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

Mid-Term Evaluation Report

Project Location: Democratic Republic of Timor-Leste (Formerly East Timor), Aileu, Ermera, Manatuto, Liquica, Manufahi, Ainaro and Dili Districts

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GLOSSARY OF ACRONYMS

ANC-Antenatal Care
BFF-Birth Friendly Facility
BPS-Basic Package of Services
CAMS-Centro-Audiovisual Max Stahl
CHC-Community Health Center
CHM- Community Health Motivators
CS- Child Survival
DHS-District Health Services
DIP-Detailed Implementation Plan
DPO- District Program Officer
EONC-Emergency Obstetric and Neonatal Care
HAI- Health Alliance International
HMIS- Health Management Information Systems
HNGV-Hospitado Nacional Guido Valadares
IMCI- Integrated Management of Childhood Illness
LISIO- Livrado Saúde Inanfante hoet Onan (Mother and Child Health Book)
MCH-Maternal and Child Health
MOH-Ministry of Health
MOS-Ministero de Saúde
NGO-Non-Governmental Organization
PMTCT-Prevention of Mother to Child Transmission
PPC-Postpartum Care
TAIS- Timor-Leste Asisténcia Integradu Saúde
UNFPA-United Nations Population Fund
USAID- United States Agency for International Development
WHO-World Health Organization

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Map No. 4111 Rev. 8 UNITED NATIONS
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A. SUMMARY

Health Alliance International's Child Survival Grant is currently implemented in four districts with planned extension to three additional districts in the next two years. This covers half of the country. The objectives of the program are to:

- improve the health policy environment and ensure that national policies reflect the most up-to-date research in antenatal care, delivery care and postpartum/newborn care,
- support cross-cutting areas such as information collection and supervision tools,
- expand the capacity of the district and health facility to deliver MCH services,
- improve six selected behaviors among the community including: 70% of pregnant women will receive antenatal care, at least 30% of women will deliver with a skilled provider, and 45% of newborns will exclusively breast feed for six months.

The main accomplishments of the program to date include the following:

- Recognition as the lead agency for Maternal and Newborn Health in East Timor by the Ministry of Health and thus an enhanced capacity to influence national practices in maternal and newborn care.
- Construction of a Birth Friendly Facility in Maubara, in the Liquica district which provides increased access for women to deliver with skilled providers. A second facility will open by December 2006.
- Introduction of Maternal Child Health District Program Officer positions in four program districts; the government then expanded this position to all 13 districts.
- Development and use of innovative communication strategies including counseling materials that use photographs of East Timorese, drama groups that enact health messages and a film shot by a well-known filmmaker that promotes health messages and acknowledges maternal/newborn health cultural practices.
- Continued support of midwives using new supervision tools that promote enhanced independence of practice, and focus on developing the midwifery mandate to provide and plan comprehensive care.
- A list of key maternal and newborn health messages that serves as a reference for other organizations and the MOH, as well as for HAI.

By investing in the HAI program, USAID has been able to achieve scale at the country-level. Not only is HAI a very careful steward of the resources entrusted to them by USAID, they are institutionally brilliant in raising funds from other sources. This capacity to leverage resources, either through getting additional funds for this grant or by contributing to activities funded from other agencies that have a national impact, has allowed the program to move forward at a steady pace.

HAI works within the Ministry of Health and uses government systems as their approach to improving maternal and newborn health. HAI's pace of implementation complements ministerial progress. Given that the Ministry is understaffed and has many demands on their time, HAI is working at a slower pace than anticipated. However, their excellent coordination garners kudos from the Ministry. The impact of HAI interventions will be significantly more sustainable over the long term because they are embedded within these existing structures and in fact, HAI often defines national norms, such as the MCH DPO

position and the adoption of key health messages. HAI undertook a census of all existing key messages in use in East Timor among UN agencies, donors, NGOs and the MOH. HAI refined and summarized the messages, the MOH approved the list, and now all agencies working in MCH refer to the same key messages.

A contextual factor of note is that in April, 2006, East Timor experienced a political and social crisis. This "situação" has resulted in internally displaced persons and a widespread sense of insecurity among the Timorese; it has affected national staff at all levels and has changed the political reality of functioning in East Timor. For example, in the original HAI grant, Peace Corps Volunteers were meant to work closely with the community health promotion program. Due to the political crisis, Peace Corps has closed its office here and all volunteers have been repatriated. This has had an impact on the youth groups doing community health promotion.

HAI's MCH plan was developed with widespread stakeholder consultation and thus is fundamentally sound as an approach. They anticipate moving to a greater emphasis on post-partum care and newborn care over the last two years of the program, in alignment with what has already been accomplished over the first two years. A program component will also cover intra-partum care in response to evidence based research. In addition, because East Timor has recently approved the National Reproductive Health strategy and HAI has won a second grant from USAID to implement a child spacing program, the child survival and child spacing program managers are determining how they can collaborate for greater impact.

There are a few significant programmatic areas in need of further attention. Data collection is one area where an institutional weakness exists but this is primarily because the national systems are so limited. Health promotion activities at the community level have been slow to get off the ground, although HAI staff have been devoting time to the government's new initiative of Family Health Promoters. Some of the reasons for this slower pace include the need for HAI to establish itself as a credible health partner and build trust with district health teams, health facility staff and community members. They have built a reservoir of good will and anticipate future community activities to move at a faster pace.

Capacity-building has focused primarily on developing the skills of nurse-midwives. The District Program Officers had a five day training course covering their roles and responsibilities, supervisory skills, etc and other midwives have received training in family planning (sponsored by UNFPA but HAI staff attended). HAI has followed up on the skills obtained in prior trainings, such as Safe and Clean delivery, which was completed before HAI began program implementation. Facilitative supervision is another HAI approach to capacity development. This supervision, using a newly completed tool, promotes greater independence among the midwives, supports the use of data for decision making and creates a mentoring system under which midwives can improve their counseling and client interaction skills. The MCH District Program Officers (DPO), midwives who function in a managerial capacity, have been included in all these trainings. One factor to note is the arrival of the Cuban brigade, which currently includes

302 nurses, administrators, technicians and physicians. Their place in the health structure and their relationships with the midwives is a program issue that HAI has to factor into its ongoing capacity building efforts.

Detailed conclusions and recommendations are found in Appendix E. The primary ones follow:

- Increase the emphasis on intra-partum care and post-partum care, including newborns.
- Continue innovative communication activities but with an added component of follow-up and discussion with the target audience.
- Drop the maternal and perinatal death audit activities at this juncture.
- Review the staffing plan and try to hire two more staff at least: one national staff for the district expansion efforts and a clinician to provide support for post partum and newborn care.
- Capitalize on the new government initiative to deploy volunteers as community health promoters to ensure widespread dissemination of key MCH messages.
- Identify linkages between family planning and MCH (i.e. post-partum visits).
- Improve communication with the USAID Mission, providing regular opportunities for participation in HAI activities.

B. PROGRESS MADE TOWARD ACHIEVEMENT OF PROGRAM OBJECTIVES

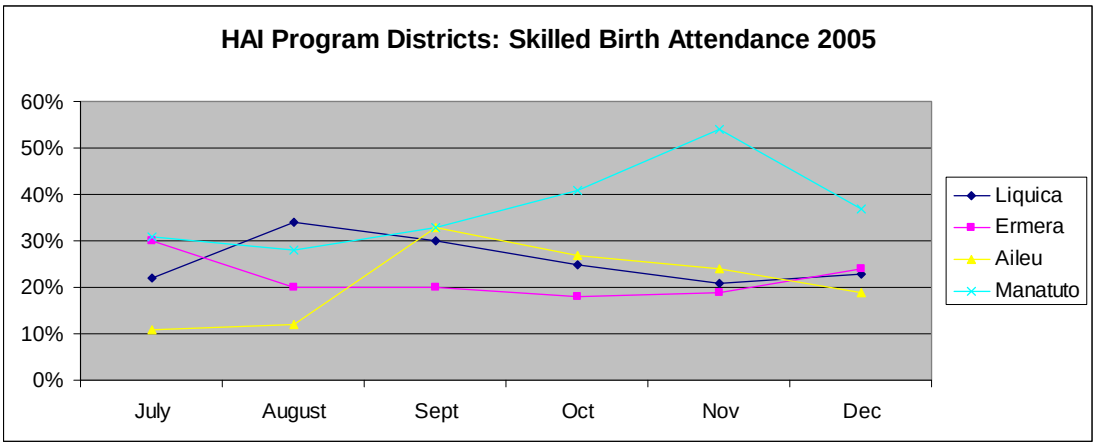
1. Technical Approach

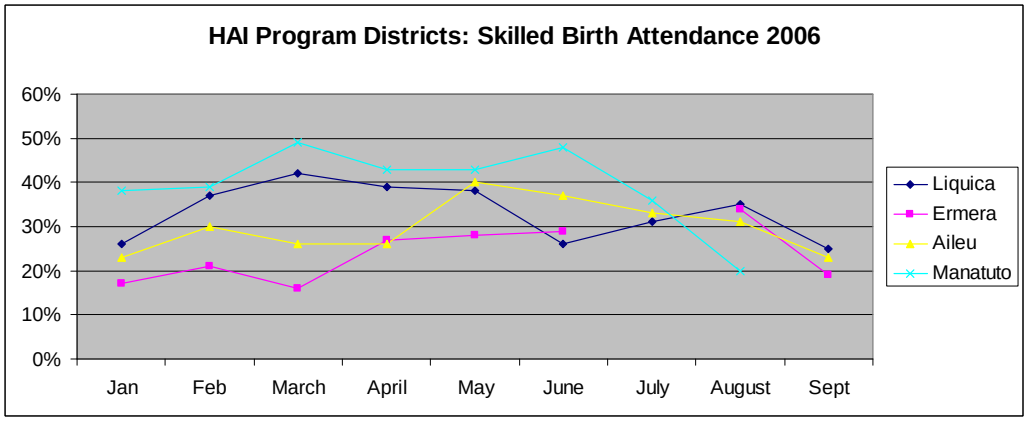
A. GENERAL PROJECT STRATEGY

This is a four year standard category grant designed to strengthen the national health program so it can improve maternal and newborn health in East Timor. The program is working in seven of the thirteen districts but some of its interventions, such as the use of a MCH District Program Officer, have already been taken to national scale by the government. The goal of the program is to reduce mortality and morbidity among mothers and newborns. This will be accomplished through strengthening district health facilities and changing behavior at the community level. Specific objectives include:

- 70% of pregnant women will receive at least one antenatal care visit by a skilled provider;
- 30% of deliveries will be attended by a skilled provider;
- 70% of women and their newborns will be protected against tetanus;
- 60% of women will receive high dose Vitamin A supplementation within eight weeks of delivering;
- 45% of infants aged 0-6 months will be exclusively breastfed,
- 50% of mothers of children under one year of age will know at least three signs of newborn illness;
- 90% of MOH facilities in program districts will have at least one staff member skilled in the key elements of ANC and communications skills.

As part of the midterm evaluation, the team summarized available data. However, these data need to be reviewed judiciously because of the flaws in the East Timor information systems. Data are provided by percentages and also by numbers, the latter an attempt to minimize problems with inadequately defined denominator. Analysis of available data cover the trends in four areas: attendance with a skilled provider, first antenatal care visit, fourth antenatal care visit, and receiving Vitamin A postpartum.





Figures 1 and 2: Skilled birth attendance for 2005 and 2006, by district and month

In the graphs above with information disaggregated by region, Aileu, which has a strong Head of District Health Services and MCH-DPO, has consistently doubled the percentage of women delivering with a skilled provider, and before the crisis had quadrupled the number of women delivering with skilled providers. Comparing data from July 2005 to July 2006 (which included the time period after the crisis began), note that Manatuto increased from 30% to 36%, Aileu increased from 10% to 32%, Liquica increased from 21% to 31% and Ermera stayed at approximately 31%

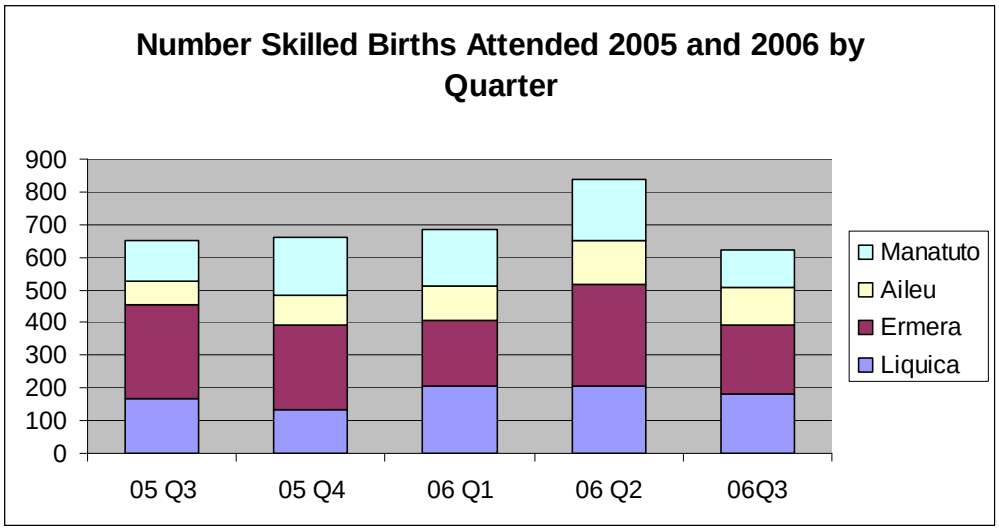


Figure 3: Skilled birth attendance by quarter and district

As Figure 3 indicates, all the districts showed a rising trend until the political crisis, which began in April and May. In the third quarter, as families and health care providers scattered, referrals and skilled attendance became more difficult. There were three hundred fewer births attended by a skilled provider after the crisis, as many families dispersed further into rural areas or were unable to access services because of dangerous conditions on the roads. Possible confounding factors for these data, however, include the arrival of the Cuban doctors in March and April and the surge of the urban population into IDP camps (where services were more accessible) as the crisis continued.

