop and conduct training for midwives and nurses in PPC / NBC	X	X	X	X
18	Advocate for funding for motorbikes for MCH-DPOs	X	X		
19	Pilot systems for improved health service delivery in ANC/PPC/NBC - home visits for PPC/NBC - outreach HP	X	X	X	X
20	Increase HP activities at HF in MNC (via DHMT + HF managers: MCH-DPO to supervise)	X	X	X	X

<b>COMMUNITY LEVEL CHW, other community groups, NGOs</b>					
<b>21</b>	<b>Pilot a package of integrated program activities in communities where the birth friendly health facilities established</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>22</b>	<b>Support district based youth groups to implement street drama for MNC</b>	<b>X</b>	<b>X</b>		
23	Develop and conduct training in danger signs of pregnancy, the value of ANC and the package of benefits	X	X	X	X
24	Work with community leaders on developing birth plans and emergency referral plans		X	X	X
25	Develop and conduct training on need for skilled birth attendant, addressing cultural practices	X	X	X	X
26 26	Develop and conduct training on need for PPC/NBC, addressing cultural practices	X	X	X	X
27	Discuss and plan specific community HP activities with existing groups or volunteers	X	X	X	X
28	Support training of CHWs	X	X	X	X
29	Work with churches to disseminate key messages MNC (pre-marriage counseling)	X	X	X	X
30	Train relevant parties in notifying non-facility based births and deaths		X	X	X
31	Pilot systems for improved health service delivery in ANC/PPC/HP <ul style="list-style-type: none"> <li>- system for identification of pregnant women/notification to HF</li> <li>- buddy system for accompanying patients to HF</li> <li>- pilot use of Face Matan ceremony as opportunity for PPC / NBC</li> </ul>		X	X	X

Variations from the original program timeline are marked in **bold**

**YEAR 2: OCT 2005 – SEPT 2006**

**Q1 Oct/Nov/Dec**

**Q2 Jan/Feb/Mar**

**Q3 Apr/May/Jun**

**Q4 Jul/Aug/Sep**

# Child Survival and Health Grants Program Project Summary

**Oct-28-2005**

## Health Alliance International (East Timor)

### General Project Information:

**Cooperative Agreement Number:** GHS-A-00-04-00022-00  
**Project Grant Cycle:** 20  
**Project Dates:** (9/30/2004 - 9/29/2008)  
**Project Type:** Standard

**HAI HQ Backstop:** Mary Anne Mercer

### Field Program Manager Information:

**Name:** Nadine Hoekman  
**Address:** Ministerio de Saude  
Timor Leste  
**Phone:** 670-725-0671  
**E-mail:**

### Alternate Field Contact:

**Name:** Ingrid Bucens  
**Address:** Ministerio de Saude  
Timor Leste  
**Phone:**  
**E-mail:**

### Funding Information:

**USAID Funding:(US \$):** \$1,500,000

**PVO match:(US \$)** \$509,600

### Project Information:

**Description:**

The goal of the Heath Alliance International’s Improving Maternal and Newborn Health project is to improve health and reduce mortality and morbidity for mothers and their infants in Timor-Leste. The program will focus the entire effort on maternal and newborn care, initially conducting intensive pilot efforts in four focus districts and expanding to an additional three districts. The program will accomplish these objectives by:

- 1) supporting the MOH to improve quality, access, and utilization of antenatal and postnatal/newborn care services, and
- 2) increasing appropriate home care and care-seeking practices for MNC by mothers and other community members.

Both approaches are consistent with the national commitment to implement IMCI and will be integrated with community IMCI activities.

**Project Partners:**

Timor Leste MOH

**General Strategies Planned:**

- Social Marketing
- Private Sector Involvement
- Advocacy on Health Policy
- Strengthen Decentralized Health System
- Information System Technologies

**M&E Assessment Strategies:**

- Health Facility Assessment
- Participatory Rapid Appraisal
- Participatory Evaluation Techniques (for mid-term or final evaluation)

**Behavior Change & Communication (BCC) Strategies:**

- Mass Media
- Interpersonal Communication
- Peer Communication

**Groups targeted for Capacity Building:**

<b>PVO</b>	<b>Non-Govt Partners</b>	<b>Other Private Sector</b>	<b>Govt</b>	<b>Community</b>
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Field Office HQ	Local NGO	Traditional Healers Private Providers	National MOH Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs
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## Interventions/Program Components:

### Maternal & Newborn Care (100 %)

(IMCI Integration)

(CHW Training)

(HF Training)

- Emerg. Obstet. Care
- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- Home Based LSS
- Control of post-partum bleeding
- Emergency Transport

## Target Beneficiaries:

<b>Infants &lt; 12 months:</b>	<b>20,000</b>
<b>Women 15-49 years:</b>	<b>100,000</b>
<b>Population of Target Area:</b>	<b>499,337</b>

## Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	<b>103</b>	<b>440</b>	<b>23.4%</b>	<b>6.0</b>

Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	<b>268</b>	<b>443</b>	<b>60.5%</b>	<b>8.6</b>
Percentage of children age 0-23 months whose births were attended by skilled health personnel	<b>70</b>	<b>448</b>	<b>15.6%</b>	<b>5.0</b>
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	<b>166</b>	<b>398</b>	<b>41.7%</b>	<b>8.0</b>
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	<b>77</b>	<b>268</b>	<b>28.7%</b>	<b>8.4</b>
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	<b>44</b>	<b>56</b>	<b>78.6%</b>	<b>25.6</b>
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	<b>0</b>	<b>0</b>	<b>0.0%</b>	<b>0.0</b>
Percentage of children age 12-23 months who received a measles vaccine	<b>63</b>	<b>173</b>	<b>36.4%</b>	<b>11.5</b>
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	<b>16</b>	<b>433</b>	<b>3.7%</b>	<b>2.5</b>
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	<b>260</b>	<b>433</b>	<b>60.0%</b>	<b>8.6</b>
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	<b>4</b>	<b>38</b>	<b>10.5%</b>	<b>14.2</b>

Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	<b>25</b>	<b>462</b>	<b>5.4%</b>	<b>3.0</b>
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	<b>430</b>	<b>461</b>	<b>93.3%</b>	<b>9.1</b>

### **Comments for Rapid Catch Indicator**

Using 2003 DHS data (Central Region) for baseline, which corresponds to the HAI project area.