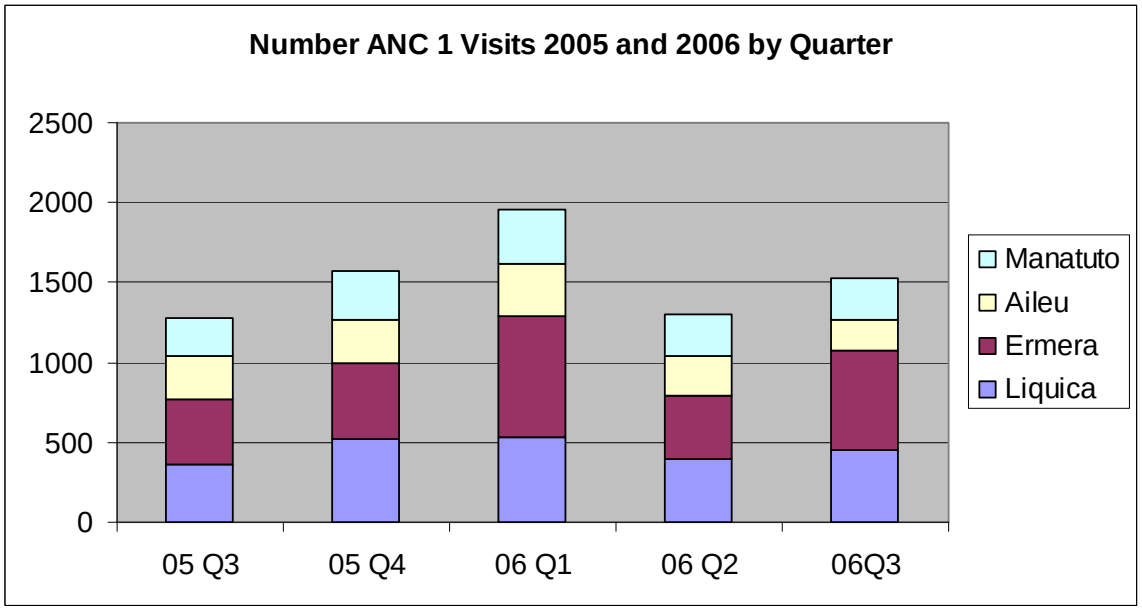


Figure 4: Numbers of first antenatal care visits by quarter and district

ANC visits are the first point of entry into the health care system and an opportunity for midwives to assist clients in deciding to seek skilled care for births. From August 2005 until August 2006 (see Figure 4), each of the four districts showed a significant increase in the number of women having their first antenatal care visit, with Ermera more than doubling. Again, the impact of the crisis is notable, and appears earlier for this indicator. All four districts experienced an early decline in first antenatal care visits in the second quarter. Ermera, which had the highest level of unrest outside of Dili, had the steepest setback, although it is currently rebounding.

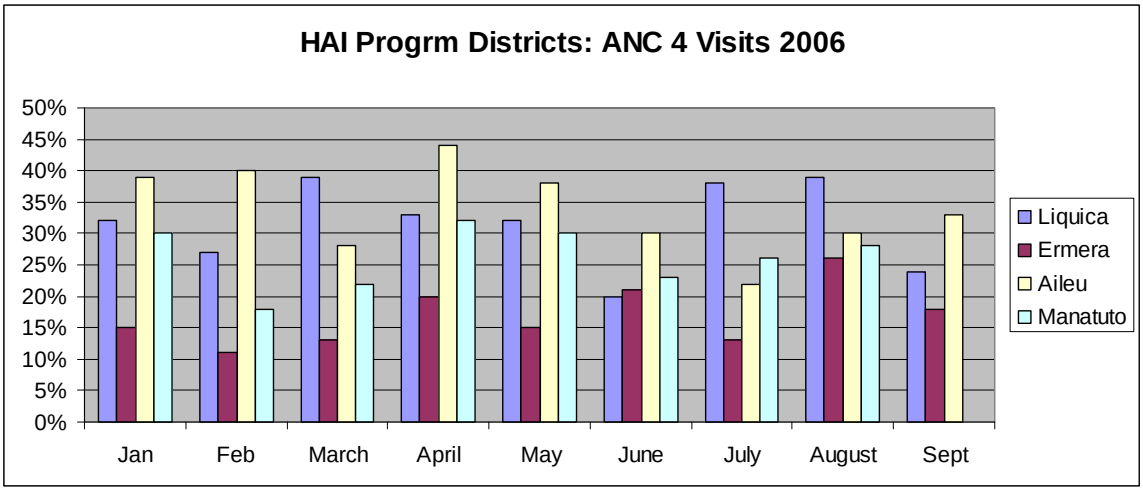


Figure 5: Numbers of 4th antenatal care visits by month and quarter, 2006

Ermera almost doubled the percentage of women receiving four antenatal care visits (Figure 5); this could reflect midwives' increased efforts to do mobile clinics and reach women. In Aileu, after a steady increase, the arrival of almost 6,000 internally displaced people disrupted health services and contributed to decline in ANC visits beginning in May. As these same people responded to a government initiative to return home, and services became more normal, there was a corresponding increase in the percentage of ANC visits.

Overall, the number of visits has been edging up over the length of the HAI project and at least 500 women are getting complete ANC care per quarter (Figure 6).

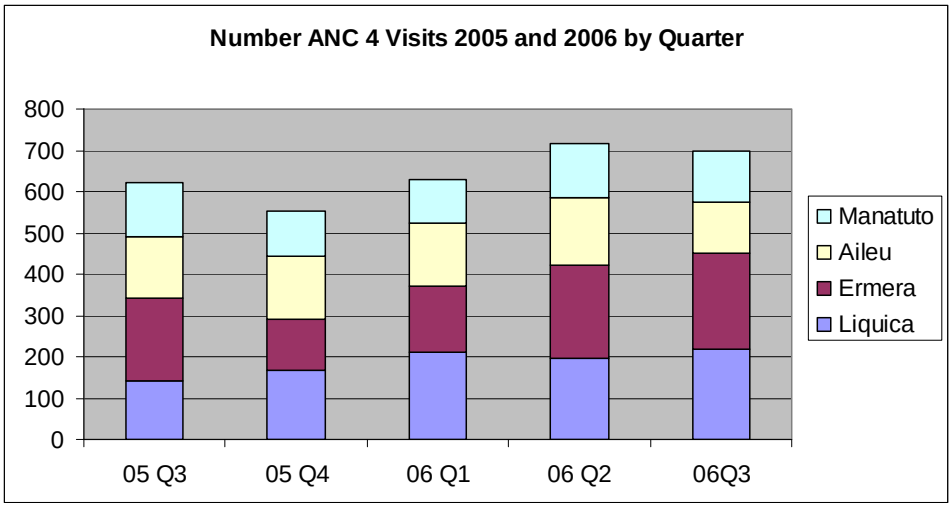
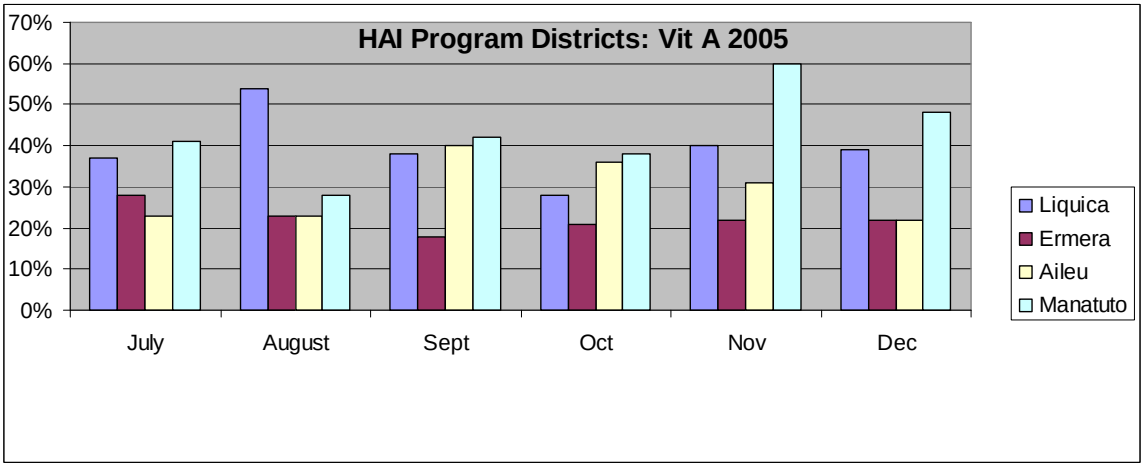
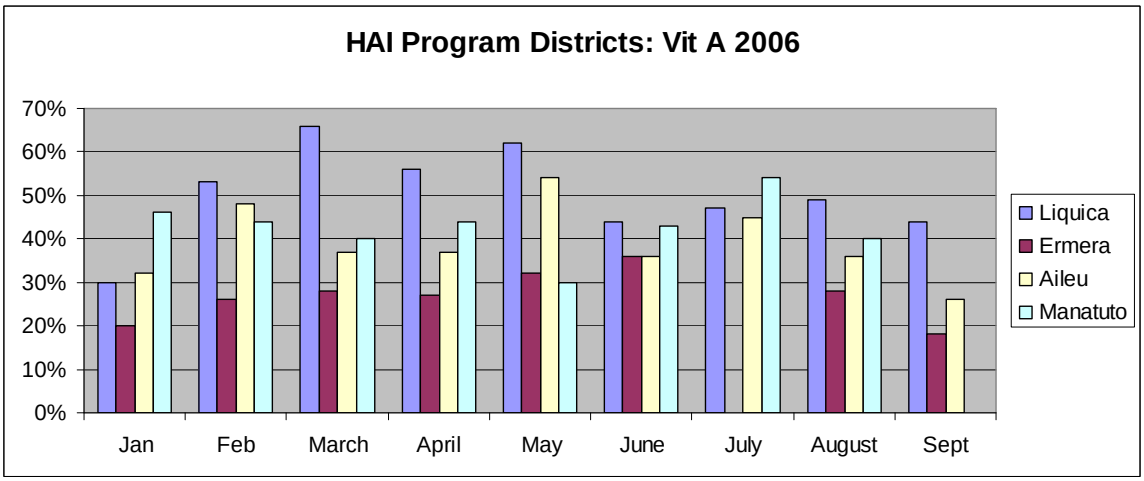


Figure 6: Numbers of 4th antenatal care visits by quarter and district





Figures 7 and 8: Postpartum vitamin A dispensed by month and district

Two of the four districts show an increase of more than ten percent in vitamin A coverage in one year (Figures 7 and 8); the third district, Ermera, continues the positive trend with a slightly lower rise in coverage while Liquica shows a slight decline.

This summary below (Figure 9) captures the number of women who are benefiting from HAI interventions. Although a consistently upward trend would be great to record, it is

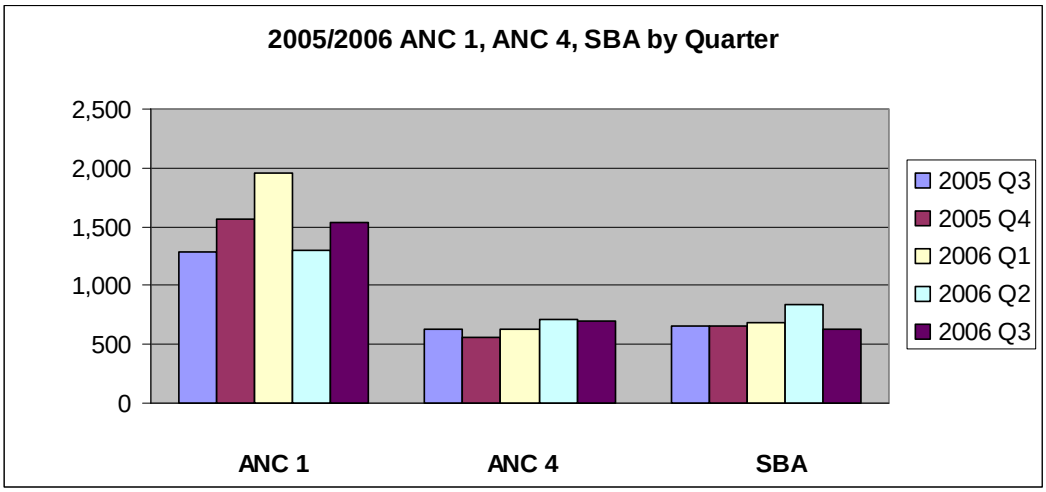


Figure 9: Summary of antenatal care and skilled birth attendance by quarter

positive to note that there were gradual upward trends until the crisis disrupted services and impacted the health care system. Future data trends will be clearer as the HAI program will work with midwives and staff at the community health centers to develop better tracking and recording systems. In addition, the January review of the HMIS will likely yield better data sources to exploit in the next two years.

Years one and two of the program were implemented in Aileu, Ermera, Liquica, Manatuto. The program will expand to Ainaro and Manufahi, and with focused interventions in Dili. These sites cluster within the Western half of the country and can be managed from Dili. The approach is multi-focused: to work at the national policy level to create an enabling environment for Maternal and Newborn Health, to work at the district service delivery level by increasing midwives' clinical and management skills and last, to work at the community level with leaders and clients to affect positive behavior change in practices surrounding pregnancy, delivery, post partum and newborn care. The paramount program strategy is to embed all program interventions with the existing MOH framework and programs and to coordinate and collaborate with all agencies working in the sector. This intensive coordination allows HAI to benefit from resources outside the grant (i.e., WHO paying for the hospital neonatal nurse training) and at the same time supports HAI's position as the MOH-designated lead agency for Maternal and Newborn Health in East Timor. In the next two years, because there will be training in managing obstetrical complications at the community health center, HAI staff will also increase their focus on intra-partum care, with a renewed emphasis on delivery care and

use of the partograph. This also coincides with the latest evidence based findings presented in Lancet on the best interventions to reduce maternal mortality.

The intervention mix used by HAI includes national policy development, training, materials development, construction of birth friendly facilities, mentoring and modeling positive supervision skills, participation in joint planning and monitoring exercises with both the Ministry and other donors, use of information for program management and innovative communication channels to promote key maternal and newborn health messages.

B. PROGRESS REPORT BY INTERVENTION AREA

National Policy Development

The Detailed Implementation Plan (DIP) listed participation in the national MCH working group to set standards in postpartum and newborn care as the primary policy objective to be achieved under this program. However, this intervention has expanded significantly and HAI has provided policy input into the following:

- Maternal Malaria treatment protocols (limited to review of protocols only)
- Input into the national debate on the use of traditional birth attendants in remote areas: what should their role be and should they receive training to promote better care?
- What should the government stance be on maternal waiting homes?
- The policy for postpartum care and newborn care, as originally planned
- Developing policy for protocols for PMTCT (Prevention of Mother to Child Transmission) in HIV positive mothers
- Essential components of the Basic Package of Services (BPS)

The activities related to these interventions have included participation in the national working group, conducting literature searches (on the global experience on maternal waiting homes) and providing findings to the Minister and the MCH department, taking part in workshops led by the MCH department to debate these policies and in the case of the newborn and postpartum care, adapting materials from international standards.

The effectiveness of these interventions has been dictated in part by the Ministry response. As a newly democratic nation, East Timor is dedicated to ensuring that all decision making is a transparent process, which means the debate can be lengthy while all voices are heard. For example, East Timor is still debating whether maternity waiting homes are the appropriate intervention to respond to access issues. An NGO, Doctors of the World, piloted a maternity waiting house in the East. Initial reviews shared by the MOH indicate it is too expensive a model which is not yet in full use. Nonetheless the debate continues. Given this delay, HAI has pursued its birth-friendly facility activity rather than wait for the final decision on maternity waiting homes. The birth-friendly facility (BFF) approach was designed in response to the observed resistance of Timorese women to delivering in MOH clinics and hospitals. With the ready acceptance of the BFF, the Ministry is now contemplating asking HAI to implement a combination approach of BFF and waiting home. In the case of TBAs, HAI has made the case that putting program resources towards training TBAs is not an evidence-based practice.

However, if the MOH decides to train TBAs or otherwise involve them in the national MCH program, HAI will work with them as members of the community. PMTCT interventions are in stasis while the government rewrites its Global Fund proposal. CCT recently created a clinic that will offer voluntary testing and counseling and hopes to pursue polices in support of PMTCT. If this is the case, HAI will collaborate with them. In addition, the head of the MCH division recently attended a training in Malaysia on this topic and is set to revitalize efforts. Given HAI's experience with PMTCT programs in Africa, HAI stands ready to offer technical assistance to develop the policy in East Timor and if the debate is rejoined in January, will contribute to ensure adequate stakeholder consultation.

Development of the standards and polices for newborn care at the health facility level has been completed. Training materials for referral hospitals are complete but need to be formally adopted. The Technical Advisor believes that HAI's advocacy for newborn care resulted in significant progress in the MOH MCH commitment to newborn care activities. In particular, HAI contributed to creating the understanding that this vulnerable time-period needs special attention and cannot be managed under the existing IMCI interventions, which was the East Timor adaptive approach. One successful argument focused on how adopting this dedicated program would help meet the Millennium Development Goals for newborn care. Training materials are scheduled to be finished in January 2007 and a training will be held in April 2007. In the meantime, HAI uses existing avenues (such as the MCH working group and the film that will be ready in March) to continue to promote the message that newborn care is essential.

Mentoring and Modeling Positive Supervision Skills

The Health Facilities assessment conducted as part of the baseline for this child survival grant found that the 41 midwives who had been trained in Safe Motherhood (starting in 2000) had only received supervision during one meeting held at the district level with Dili trainers. In addition, supervision tended to be viewed as punitive and not as a resource for problem solving. The DIP identified the creation of a supervision tool and modeling positive communication strategies as two key activities.

Both of these activities have been accomplished. HAI covered facilitative supervision in the MCH DPO training and as a result the DPOs have significantly increased the frequency of supervision. They submit a monthly supervision report to the district health services, a report also received by HAI. This form includes a column where midwives can propose solutions to identified problems, a detail best illustrated by the example in Remexio in October where a supervisor noted through a report that a flipchart used for counseling was missing and proposed that the midwife come to the district health office to get the materials. At the workshop to disseminate preliminary findings from the MOH review of midwifery skills (recently concluded in November, 2006), the team noted that only the MCH DPOs in HAI-supported districts conduct supervision and use supervision tools as outlined in the national policies.

As part of the MCH working group, HAI staff developed the supervision tool, currently regarded as the national model. It is a check list used to monitor the key behaviors of a

midwife during antenatal care, a checklist that later serves as a tool for discussion between the midwife and her supervisor and a way to provide constructive feedback. Observations during the evaluation indicated that conversations between midwife and supervisor were not defensive when the tool was used and that it provided a transparent approach to improved services.

There has been one change from the technical approach outlined in the DIP. At the onset of program implementation, HAI anticipated doing a specific training course on communication and counseling. However a training assessment indicated that counseling had been included in previous trainings with little impact on improved communication or counseling skills from the midwife. Rather than repeat the intervention, HAI decided that role playing and modeling good communication skills in a one-to-one approach would get better results. Thus during the routine supervision visits, MCH DPO and HAI staff model good behavior, including greeting women, sharing information during the visit, asking clients if they have questions and verifying that they have understood counseling. In field observations during the evaluation, it was clear that this model had made an impact. The senior midwife from Ermera demonstrated very good counseling and communication skills during a routine ANC visit. The Cuban physicians in Ermera credited HAI with teaching midwives to get better information on when pregnancies were conceived and date of last menstrual cycle because of improved communication skills.

The arrival of the Cuban physicians has changed the practices of midwives. In many cases, responsibility for routine ANC care delivered by the midwives is now being shared or assumed by the physicians. Both midwives and physicians describe working together to attend to women during ANC, although observation indicates that the midwife records data and the doctor does the clinical exam. This means that routine supervision is complicated because it is not in the MCH DPO job description to supervise the Cuban physicians. Yet at the same time, they cannot supervise midwives either if the midwives are no longer performing their identified functions.

Use of Information for Program Management

In the DIP, inefficient documentation systems and a recent changeover in documentation were noted as contributing to the poor use of information for program management. The subsequent facility assessment found that postpartum visits were recorded either in the new ANC book, the IMCI register and/or in general registers for both mother and baby. Of facilities reviewed, only 15 had partographs and they were rarely used. The DIP stated "Currently at the district level, there is a lack of understanding of the relevance of data and minimal use of data collected to formulate effective workplans."

This lack of understanding was to be addressed by the DPO training, but even after the training documentation systems remain weak. The CS Program Manager receives data from the monthly reports which are inputted to HAI computers by the Health Promotion assistant who is also a midwife. She reviews the data and shares it with the CS program manager. If there are evident discrepancies, the Program Manager then works with the appropriate DPO to try and clarify the data. These interventions are not sufficient and more attention needs to be paid to data collection, analysis and use.

HAI did not conduct a mid-term survey so was not able to provide mid-term CATCH indicator data. Other data sources that are available at the district level should be analyzed for relevance to the HAI indicators. In addition, the MCH DPOs need to more actively participate in using available data to monitor the program. For example, all the Cuban physicians report an increased use of the service delivery facilities. However, there has not been an analysis of the existing registers to see if the data support this assertion. HAI is trying to improve the system; the Birth Friendly Facility will have a log book that will capture significant information on attendance by skilled providers, ANC visits and referral, but this is not enough. Given the recent changes in global USAID program management and a renewed emphasis on reporting against common indicators, it behooves HAI and the MCH DPOs to make data collection and analysis a priority. In the January 2007 review of the HMIS, HAI needs to be present to identify what would make the system more user friendly.

HAI is well aware of the importance of monitoring and evaluation to improve ongoing program outcomes. They have already conducted a follow-up monitoring to measure the impact of community dramas. This monitoring indicated the need for increased follow-up and review of key messages with the audience as part of the drama process and HAI has already instituted this change. Similar efforts need to be made using the service delivery information.

Birth Friendly Facilities

In the DIP, HAI planned to implement the pilot of the Birth Friendly Facility, in addition to waiting for the debate on maternity waiting homes to be resolved. After doing the community assessment—the first and most comprehensive look at traditional maternal health practices in East Timor—the program determined that a Birth Friendly Facility was important to increasing access, a finding further confirmed when the program conducted district meetings with community members and solicited solutions to some of the identified maternal health challenges. The BFF is designed as a Timorese house located very near a clinic or hospital that is meant to provide a more comfortable, culturally acceptable site for deliveries while still making possible care by a skilled birth attendant.

Selecting Maubara as its pilot site, the program began to build the first Birth Friendly Facility in 2006. Community members contributed to its development, including Senhor Carlos, whose wife died five days after a home delivery one year previously; he stated that he contributed in order to support "the children of the future." The facility responded to community information on essential criteria for a "friendly" facility, which included privacy, hot water in abundance and a rope for pulling on during labor. In addition, the program had a local artist paint murals with health messages on the walls and the Alola Foundation made curtains to provide privacy. The building was opened on November 3rd by the Minister of Health. By the time the evaluation team arrived on November 8th, there had been three normal births, a client arriving post-delivery for follow-up care and one referral to the Dili National Hospital.

During the evaluation, two BFF clients were interviewed. The first mother had come to the opening ceremony, when she was already near term. She was impressed by the facility and since her last baby had died after being born at home, she decided she would try the facility. She was pleased; she particularly liked the fact that her family could come in and be with her but there were not lots of other people. She was delivered by the Cuban physician and she had no complaints; she said the midwife had been absent delivering another baby. She did not use the rope during her labor but did like the hot water and the continued support of the midwife. Because she was so close to the clinic, during our observation the midwife came to check on her and offered breast-feeding support.

The second mother was the Community Health Center midwife. She had delivered her other babies at home assisted by another midwife, but wanted to try this facility. She too was pleased with her delivery and liked the ability to have her family near. She certainly thought she would recommend the facility to other clients and even suggested that perhaps tours of the BFF should be included as part of routine ANC care.

The second BFF in another district will open in December. The quick adaptation and use of the facility by community members augers well for increased access and increased numbers of births attended by skilled health providers in the HAI-supported districts over the next two years.

C. SPECIAL STUDIES

HAI developed an innovative communication approach with a stage performance by Bibi Bulak, a professional Timorese drama troupe. The performance was a drama that included the key messages about health behaviors and the need for care during pregnancy, delivery, and post-partum. In October 2005 the troupe performed four times in four towns in HAI's program area. Audience sizes ranged from 200 to 800, with a total of approximately 1800 viewers of the four performances.

According to the summary of the special report (complete report in Attachment G.3) "The drama performances by Bibi Bulak were evaluated using a pretest-posttest survey design directly before and directly after the performances. The surveys tested knowledge and attitudes about maternal and newborn health. Evaluation results showed a statistically significant improvement ($p<0.05$) in the majority of maternal and newborn health messages (10 out of 12 questions). Where messages proved unclear or inadequate, recommendations were developed for improving the drama for future performances."

As a further follow up during the mid-term evaluation, members of last year's audience were interviewed informally to assess message recall. Although most could offer generalized recognition of having seen the performance, it was disappointing that many people could no longer recall the key messages without prompting. This problem was highlighted again by the head of the Manatuto district health services, who said he didn't yet know what follow-up would be necessary to ensure messages were retained. In earlier plans, US Peace Corps volunteers would have partnered with HAI to conduct community follow-up. Since all volunteers were pulled from their posts after the May 2006 crisis,

they have not been able to do the follow-up. HAI has already begun to address this by having their staff do message review with the audience after drama presentations but will need to find a more long term solution, such as training the community health center staff to do interactive sessions with the audiences after the drama group. HAI will also address this issue of knowledge decay by making the maternal health film accessible and screened frequently. The use of the film in conjunction with the dramas will continuously reinforce positive messages.

2. CROSS-CUTTING APPROACHES

a. Community Mobilization

Birth Friendly Facilities

HAI has three primary strategies for community mobilization: the establishment of birth friendly facilities, the creation and support of youth groups to do drama outreach, and the training of community health promoters to deliver key messages. While the activities are not as advanced as initially planned, the feedback and evaluation on the quality of the existing activities is quite good. During one of the evaluation interviews, a partner respondent who worked with many NGOs and UN agencies stated "HAI is one of my favorite NGOs; their community consultation skills are superb."

As an example of the positive effects of HAI's community mobilization efforts, the head of MCH services stated the reason there had been five births at the Maubara house during its first week of operation is the community felt real ownership because of the process that HAI had followed. From the beginning of program implementation, HAI staff did a series of community assessments and dialogues to isolate the necessary characteristics of a Birth Friendly Facility, according to East Timorese culture. Then, in monthly meetings, HAI staff identified community members who were interested in contributing to the building of the facility and helped them get organized. They were included as key members of the inaugural ceremony where the Minister of Health dedicated the building and they have an ongoing role in its maintenance.

As another compelling example of effective community consultation, consider the village head in Acumau who walked ten kilometers a day for six weeks to help rehabilitate the building that will be the Birth Friendly Facility in Remexio (opening in December). His motivation stemmed from the belief that it was too hard to have babies transferred to Dili and if they were born near the community health center, it would be safer. In addition, because he served on the rehabilitation committee, he was able to learn about the importance of identifying pregnant women in the community as a means of providing support to safe delivery. He is now using his role as village leader to census pregnant women, currently 12 out of a total population of 1700. Two more Birth Friendly Facilities sites have been identified in Laclo of the Manatuto district and Ermera of the Emera district. HAI hopes to begin the community consultation and development process by January, 2007.

Youth Drama Groups

The second strategy focuses on harnessing or creating youth groups to promote key health messages through drama. Working with Bibi Bulak and the local Peace Corps

volunteer, the Liquica youth group was the first group to receive training. Bibi Bulak provided training not in drama techniques alone but also in conflict resolution and organization and administration. This integrated training contributes to developing the leadership of youth and providing them with skills that can be used in other settings. The Liquica Youth Group is still active but the early departure of the Peace Corps volunteer further reduced their already limited interaction with the District Health Office, which they feel to be a problem. The evaluation observed them performing for a group at the health center and from the interactive nature of the performance and the audience response, it was clear that drama was a very good media for health messages.

There is a second youth group in Gleno but political unrest severely impacted their social cohesion as one member lost his father to the violence and the others disbanded and went to different villages. Nonetheless, as HAI is convinced that this is an appropriate channel to reach the community, Bibi Bulak has started from scratch and with just one member of the original group, has recreated a second troupe who performed for the first time on the 7th of December. HAI staff work as community liaison between Bibi Bulak, the youth group and the Ministry of Health.

There is also a third possibility for a youth drama group in Aileu, collaborating with lay missionaries who currently work with the Maryknoll Sisters. The two men, one a talented musician and one with interest in drama, teach at the high school and are highly engaged in the youth community. Both are functionally fluent in Tetun. HAI could begin discussions with the youth to determine their interest. The Liquica group report that a strong leader and close relationship with the DHS are important to success, and Aileu has one of the strongest Head of District Health Services. HAI has already had discussions on this and will include it in the plan for next year.

Health Promoters

HAI identified community outreach via health promoters as a key strategy to create greater community awareness on practices such as delivering with a midwife and getting antenatal care. Unlike many other NGOs, HAI also believed community health promoters could monitor the community's satisfaction with care as well and contribute to a dialogue on community demand for services of good quality. In early planning stages, HAI intended to tap into existing volunteer networks such as the Caritas-trained TB workers in Letefoho and Remexio and the group of 100 Community Health Motivators (CHM) working with the Maryknoll sisters in Aileu. The CHM provide training on various health topics to 20 families. Although they do not provide clinical care, they do act as a referral service to the CHC.

A new development has been a pilot initiative proposed by the government that would create a cadre of Family Health Promoters, who could also serve as potential community outreach workers for the HAI program. The Family Health Promoters are to be trained volunteers who work four to five hours a week serving the community and disseminating health messages. Currently, HAI's interaction is in hiatus while issues get resolved. Among the issues causing significant donor debate are:

- The profile of the volunteer;

- The question of compensation for their time;
- The nature of the training they will receive;
- How the community will select the volunteers so they are representative of the community;
- How the government will work with the district health planning teams to inform the public of these volunteers and the benefits they will bring to the community;
- The relationship between these volunteers and the village health committee, which has been decreed by the government as an element within the health care system but which is currently non-functional.

Until these questions have been thrashed out, HAI will use existing networks of community volunteers as health messengers. The approaches that HAI has refined during the first two years of implementation, namely frequent consultation with the community, sharing of assessment results and discussions as to what that means to the community and working in partnership instead of through a hierarchy will serve in good stead once the new government program is launched.

Throughout these approaches to community mobilization, HAI has taken steps to address barriers that prevent the community from benefiting from the program. This has included funding transportation costs for the Liquica Youth Group so it could get to the community, ensuring adequate female participation in the Gleno Youth Group and operating in a transparent manner. There are however some political and socio-ecological factors that HAI is helpless to address. These include the fact that the weather patterns during the rainy season isolate villages by making roads impassable. Security is also a rising concern. HAI tries to stay abreast of security issues and adjust outreach and training but sometimes it is impossible to predict. Luckily for HAI, although there are other community priorities, health figures among the most prominent concerns and they have not suffered from competition from other sectors. One possible area for concern is that the volunteer groups interviewed were asking for stipends to offset the use of their time; there are cash for work programs being administered by other NGOs that might be influencing this. Thus HAI is still grappling with identifying necessary motivation tools for long term volunteer involvement.

b. Communication for Behavior Change

HAI has a behavior change strategy in place. The elements of the strategy include inventorying and refining current messages in use in East Timor, assessing traditional practices toward birth and using that as an entry point for communication, using non-traditional channels to disseminate messages (i.e., video and drama in addition to posters and the printed word) and using schools, youth groups and community health volunteers as agents of change. There is not yet a national East Timorese reproductive health communication strategy. At this time, UNFPA is drafting the terms of reference for a team to help develop a national strategy but it is only in the planning stages.

HAI conducted a community needs assessment as part of its initial activities for behavior change, which included extensive qualitative information about the pregnancy, delivery and postpartum practices and beliefs of Timorese women. This information augmented

information from the 2003 Demographic and Health Survey. As a result, HAI compiled a list of traditional behaviors surrounding pregnancy and delivery. As the assessment report states, "Until now traditional beliefs and practices have not been widely acknowledged or incorporated into health promotion messages in Timor Leste. However it is likely that doing so will increase the effectiveness of communication of health messages." These traditional beliefs are included in Attachment G.2 and serve as the basis for many of the materials developed under the program.

In addition to the community assessment, HAI compiled and refined the first-ever list of current health messages for MNC, a list now being disseminated and promoted throughout East Timor by both the government and international and local NGOs. This document has become an official Ministry of Health document and is used to ensure that all players in the maternal and child health sector are reiterating the appropriate messages. It is included in Attachment G.1. During the mid-term evaluation, this list was reviewed. The messages are mostly up-to-date technically. It could be argued that reference to "high-risk" such as being over the age of 35 or younger than 18 should be removed and more emphasis should be placed on the message that complications can arise at any time to anyone, which also on the list. HAI has indicated this before to the MOH but they choose to keep the message as they maintain it is still relevant to an East Timor population and is carried in many of their materials. Only one message is missing and HAI had debated its inclusion. This message would be to promote the use of family planning during the post-partum period. Now that HAI has a FP grant and the MOH has published its National Reproductive Health strategy, it should be easier to include this among key messages.

HAI is using photographs rather than sketches in the health promotion materials they develop. This approach has proven successful in engaging the interest of the target audience; they tend to wonder about who the person is in the photograph and how they happen to need care, etc. The head of the MCH services confirms that this approach is favored in East Timor, except for sensitive subjects (such as condom use) which are still better depicted through sketches. HAI has developed a series of photographs (many from the film footage) that depict practices that need to be changed; having the information reality-based makes it more accessible to the communities because they recognize the images as fellow Timorese.

HAI has also invested in drama and youth groups to disseminate messages, as described above. HAI has introduced interactive sessions as a way of further reinforcing the long-term recall of messages. Although the clinical staff are responsible for the content of the messages, the youth group had changed one message and presented incorrect information concerning antibiotics and retained placenta. Because of the follow-up session, HAI staff were immediately able to correct that message and conduct a discussion to further clarify the message.

In addition to these two efforts, HAI has invested in creating a film on the messages of safe motherhood. This film, funded by five donors (using no USAID grant funding), will show existing maternal health practices in East Timor and at the same time demonstrate

desired practices. Most of the footage has already been shot and the final edition of the film should be ready by March, 2007. The team went into hospitals, into remote and isolated villages of the mountains, and to both the East and West districts in order to get footage. In previewing the film as part of the evaluation, we found it a very powerful story with striking images.

The film was filmed and edited by a team of young Timorese from CAMS (Centro-Audiovisual Max Stahl), which enabled the crew to have intimate access to rural populations, something not possible if done by outsiders. They were guided by Max Stahl, an English-born film-maker, with particularly high credibility in East Timor. He was present for and filmed the 1991 Santa Cruz massacre of hundreds of Timorese civilians, which was instrumental in changing world opinion on the Indonesian occupation of East Timor. Any of Max Stahl's products carry weight in the community.

There have already been expressions of interest in the film from other countries, such as India, because using this filmed documentary approach is very innovative. Ministry of Health counterparts say that film is appropriate to use because of the low level of literacy; they anticipate there will be large crowds in the regions to view this film. If the promotion of the film goes well, CAMS hopes to have other opportunities for collaboration with the MOH health promotion department.

HAI's dissemination plan includes having the film available in VHS and DVD. Other elements include:

- Contacting other NGOs and determining their interest; many have already responded positively;
- Obtaining a TV to use in screenings for small groups;
- Using the existing LCD projector for screenings to larger groups;
- Providing copies to the District Health Services that own TVs so they can set up a screening schedule;
- Showing the film during routine community and supervision visits.

The only element of the dissemination plan that is not yet clear is how to capitalize on the networks used by Health Net, a local NGO that has experience in this kind of communication effort.

The HAI technical advisor has selected still photographs from the film footage which illustrate the key messages HAI promotes. These will be incorporated into new materials developed for newborn care training modules for midwives. Footage could also be used as an advocacy tool overseas, where it could be screened at public meetings such as the Global Health council to increase awareness about East Timor.

C. Capacity Building Approach

I. Strengthening the Grantee Organization

HAI is a very strong organization. Because it has a focused technical scope and targeted geographic regions, it functions very effectively in East Timor. The primary internal capacity building approach has been to pair national staff with advisors so there is a

gradual transfer of competence. In addition, HAI has identified a significant number of local training opportunities for their national staff provided by international organizations. Because of this, one of the health program assistants has become a national resource for the training and management of community promoters. The other program assistant has taken on a more proactive role managing the facilitative supervision. She says that at the beginning of her role, because of the hierarchical nature and small number of midwives in East Timor, there was some resistance to her because she was perceived as less "senior" than some of the field midwives. Now she feels she is well accepted and able to put her new expertise to good use. In observations during the field work, she certainly moved easily in her position of offering guidance and feedback.

One minor deficit to organizational capacity is the limited reference to the work plan as a tool for structuring work. Although there is an annual work plan and there is integrated planning with primary partners, as the demands on the time and expertise of HAI staff increase, the work plan becomes very ad hoc. The DIP specified that they should have quarterly reports on progress to date; this should continue and the program manager should ensure that the team does refer to the work plan for guidance.

II. Strengthening Local Partner Organizations

The local nongovernmental partners with which HAI works, in addition to TAIS and CCT, include but are not limited to The Alola Foundation, BiBi Bulak, SHARE and Health Net. HAI also works with local groups in the district such as the Maryknoll Sisters in Aileu. Since the MCH section identifies 35 NGOs who are involved in the MCH sector, HAI has to be selective in choosing local partners.

HAI does not focus on improving organizational capacity of their local partners except tangentially. For instance, the SHARE staff feel they learned participative evaluation techniques because the CS program manager was a part of their evaluation. They also participated actively in this midterm evaluation and reviewed the field interview instruments as a tool of possible interest to them. HAI's emphasis with local partner organizations is on creating common approaches and standards, complementary programming and a transparent communication style, all the while promoting the MCH division as the agency head for the sector.

III. Health Facilities Strengthening

Strengthening health facilities at the district level (not hospitals) has been one of the primary objectives of the HAI program. The district level is an appropriate level for focus as it is where the majority of care is delivered. However, because HAI doesn't work in isolation, and because the technical advisor is highly skilled and sought after, HAI also developed a two week neonatal training course for nurses and provide EMONC instruction and materials for the maternity packs at the national hospital in Dili District. The technical advisor was used as a resource at the hospital, providing follow-up and supervision to hospital staff. The MCH division of the MOH views HAI as a bridge between the districts and the central level and the districts and other donors. In this role HAI has been able to provide substantive guidance as to what is needed in terms of

supplies and equipment for facility strengthening, even though they do not provide equipment directly.

The facility surveys done by HAI were very comprehensive and each assessment included:

- A questionnaire for the head of the District Health Management Team
- An interview with the health facility manager
- Focus Group Discussions with all midwives present on the day of assessment
- Direct observation of midwives conducting antenatal consultations
- Exit interviews with mothers following antenatal consults
- Review of a sample of partographs
- Direct observation of the health facility equipment and supplies relevant to maternal and neonatal health

In this program HAI has been careful to link creating community demand at the same pace as the improvement of the facilities. They did community assessments, which used focus groups, key informant interviews and semi-structured household interviews to obtain information. Out of these assessments, HAI was able to contribute to the larger MCH community a report on how traditional practices are viewed in terms of the reproductive health cycle. It is this linkage that resulted in the decision to build birth friendly facilities, essentially creating spaces where women could be delivered by skilled providers yet at the same time have an environment responsive to known cultural practices, such as pulling on a rope during delivery.

IV. STRENGTHENING HEALTH WORKER PERFORMANCE

HAI's approach to strengthening health worker performance is to focus on the midwife as the primary clinical agent. Activities include training, facilitative supervision, on-the-job modeling of positive client interactions, and problem-solving techniques. The arrival of the Cuban primary health physicians has impacted this approach because the doctors now assume responsibility for clinical activities once done by midwives and the doctors don't fit into the existing clinic and health center management structure.

The approach to strengthen health workers is to provide facilitative supervision using a newly modified tool, to model good clinical skills and behaviors (i.e., communication skills during a consultation) and to lead the midwives and clinic managers in problem solving exercises so they own the solutions to identified problems. In terms of formal quality improvement, HAI had intended to use the maternal death audit tool but because of MOH policy shifts this will no longer be a part of the program. Instead, they are reviewing health center data as a way to improve quality. HAI will also have a community consultation process to determine whether the community thinks the quality of services is sufficient. If there are identified weaknesses, the supervision visits and the district health management team will address them.

One of HAI's partners is the other USAID-funded collaboration of BASICSIII and Immunization BASICS, the health project TAIS (Timor-Leste Asisténcia Integradu

Saúde). It focuses on strengthening best practices in child and maternal health by using integrated management of childhood illnesses (IMCI) in clinical and community settings. TAIS is implementing a formal quality improvement process and they currently have one district which overlaps with HAI, however additional joint districts may be added in the next two years. TAIS used the IMCI tool developed by HAI as a basis for their quality assurance. As TAIS further identifies issues and works with the local health team to redress the quality gaps, HAI will participate in the process as much as possible and will use their results to refine the supervision tools.

V. TRAINING

HAI has planned and implemented a judicious training strategy because there has been so much recent training in East Timor, such as on IMCI and Safe and Clean Delivery for Midwives. HAI conducted informal training needs assessments which allowed them to change the format of anticipated courses to be more responsive to the needs of the clinicians. They conducted a training for the District Program Officers in MCH, and they supported supervision for midwives already trained in antenatal care, both activities outlined in the DIP. In addition, the technical advisor created the curriculum and served as the lead facilitator for a training course in neonatal care for nurses at the National Referral Hospital in Dili, which was not originally in the DIP. She also supported EMONC training and supervision with UNFPA.

One of HAI's community health program assistants received training as a Master Trainer for the new community health volunteer program which will be instituted by the MOH; his training was supported by the Ministry of Health and UNICEF. In return for this skills development, he is expected to continue to serve as a facilitator for other national trainings in the new community health volunteer program. A second program assistant, responsible for much of the facilitative supervision for HAI, was included in the course entitled "Training of Trainers for Management and Leadership for Health Center Directors," giving her the skills she needs to address management issues which come up during supervision. She also participated in a second ministry-sponsored training for midwives in family planning.

The Postpartum Care training and the community demand training currently in the work plan are behind schedule. Materials are still being developed for the community demand training; the photographs have been selected and developed but need to be pre-tested. In terms of Postpartum Care training, the following has been accomplished:

- Consensus from all stakeholders on the need for PPC training;
- Agreement that HAI would take the lead on the training;
- Materials review and development by a committee that included the Institute of Health Sciences, the MOH, DPOs, the national hospital nurses and midwives, East Timorese doctors, a Cuban neonatologist and obstetrician stationed at Dili National Hospital. This process continues and the materials are being adapted for local use from generic international course materials;
- Throughout the process of adapting generic international course materials, HAI supported midwives who analyzed and resolved, to the extent possible, technical discrepancies between existing material in East Timor and the new material;

- TAIS supported one person to the training of trainers on Essential Newborn which was done in Bangladesh by SEARO, and WHO supported two others;
- The December, 2006 master coordination meeting of the primary partners of the MCH will include developing the training calendar for this event;.
- TAIS, HAI and WHO will then facilitate the training once the materials have been completed and approved.

One implication of the postpartum training course is its impact on IMCI, because there is an overlap in technical materials that could cause confusion. This will be addressed during the IMCI review to ensure that there is a plan on how to integrate the two approaches.

Two HAI midwives will participate in the future UNFPA comprehensive national training for the management of Basic Emergency Obstetric Care (BEOC) so they are adequately prepared to address these areas in their supervision activities. HAI, through the services of its technical advisor, has already supported the UNFPA effort for the last two years by providing two days of training in neonatology and then by doing supervision and follow-up for six months to ensure those skills were practiced competently. HAI will continue to collaborate with UNFPA to ensue that there are linkages between that ongoing training and the planned PPC training.

Some factors have affected training globally. Recently, East Timor changed the National Center for Health Training (NCHET) into the Institute for Health Science. This means that there is some confusion on the locus of control for health trainings. If the training is short-term or focused on specific skills, the Ministry of Health technical department conducts the training, using trainers from the Institute. If the training needs to be accredited and is longer term, it reverts to the Institute. Because this affects resource allocation for training, at times there is uncertainty over who should be responsible for managing the training. This uncertainty has negatively impacted HAI, who ends up serving as intermediary and communications coordinator between two competing divisions, taking an enormous toll on staff time.

The strongest evidence to date that training has been effective is included in the preliminary results of the UNICEF/MOH review of midwifery skills which found that in the HAI supported districts, midwives are working at a higher standard than midwives in non-supported HAI districts. In addition, the Cuban physicians report their observation that HAI has been instrumental in improving the counseling skills of midwives. Although external to the focus of this evaluation, the team was able to see that the Family Planning training conducted two months ago has impacted services. The midwife in Laleia had already inserted five IUDs after the training and in another site, the midwife had inserted two Norplant implant sets.

d. Sustainability Strategy

The HAI sustainability strategy has four elements: embed all technical assistance and support within the MOH structures; target individual capacity building to district health officers, MCH DPOs and midwives at the district level; increase community demand and

involvement through the use of community volunteers; and increase the linkages between the community and the demand for quality services.

Progress to date has been as planned, except in the selection and use of community volunteers. Although a Ministry of Health priority, issues regarding selection, training and compensation of volunteers have slowed progress (see details on pp. 15-16). HAI will move ahead with developing training modules on danger signs for newborns and mother, child spacing etc and use these modules to train existing community volunteers in January so as to move ahead in this important effort. The training modules will then be used by the national program for family health promoters, once it gets underway.

No phase-out strategy has been developed because the Ministry of Health is clear that they will continue, as part of the national program, many of the primary elements of the HAI program. The MOH has already incorporated the salaries and support of the MCH DPOs into the national infrastructure. All training materials and education materials developed by HAI have been adopted as the national norm and are being used by all agencies and partners. Behaviors, such as facilitative supervision and learning to use data for analysis of program objectives, are now an integrated part of the national program.

When the MCH DPOs were interviewed, they all said they valued the HAI technical assistance. They further stated if the program ended, they would be able to continue implementing the program without external assistance because the elements of the approach are intrinsic to the national plan. Transportation is the only element of the program that is not yet clearly sustainable; right now HAI provides regular transportation to facilitate quarterly supervision visits. Transportation is frequently cited by counterparts as one of the most problematic elements of the national health system and one with no solution to date; vehicles are either broken, out of gas or being used for other purposes.

Unlike other countries, cost is not yet a factor in the health program in East Timor. There are no fees associated with any of the care offered in the national health care system and there are no plans in the immediate future to start charging. Most of the clients HAI serves do not access private services, which are largely only available in urban areas. The cost elements cited by the community as issues include the need to pay for funeral transportation costs if a woman who is referred dies away from her home and the costs of getting to care from remote villages. HAI does not address either of these under their program.

3. Family Planning

There are no family planning funds in this child survival grant. However, because HAI has received a second grant dedicated to child spacing and because the health care system uses the same providers for maternal child health as they do family planning, HAI is seeking to develop linkages between the two programs.

A community assessment has been completed that identifies some of the barriers to family planning utilization. UNFPA has recently finished training a second group of midwives but post-training competency checks haven't yet been completed and many

more midwives still need to be trained. From initial observations, there appears to be a pent-up demand for family planning from the community. As supplies and skills are made more available through UNFPA support, midwives are seeing an increase in the number of IUDs and Norplant implants being provided. The only recommendation for this CS grant is to ensure that every opportunity in antenatal and post-partum care is used to provide information on family planning. In addition, in the midterm evaluation dissemination workshop, HAI was noted for its good outreach to men in its current community activities. HAI should definitely continue focusing on men under the communication activities in the child spacing program.

C. Project Management

1. Planning

HAI has been vigilant and diligent in practicing inclusive planning. Planning for the Detailed Implementation Plan included key counterparts from the Ministry of Health, International Organizations and district staff. In addition, community members have been consulted as to the implementation of activities that are directly targeting them, for example the Birth Friendly Facilities in Maubara and Remexio.

The work plan submitted with the DIP is behind schedule in the community promotion activities, while activities focused on national policy change, clinical training, supervision and support to the districts have been unfolding as planned. HAI has had to face several complicating factors in its implementation of this program, not least of which was the April, 2006 violence that engulfed the nation. "La situaçó" as it now being called, wrecked havoc on the development of the entire country and has resulted in a renewed presence of international peace keepers and a heavier UN presence. On a practical level, it means staff have not been able to get to the program sites because the road to sites in Liquica and Ermera has been closed for days at a time. During the worst of the crisis, travel to the districts was interrupted for weeks at a time. In addition, staffing both at the Ministry of Health and within the program has been disrupted, as families have moved to safer areas.

The program objectives are clearly understood by the field staff and headquarters, quite well understood by the Ministry of Health counterparts at the national level, well understood at district level and marginally understood by the community. In specific instances, such as the community consultation for the Birth Friendly Facility, the community voiced strong appreciation for the way that HAI staff solicited their input and incorporated them into their planning process. What is less clear to the community is that HAI is an international organization receiving funding from the US government to help the Ministry of Health in East Timor improve local maternal and neonatal health conditions. Local partners, such as SHARE (a Japanese NGO) and the international donors are very clear on HAI's objectives.

One of the few problematic findings in this evaluation has been the extent to which program monitoring data are used for planning and revising program implementation plans. While HAI understands the use of data, there is a somewhat complex status of data collection in East Timor. This will be covered in greater detail in Section Seven on

Information Management. One aspect noted is that the program manager has a great deal of qualitative information available to her which could assist in revising program implementation but much of it is not quantified. For example, during the evaluation, the team interviewed Cuban physicians and asked them whether they had seen a change in service utilization patterns. They replied that they were seeing up to a three fold increase in clients in some sites. They attributed this in part to the increased competence of midwives and their more consistent promotion of ANC within the community. This is exactly the kind of outcome that HAI is seeking; however they cannot report this information until it is captured in routine data.

2. Staff Training

HAI has provided training opportunities for all the technical and administrative staff under this grant. Just prior to grant implementation, the CS program manager came to East Timor to study Tetun on an intensive basis with local language teachers. Her facility in the language, and the strong language capability of the other three expatriate advisors, has been instrumental in creating the harmonious relationships that HAI enjoys with district counterparts. Using additional funds provided by the USAID mission, the Program Manager and Technical Advisor attended a workshop in Bangladesh on community based post-partum care. The technical advisor also went to a follow-up workshop in India in July, 2006.

One health promotion assistant attended a training in family planning that was organized for the MCH DPOs, along with leadership management training. The second health promotion assistant received training to become a master trainer for community health promoters. In addition, as other local training opportunities are organized by the MOH, HAI staff are frequently invited to attend and do so when program duties don't interfere. Besides the technical staff receiving training, the office manager has been trying to organize language training in both English and Portuguese to respond to the institutional complexities of language use in East Timor. However, because staff no longer are willing to work after dark based on the security situation and because there is no longer a dedicated meeting room, this initiative is slow to begin. The book-keeper is the newest employee but she says that she too received training in accounting systems which benefited her work ability.

Follow-up is done by the program manager during her routine visits to the field and her general supervision; all the training has had immediate use for program management. Given the lean budget of the grantee, adequate resources are dedicated to staff training.

3. Supervision of Project Staff

The program manager is a superb supervisor, demonstrating impeccable leadership capacity. Coupled with the technical advisor, who has significant experience in East Timor and outstanding clinical skills and knowledge, the program manager fostered an equitable partnership which drew on both their strengths. This positive working arrangement has served the program well. Leadership provided from the headquarters office is equally good; both the Deputy Director and the East Timor Program Advisor have established supportive and strong relationships with the field staff. Frequent communication, knowledge of the field situation in East Timor and regularly scheduled

field visits from HQ promote a strong sense of receiving adequate back-stopping and support.

It is important to note that all these systems were sorely tested during the crisis months of April and May. However, because:

- Seattle HQ trusted the field staff to make the difficult decision as to whether they were safe in country;
- Expatriate staff were experienced enough in other conflict zones to adequately assess risk and thus were comfortable staying;
- National staff receive an enormous morale boost from the expatriate staff presence, as many of them felt "abandoned" as Peace Corps and other international NGOs left the country,

the HAI office was able to continue in its program activities to the best of its ability during a very difficult time.

The HAI country program is expanding with an additional family planning grant and the Ministry of Health continues to call on them for constant input into the greater maternal and newborn health program of East Timor. This has stretched them too thin. Moreover, the grant resources are also very carefully budgeted and they are in the unenviable position of needing to add new hires without having sufficient resources. HAI needs to review the budget and see if they can reconfigure categories to free-up funding for staff; they need to consider if there is any possibility to use organizational resources at HQ to help with staffing or if there are additional resources available from the donor to address this need.

4. Human Resources and Staff Management

a. The program's personnel management system is strong. The Project Manager has received universal high marks from all the staff as to her skill in program planning and her responsiveness to staff needs. She is also highly respected by the wider health sector community as evidenced by their comments during private interviews. The technical advisor, having been in East Timor for many years, is also viewed as the "face" of newborn care and highly valued for her technical contributions. At the same time a number of changes in the staff roster deserve comment.

The Health Promotion Advisor left the program in 2005 to take a position elsewhere. Her position has not been filled, despite active recruiting attempts. HAI faces the challenge in East Timor of significant competition from other international agencies for the same small pool of talented advisors and the disadvantage that they cannot compete on salaries to attract personnel. This has complicated their search for replacements despite advertising and using their networks to identify candidates.

The technical advisor went on maternity leave in August. She was scheduled to step down to half time in the latter two years of the program, but post-maternity leave has elected not to return to that position; the budget from that position was re-directed to support the new district position. She will return in January 2007 in a consultant capacity to finish certain key training and materials development activities but after that her

available time is unclear. In addition, during the first two years of the program, because of her excellent skills and strong reputation, she was repeatedly drawn away from her core HAI activities to provide technical guidance to other international organizations, such as WHO. HAI agreed, since the programs seeking her advice were interconnected to the HAI activities and promoted overall newborn health, a key objective of this grant, and since her participation was also requested by the MOH. The only disadvantage was that these extra activities took more time than anticipated. It will be difficult to find another advisor of her technical caliber who also understands the complexities of the East Timor situation.

HAI has recently hired another long term staff member, not budgeted for in the original proposal, to serve as the district coordinator. In filling this position, they are once again anticipating future health systems changes, which will also place advisors at the regional level in 2008. The new member of the team brings excellent language skills, previous East Timor experience and behavior change management skills to the team, all useful in expanding the program to the new districts.

HAI has a strong relationship with the University of Washington and has been able to draw on graduate students from the International Health program there to provide interim technical support to the program. It was the use of this mechanism that resulted in an evaluation of the impact of the dramas on understanding key health messages. The HQ staff provide very good backstopping. The Deputy Director for the HAI program has been coming to East Timor since 2000 and is well known and respected by the MOH staff. The ET Program Advisor has also developed positive long term relationships with counterparts and is in country once or twice a year. The HAI office in East Timor uses Skype (internet phone) and internet to stay in frequent touch. The team in East Timor indicated that home office staff are always very quick to respond both technically and administratively.

The only unfortunate personnel issue arose during the crisis. A short term book-keeper near the end of his three month contract took advantage of the crisis to forge signatures on a check and remove a substantial sum from the HAI bank account. However, because of the vigilance of the office administrator, this discrepancy was found immediately and the matter was resolved with ANZ bank, resulting in the return of the funds. The program has followed all the current legal avenues open to them in the prosecution of the individual but because of the crisis he is still at large.

Morale and cohesion are very strong in the program, despite the fact that the crisis has created personal hardship for all the East Timor national staff. Drivers no longer feel comfortable driving to the East; some program staff have lost their homes and live with extended family members in uncomfortable situations and local staff prefer to leave promptly at the end of the day because of uneasiness that there might be violence at night. Some staff have families who have moved outside of Dili in response to the crisis, which also has been difficult to manage. The Program Manager is very sensitive to these issues and has done a good job of managing them. Because of her strengths, there has been almost no staff turnover. HAI is seen as a very strong organization and staff are

proud to be associated with the program. Elements such as the international staff being able to speak Tetun and the national staff being asked to contribute to HAI's global newsletter also support morale.

Overall in East Timor, there is an appreciation that things are much more difficult to manage because of the crisis. Ministry Staff reported that there are East/West factions in the health services; another USAID project discovered that its staff were primarily from the East and thus felt very uncomfortable when they worked in the West. In the recent USAID partners meeting, significant time was allocated to address the impact of the crisis on staff and program implementation. Counterparts have a more disrupted life and are sometimes absent from the field, which has slowed the implementation somewhat. HAI needs to provide opportunities for its staff, both national and international, to get relief from the stress of the current uncertain situation in Dili.

In field visits, counterparts seemed clear on the job descriptions of HAI staff they work with. However, despite efforts on the part of the program to be transparent and despite repeated explanations, Ministry of Health personnel in Liquica do remain confused over one midwife position. The existing midwife was promoted into the newly created District Program Officer position. HAI initially covered the salary of replacement midwife, with the clear intention that her salary would later be subsumed into the normal district health staff budget. When she resigned, HAI made the decision to stop funding that position but district health staff continue to wait for a replacement midwife who would also be HAI "staff," instead of using the existing Ministerial personnel systems.

Headquarter roles seem clear, as do the carefully thought-out job descriptions for field staff . The only position that needs some clarity is the Program Manager position. She holds the title of Country Director for HAI and Program Manager for the Child Survival Grant. Because of HAI's excellent reputation, they have attracted other funding and have more programs in-country now than just child survival. This means that the current program manager is working more than full-time because she remains fully dedicated to the child survival grant and works evenings and weekends to perform her other functions. This is not sustainable and HAI HQ needs to think about additional staff.

Because the staff currently work full tilt in the implementation of the program, little thought has been given to staff transition to other jobs. However, given the unique environment of East Timor with high demand for staff from UN organizations and other international groups, and respect for the high quality of HAI's work, all of the HAI staff will be able to find jobs immediately. They all have experience with other international organizations and they are all multi-lingual and thus well poised to take advantage of the tight job market.

5. Financial Management

The program uses Peach Tree accounting systems to manage the financial systems. A paper system is used to track receipts and issue budgets for key activities and then entered into the accounting system. Budgeting analysis is done in Seattle, Washington and the monthly report shared back with the East Timor office. Currently, the program

has spent 40% of its funding during 47% of program time. One category, small grants, is seriously under-spent and the program will need to look at a realignment of resources, particularly with the increased need for staff.

It should be noted that HAI East Timor budget is very lean given the program scope and HAI has been an exceptionally prudent steward of USAID resources. They leverage funds from other sources, such as private donor contributions to the making of the health promotion film, and they also use resources from the Ministry of Health. As a result of a USAID Mission small grant award to rehabilitate a burned out building, HAI is co-located with the Ministry of Health and with TAIS, another USAID funded project. The Ministry paid for security services and while HAI paid for utilities for six months, TAIS will now pay for those services for a year. If TAIS moves out of the current building as recently considered, there will be an additional burden on the HAI budget to cover utilities. HAI should be congratulated for their careful management of limited resources.

6. Logistics

Logistics have run smoothly during program implementation to date. HAI received an additional vehicle from Family Health International when they left Dili and has three cars to manage field work. Staff have sufficient computers to work with. It is not in the program description to provide goods to the sites. However, because of their constant field presence, HAI does provide information to other donors, such as UNICEF, on needed supplies. Items they have suggested include speculum, sterilizers and materials to manage newborn asphyxia. A logistical challenge will be to manage the transportation system with an expanded number of field sites during the last two years of program implementation.

7. Information Management

HAI uses the data collected from the Ministry of Health as its primary monitoring tool. On a monthly basis, HAI gets a MCH report from each CHC, which primarily captures clinical data from clients that have been seen during the month. HAI enters this into their data base and the program assistant highlights any data that seem unusual. There are problems with the quality of the district data; a 2004 national immunization survey found significantly lower figures compared to data arising from district level routine reporting. HAI attempts to validate data from the registers on supervision visits, and the CS program manager also reviews data as part of her CHC supervision, as well as during the scheduled quarterly meetings. These primary data do not tell the entire story however because they don't record community events. If 90% of Timorese women are delivering at home, then considerable information is not being captured. Despite extensive planning in the DIP to analyze and use data, it does appear this has not been implemented as planned. HAI needs to be more diligent in tracking data and in using it, for program monitoring as well as for informing the government of observed trends and tracking results against indicators. For example, anecdotal information received from all the Cuban physicians during this evaluation would indicate that the number of ANC visits in the HAI districts is up substantially in the last six months. HAI needs to investigate as to the cause for this increase and take credit for contributing to it, if possible.

In fairness to the grantee, it is important to note many of the qualifiers and to recognize some of the positive behaviors around data collection in East Timor. These observations are bulleted below:

- The current HIMS system is new and it is flawed, despite many thousands of hours of consultant input. The government is aware of this and plans to review the system in January. HAI will be a part of the review.
- Some of the instrument flaws reported by the midwives include: no field to capture more than four pre-natal visits, no place to record new acceptors of family planning and no place to indicate if assistance at birth was delivered via the family or a traditional birth attendant.
- CCT, which delivers health care to a large population in Ermera and Aileu, has not routinely shared its data with HAI. With the arrival of the new MCH coordinator for CCT, there has already been discussion about sharing information and data which should contribute to providing a clearer picture of overall MCH coverage in the target districts.
- TAIS has not yet created a system to share the data they collect with HAI but again, with the arrival of the Technical Director, this is one of the issues that will be addressed.
- Despite the problems with routine data, a significant amount of information has been collected on HAI's target population in the last four years. This includes the first UNICEF Multiple Index Cluster Survey in 2002, the Demographic Health Survey in 2003, the census in 2004, the malaria and maternal health survey done by HealthNet International, and the midwifery-skills survey just being completed by UNICEF in late 2006. In addition, HAI contributed significantly to the national body of knowledge through community and health facility assessments.
- New data collection is ongoing; there is a planned second UNICEF MICS. In addition, HAI has created a log book for the birth friendly facilities which will capture data they need to report on for measuring change in indicators.
- The system of log books and registers at the community health center is new but already there are problems. The Cuban physicians record ante-natal care on separate pieces of paper that they use for their own clinical reference. Meanwhile the midwives adjust the registers to include information they want to track. The majority of midwives do not use a partograph to track labor.
- HAI facilitative supervision is successful in imparting the need to do data analysis. In Aileu, the DPO has organized focus groups, bringing together midwives and community members to discuss some of the findings and problems she was noting in the routine registers. In Same, where HAI will begin expansion activities in January, health staff wanted to have computers available to them because they believed their ability to capture data in graphic form would be useful in explaining trends in health care.
- The Head of District Health Services in Manatuto thought HAI's contribution to the use of data should center on concrete and pragmatic behaviors: using supervision to teach the DPOs to want to use data (demonstrating the relevance for program planning), how to enter data into computers, how to create graphics

that tell the story and how to review survey instruments and results from different NGOS who wish to conduct health data research in their area.

8. Technical and Administrative Support

Because the program budget for technical assistance is modest and the capability of the field staff is large, limited technical assistance has been provided from external sources. During the first two years of implementation, the program has received the following technical assistance:

- A capstone study on the effectiveness of the community drama, completed in the spring of 2006 by Andrew Bryant;
- George Povey's contribution to the maternal and perinatal audit process in late 2005,
- Support to the management process through Tom Martin, HAI grants manager,
- Anthropologist Chris Steele's facilitation of the training for the use of community assessment tools during the start-up phase of the program.
- Rachel Chapman, an anthropologist from the University of Washington, who provided help with the design of the qualitative baseline assessment (although she didn't come to the field).
- Indira Narayanan of BASICS, who collaborated with the technical advisor on newborn care issues

With the exception of Dr. Povey's work, which for reasons of national policy will not be included in future programming, the technical assistance has been timely and useful in accomplishing program objectives. In addition to providing pertinent information on the impact of the community drama, the Capstone study will be submitted for consideration to Health Promotion International and/or The International Journal of Health Communications.

The anticipated technical assistance needs of the program in the remaining time will focus on newborn care and will be provided on a consultancy basis by the previous technical advisor. It is anticipated however that the program will not have to pay for her services, which will be covered either by TAIS or WHO, because of existing reciprocity agreements (i.e., HAI already covered her time when it was used to benefit other agencies, now they will cover her time when it is to benefit HAI.) Possible technical assistance might be needed in the collection of the final data, although the East Timor program advisor in Seattle is very strong in this area and could provide TA during her routine monitoring visits. Another possibility for technical assistance includes identifying someone with community level training/BCC expertise.

HAI has no regional support for the program, drawing all its backstopping from Headquarters in Seattle. The budgeted time for HQ staff includes 15% for the Deputy Director and 40% for the East Timor Program Advisor. This allows for two field visits a year, in addition to routine support provided by phone calls and email. During the crisis of May and June, this support increased significantly. All staff indicate that this level is adequate and has provided the support they need. Recently HQ has been able to provide increased support because of winning a new FP grant and this has also benefited the CS

grant. As HAI increases its institutional presence in East Timor through other donors, they will need to safeguard that adequate time is still available for the CS program.

9. MISSION COLLABORATION

The USAID Mission in East Timor designed a special objective for health in 2004, which stated "Improved health of the Timorese people, especially women and children at greatest risk" as the desired outcome. The intermediate results are:

1. Increased use of key maternal and child health practices, and
2. A community health network established to effectively support key maternal and child health practices.

At that time, the focus was on maternal and child health (without a family planning component), emphasizing child health including immunizations and continued support to the private sector Café Cooperativa Timor, with its health clinics. In 2005, the Mission revised their strategy and began to incorporate family planning in their program. In December 2005 HAI received a grant for family planning from the USAID Flexible Fund, through World Learning.

In the DIP, HAI expected that they would work very closely with TAIS, which implements the child health program. However, TAIS has experienced a slower than anticipated start-up and the crisis of April forced TAIS to withdraw from Ermera, the site where the two programs would have coordinated. Now TAIS has just started in Manatuto, where HAI has had activities for two years, thus their program cycles are at different places. The recent arrival of the Technical Director for TAIS and their co-location with HAI does facilitate joint planning as much as possible given the different stages of the programs. HAI will continue to coordinate with CCT, which receives funding under the Economic Growth objective of the USAID Mission. This collaboration will focus in Ermera as well as in Manufahi and Ainaro and will include planning activities between the newly hired Maternal and Child Health advisor of CCT and the MCH DPOs of the respective districts. This complementary health programming will maximize overall impact at the country level.

There is a newly appointed health officer at the Mission and he was able to participate in this mid-term evaluation, which was very useful to HAI staff. In the first three months of his tenure, he was absorbed with responding to the emergency but now will be able to participate on a more regular basis in HAI activities. The health officer doesn't feel as if he has administrative oversight for the HAI program as the funding comes from Washington rather than from bilateral funds. In the debriefing meeting with the USAID Mission, they indicated they would appreciate receiving more reports and communiqués on the program status. HAI welcomes increased USAID participation in their program and plans to offer frequent opportunities for input, as well as providing USAID with more information on program impact. The Mission has drawn on HAI's technical expertise to answer programming questions and HAI hopes this will continue.

One area in which HAI will need to interact more with the USAID Mission is in carrying out the "branding" mandate under USAID grants. Up until this year, HAI was not required to brand any of the vehicles or program materials. Now, with funds received as

of October, 2006, they will need to brand and use the USAID logo. HAI is just completing its marking plan; they intend to work closely with the Mission to accomplish compliance.

HAI will also work closely with the Mission to understand the new reporting requirements from Washington which will need extensive data. While there is no formal change in the reporting requirements of the grant, USAID East Timor will need to draw on HAI for information to "tell the story" to Congress. Unfortunately, the health information systems of East Timor are still in process and it is sometimes difficult to extract quantifiable data which measures the success of interventions. Nonetheless, HAI understands the importance of being able to provide this information to the Mission and will work closely with them on this issue.

USAID typically seeks to increase the impact of their development budget through leveraging resources from other donors in support of their program objectives. By investing in the HAI program, USAID has been able to achieve scale at the country-level in an unprecedented way. Not only is HAI a very careful steward of the resources entrusted to them by USAID, they are institutionally brilliant in raising funds from other sources. For example, HAI raised funds from AusAID to rehabilitate two birth friendly facilities. They received funding from AusAID, UNICEF and three private donors to fund the maternal child health film which is being done by Max Stahl, a film-maker of some note, and did not have to draw down on USAID funding. UNICEF helped fund the development of the Bibi Bulak dramas and WHO is contributing to the Post Partum Care Modules. In addition, the Ministry of Health took to national scale the Maternal and Child Health DPO program.

Furthermore, HAI provided technical input to almost every major maternal and child health activity implemented in East Timor. The CS program manager is participating in the EU-led effort to define the basic service package for MCH, and HAI technical staff have had input into the MOH midwifery skills evaluation funded by UNICEF (and will benefit from the findings to further refine their program). It was HAI staff that compiled the list of key messages in maternal and child health, now used by the Ministry for all donors and NGOs. Other collaborations included:

- participating in the evaluation of SHARE (a Japanese NGO with an active program in maternal and child health in Ermera);
- collaborating extensively with TAIS when it began to conduct its initial baseline assessments;
- providing ANC care to IDPs in camps in Dili during the crisis (with UNFPA);
- donating staff time, vehicles and drivers to the FP evaluation, particularly in Ermera;
- joining the steering committee to develop the National FP workshop;
- participating in the Safe and Clean delivery training assessment;
- sitting on the steering committee for the national workshop on Safe and Clean Delivery;

- providing staff and logistical support to the UNFPA funded MCH services assessment, led by the MOH. This assessment looked at the impact of IDPs and the crisis on MCH services in the districts.

D. Other Issues Identified by the Team

While the guidelines for the midterm evaluation are comprehensive, there are other major issues which fall out of the guidelines but still affect the implementation of the program. These issues are:

- The arrival of the Cuban brigade in March 2006 and the posting of at least 95 primary care physicians to the districts and sub-districts.
- The ongoing insecurity and social unrest which creates a sense of tension in the program environment, including anticipated disturbances around the up-coming May 2007 elections.
- The closure of Peace Corps because of social unrest and the loss of volunteers to assist with community initiatives.
- The impact of multiple languages on the efficacy of training.
- Rehabilitation of the office site and the impact of co-location.
- HAI's coordination and facilitation role -EU, SHARE, WHO, UNICEF, UNFPA.

Each of these issues are discussed below and illuminated with examples from program implementation to show the impact.

THE CUBAN BRIGADE

In an effort to address the chronic need for more primary care physicians, the government of East Timor has negotiated a program with the Government of Cuba. Approximately 95 Cubans are primary care physicians stationed at Community Health Centers throughout the country and there are 128 Cuban specialists working at various health facilities, including referral hospitals. The program also includes nurses and administrators. 600 East Timorese students attend medical school in Cuba. The Cuban physicians in country are placed at the district and sub-district level in throughout the country and are accompanied by administrators, logisticians and nurses at the national level.

During the mid-term evaluation, one of the HAI staff who is fluent in Spanish interviewed Cuban physicians in each of the areas where HAI works. This was added to the scope of the evaluation because the Program Manager for CS felt that HAI's work had been significantly impacted through its relationship between the national midwives and Cuban physicians who are the primary counterparts for HAI.

The interviews were conducted in Spanish and used a questionnaire to probe both what the Cubans had observed in terms of primary health changes since their placement and their knowledge of HAI and the work of the midwives (these are available in Attachment G.4). There was a certain sensitivity around the interviews: the physicians requested that the interviews not be taped and that they not be identified by name because of Cuban regulations concerning public disclosure. In addition to interviewing the doctors

themselves, the team asked midwives and administrators what they thought the impact of the physicians was.

In general, the physicians have quickly learned Tetun and thus are able to converse with most of their clients. They also are willing to live in remote sub-districts and do mobile outreach to the clients in isolated areas, although they too suffer from transportation and vehicle problems. Their presence at health clinics has increased the demand for services and has allowed health centers to clinically manage some cases (such as mild pre-eclampsia) that would have been referred earlier. They do assist in many of the births but an informal rota system has been established such that midwives continue to do most of the monitoring and management of routine births and only call the physicians when they believe there to be complications. However, in the cases where midwives have delivered at night, the Cuban physicians were then on duty. Because of the shared caseload, one of the physicians observed:

> "Only 20-30 pregnant women were coming into the clinic for prenatal care, now there are 128 women coming into the clinic at the prenatal times. There are many more people (three times or more) women seeking ANC. Many more people giving birth at the clinic. It is due to the midwives and their efforts in health promotion. Midwives advise patients to come in if there are any danger signs, to plan to have their births in a facility if possible. Midwives are doing a great deal of outreach to women who do not come into the clinic and who live far out."

This same physician went on to say that she had noticed that clients were coming in much earlier for ante-natal care and that the first prenatal visit was often now within the first two months of pregnancy. At another health center, where the doctors had also noted an increase in ANC visits but not until the second trimester and with no corresponding increase in delivery at the health post, they said:

> "Well, when we first arrived (*sic ten months ago*), very few women knew when they had conceived. The midwife always asked - how many months pregnant are you? And that's what was charted. HAI has taught them how to ask the right questions and try to figure out when their last menstrual cycle was. This has helped a lot. This has gotten a lot better."

One center manager observed that because physicians are posted there, the clinic is able to give more injections, which makes many of the clients happy. Other managers have indicated that since the Cubans are not integrated into the district management team and since they respond only to supervisors in Dili, it has been more difficult for the managers to foster team spirit. In Laleia, the midwife said that she had to protest the Cuban's intended division of labor. They had announced they would see all the children under the age of five and that she no longer needed to use the IMCI algorithm. However, she rejected this because she had been trained in IMCI and felt it was still in her job to treat children. The resolution was that they both treat children but the Cuban physician prescribes medication. As of now, a manual outlining the expected job descriptions for all health staff, including the Cuban physicians is still being drafted by the Ministry.

The Cuban physicians have been uniformly criticized for their response to IMCI; East Timor invested significant resources in IMCI training and the Cubans as of yet don't appreciate it as a primary health care intervention. There is anecdotal evidence that some of their maternal health interventions are not evidence based. For example, in Aileu, they indicated that they would not prescribe hormonal family planning methods to women over the age of 35. At the referral hospital, where many other expatriate physicians work in the maternity wards, there has been a general feeling that some of the surgical interventions are not up-to-date with current thinking. One observed drawback during field visits is that Cuban physicians are creating a parallel information system, noting ANC and delivery findings on separate pieces of paper to keep track, instead of using the East Timor LISIO (Livrado Saúde Inanfante hoet Onan) and clinic registers.

Clinic midwives interviewed for this midterm evaluation feel that the presence of the physicians is benign and contributes positively to their ability to perform their key functions, though they don't get any personal benefit of mentoring or supervision. Other sources say there is more potent discontent being expressed by midwives but because national management doesn't want to hear any complaints about this innovative program, the disagreements are only voiced in private. UN agencies are concerned that the midwives will be displaced because of the physicians and their clinical skills will atrophy.

"LA SITUAÇÃO"

The impact of the crisis in April and May is huge. In the immediate aftermath of the crisis, the health care system addressed the needs of internally displaced people, which drew them away from basic health planning. HAI staff responded to ad hoc emergency assistance requests from the MOH, providing assistance in the IDP camps because MOH staff had been forced from their posts. HAI's newborn care training at the hospital was interrupted and never completed; access to program sites was unavailable because of road closings; and the referral system for management of obstetric complications was disrupted as women could not come into Dili. In addition, there was a personal impact: HAI staff lost belongings and houses as did their primary counterparts in the MCH division.

The longer term impact has been a chronic sense of unease and anticipation of social unrest, so that many government counterparts are experiencing high levels of stress. There is a renewed international military presence in Dili, which while providing security, is a very visible symbol of the crisis and a reminder of political failings. In addition, the operating environment is more complex because of the announced divide between East and West. Staff from one region are reluctant to travel to the other region; divisions in the Ministry that had demonstrated a national unity are no longer cohesive. There continues to be low level and sporadic violence in Dili, with rock throwing and police check points in evidence. The country is scheduled to have presidential elections in May 2007. Informed observers feel that this might be a political flashpoint which will disrupt routine activities again and spread the violence out of Dili to other parts of the country. Overall the impact of the events of April and May has been to deflate the optimism of East Timor and raise the spectre of a descent into long-term chaos. The HAI

program works in a far more uncertain environment than anticipated and needs to factor this into its revised work plan.

LANGUAGE AND TRANSLATION NEEDS

The best illustration of the complexity of language in East Timor is the following paragraph drawn from the report on the training of nurses in neonatal care at the referral hospital:

> The training modules were provided in Bahasa Indonesian and English; facilitators included a mixture of English, Tetun and Spanish speakers. Generally the teaching was done in Bahasa Indonesian language. Non-Bahasa Indonesian speakers followed the English modules. Questions were fielded and translated into any of the languages.

At all the health centers visited for the evaluation, IEC materials were available in Tetun, Portuguese, English and Bahasa Indonesian. However, because of the presence of the Cuban physicians, the government of East Timor has worked with the Cuban brigade to translate the protocols for the most common diseases into Spanish. The result has been protocols written in a combination of Portuguese, Tetun, Spanish and English. These were presented to the doctors upon arrival and are sometimes also used by Timorese nurses. The Cubans further note that even Tetun is not sufficient for communication at the local level. They often ask the midwives to translate client information from Tetun into yet another local language. The Director of Health Services at the MOH says that in any given working day, she speaks five languages.

HAI has had to grapple significantly with translation costs and deciding which languages to use in terms of materials development. Many of the midwives and counterparts were trained originally in Bahasa Indonesian and many international standards by WHO etc are available in Indonesian, making the use of Indonesian expedient, if not popular for clinical training.

CO-LOCATION-BENEFITS AND DRAWBACKS

One of HAI's strategies was to be co-located with their counterparts in the Ministry of Health so as to facilitate joint planning and review. In the first year of program implementation, they were located within the Ministry but didn't have a dedicated, shared space that contributed to the original intent of co-location. With a grant of $100,000 from the USAID small grants program, HAI was able to renovate a historic building and move there, along with the MCH department of the Ministry of Health and TAIS, the other USAID health project. The building had a large meeting room used for brainstorming, planning, monitoring and review sessions that contributed very much to the partnership between HAI and the MOH.

However, the Dili District Health Office moved into that space in September and once again, HAI doesn't have a common space to share with the MOH. TAIS is considering moving out the building, which would be a pity because its position there facilitates working with HAI. They are also considering more extensive remodeling. If that is the option that is approved by USAID, then once again there should be a common meeting

room created so as to facilitate the joint MCH-HAI program. If that doesn't work, HAI needs to consider another way to obtain common meeting space again.

One of the other benefits of co-location is the MOH-provided guard service, useful in these tense times. Recently TAIS has paid for security from a private firm because the government guard service is no longer reliable. HAI does not have the budget to continue this if TAIS moves. TAIS currently covers utility costs for the building which reduces budget demands for HAI.

LEAD AGENCY DEMANDS

HAI is in the enviable position of getting uniformly positive feedback on its technical capability, its community responsiveness and its integration within the MCH department of the Ministry of Health. While this is all well and good, it does mean that HAI staff are pulled in many directions. For example, HAI has done a very good job of getting the BFF established in Maubara. However, it was a lengthy process with intense community consultation (one reason why it is so successful). Because of this success, the MCH department is thinking of asking HAI to spearhead the newly approved ministerial strategy to build maternity waiting homes, although they would convert some of them to the HAI Birth Friendly Facility model. There is the national expectation and donor funding to build 65 of these institutions; in fact some districts have already gone ahead and implemented this as a pilot. HAI does not have the capacity to assist in building 65 homes nor do they have the mandate under the terms of their grant from USAID, which focuses in seven districts only. Thus, HAI needs to ensure they are responsive to the MCH department yet at the same time remain true to their core mission; in fact, it is to this focus and limited geographic scope that many observers attribute HAI's success.

NATIONAL ADMINISTRATIVE CHANGES

There is current draft legislation which would re-district East Timor and move it from 13 districts, which it inherited from Indonesia, to approximately 32 municipalities. This would re-order the entire structure of the health care delivery system. This could happen as early as 2008, the last year of the HAI grant. Although it is difficult to predict the outcome of such re-districting, HAI should monitor the development of this strategy closely in order to minimize any disruptions to the final year of implementation.

E. CONCLUSIONS AND RECOMMENDATIONS

This section presents the main conclusions based on this mid-term evaluation. The corresponding recommendations are primarily focused on the technical changes that should be made to the program over the next two years, with some additional suggestions for management changes. They are not ranked by priority.

1.CONCLUSIONS:

1. HAI is considered a success by all the counterparts interviewed for this evaluation. HAI sought to embed itself within the MOH, and they have done this successfully by co-locating with the MCH department, frequent communication with the districts, and joint supervision to the districts. HAI has been able to

meet their primary goal and objectives of promoting the MCH agenda of the government of Timor Leste.

2. HAI has functioned as a key agency in the MCH sector. This is demonstrated through their participation in all key working groups and the demand for their input into any significant national policy work and training effort, such as the review of the midwifery standards, the Basic Services Package being managed by the EU, emergency newborn care at the hospital and the upcoming National Workshop on Safe Motherhood. In addition, they participated in the evaluation of the Japanese health program, contributed to the current evaluation of midwifery skills being done by the MOH/UNICEF and worked with the two other USAID-funded groups (TAIS and CCT) to ensure coordination. They are able to do this because many of the HAI staff have strong Tetun skills, prior work experience in the health sector in East Timor (which allows them to access existing networks), sound program management skills and a commitment to extensive stakeholder consultations.
3. HAI has been a very careful steward of USAID funds, leveraging resources from other donors such as $12,000 from AusAID to pay for two birth friendly facilities and $45,000 from various donors for the film.
4. District program performance is in part a function of the strength of existing counterparts. HAI has very strong counterparts in the district health services, particularly in Manatuto and Aileu, who contribute to the strategic planning. At the national level, HAI benefits from having a very strong Minister of Health and MCH Division leader, who are able to provide guidance, support and problem resolution.
5. The introduction of a Maternal and Child Health District Program Officer, for whom HAI both lobbied and developed the job description, has been key to getting MCH services functioning at a higher level.
6. The program is being implemented as scheduled except for the community health promotion efforts. This is in part due to the departure of a key staff member, the departure of the Peace Corps Volunteers, and also too lean a staff. Another factor is that HAI needed to concentrate on improving the quality of services offered before increasing community demand. However, what community health promotion efforts that have been implemented have been considered excellent and very inclusive.
7. The social unrest which began in April and continues to the present day, with its underlying tension, has had an impact on program implementation. For example, when the airport road closed because of the events, it was not possible to get to program sites. The drivers for the program were uncomfortable going to program sites because of the East/West divide and the mid-term evaluation had to be delayed from August to November.
8. Counterparts think that HAI's BCC efforts are both innovative and well-targeted. For example, the use of film as a media for message dissemination suits very well the low level of education that many community members have. The dramas also are a good channel for message dissemination but they need further post-production follow-up.

9. HAI does a good job in including men in the behavior change strategy, which is essential in East Timor because men are key decision makers on family health issues.
10. Behavior change message content is appropriate and focused, needing some minor improvement to link family planning and post-partum care.
11. Training is a key strategy but needs to be better organized against a master plan of training needs. HAI is able to adjust training plans based on assessments, i.e., the decision not to support yet another stand-alone counseling and communications training was sound.
12. HAI serves as a link between the districts and Dili and as such can influence requests to donors for equipment at the district level, even though they don't provide this kind of "hardware" independently.
13. The arrival of the Cuban physicians working at a primary health care level in the districts and sub-districts has affected the way HAI-supported midwives work.
14. HAI has a new grant on family planning and they need to make more explicit the link between family planning and maternal health, particularly in the post-partum period.
15. Antenatal care is improving, thus it is still appropriate for HAI to now turn its attention to intra-partum care and post-partum care.
16. The referral system for complications is not sufficiently utilized by the community because of cultural beliefs and a lack of understanding about the benefits of referrals. HAI should move to promote birth preparedness planning, which will clarify the benefits of the referral system. HAI should not focus on improving the quality of health facilities among the five referral hospitals, but should support the efforts of other agencies to do this (such as WHO and the training of nurses in neonatal care at the Dili hospital)
17. Data collection is not functioning sufficiently to serve as a program management tool and can be improved.
18. The preliminary finding from the UNICEF report on the assessment of midwife skills shows that the midwives in the HAI districts are working to a higher standard than in other districts.
19. The community consultation practice implemented by HAI has succeeded in creating a great sense of ownership of the Birth Friendly Facility in Maubara and in Remexio.

2. TECHNICAL RECOMMENDATIONS:

1. Create a master training list. The information should include a census of the midwife and DPO staff and what sort of training they have received and when (Senhor Jose Magno has an example of this in his office.) The master training list should document which national trainings have been facilitated and attended by HAI staff and what follow-up to training is being offered either through routine supervision or planned assessment (such as the current UNICEF/MOH Midwifery skill assessment).
2. Drop the effort to do maternal and neonatal death audits. Although useful in the overall analysis of causes of death, enough information is currently available in East Timor that resources programmed for this activity are better used

elsewhere. In addition, the MOH wants to concentrate on getting the vital statistics recording system of births and deaths operational first before narrowing the focus to maternal deaths. There are also concerns that this approach might be used to assign blame, a deterrent to finding helpful solutions, so overall it is better to be dropped.

3. Consider modifying the activity focused on identifying health promotion messages applicable to school age children (as currently in the workplan) to identifying health promotion messages that could be used to support the National Reproductive Health strategy to reduce pregnancy among young women.
4. HAI should participate in the January 2007 review of the Health Information Management Systems to ensure that registers and other tools reflect the needed MCH information.
5. HAI should do a review of existing registers to determine if the trend in increased use of service delivery facilities, as noted by the Cuban physicians, is supported by data.
6. During supervision services, renew the emphasis on use of the partograph as a tool to monitor labor. The evidence base for the positive impact on delivery outcomes because of using a partograph is strong and partograph use should be heavily promoted.
7. HAI should work with the district management teams and the MCH DPOS to determine how the existing registers can be used more effectively in program management. Activities could include a half day meeting with analysis of registers and brain-storming on what the data are indicating and what program responses should be.
8. HAI should discuss with DPO Amalia de Araujo of Aileu the outcome of her focus groups, where she gathered midwives and community members together to discuss findings from data. This model could be implemented in other districts if it is successful.
9. Clarify with the MCH division and the Institute for Health Sciences HAI's appropriate role and involvement in training courses. This will serve to reduce the time staff dedicate to coordinating training between two competing divisions.
10. HAI should remove advocating for motorbikes for MCH DPOS from the work plan. HAI has already identified that there are cultural constraints to the use of motorbikes (i.e. women not using them at night because it is inappropriate to be out alone at night or out on a motorbike with a man who is not related to her) and no longer thinks that motorbikes will contribute to increasing supervision visits or community outreach.
11. HAI should work with staff of Bibi Bulak and the Liquica Youth Group to devise better linkage between the district health services as a follow-up to drama performances, to support better long term retention of key messages.
12. HAI should develop a training module for community health center staff to promote interactive behavior with audiences post-drama presentations. This will serve to reinforce the messages presented in the dramas.
13. In Ermera, HAI should create a joint plan of action with CCT to ensure maximum coverage of services. The plan of action can identify areas of

expertise that could be shared with other partners (such as CCT's possible pilot of a program on PMTCT).

14. In Aileu, HAI should coordinate with the Maryknoll Sisters and their volunteers on managing inputs into a youth drama group. The volunteers speak Tetun, have a background in drama and already work with the high school. This can support the national strategy to reach out to adolescents with information on reproductive health.
15. HAI should identify other Ministerial funding sources, as suggested by the District Health head in Aileu, to support the youth drama groups in their work.
16. HAI should develop a marketing plan for the maternal health film, and contact groups both within the region and globally to identify opportunities to screen the film. There are many film festivals in the region that have documentary categories and that could help maximize exposure to the film.
17. When the communities select the new health promoters, HAI should facilitate community groups to draw from the pool of effective volunteers who have had both training and experience in community outreach and health promotion, to capitalize on past experience.
18. HAI should address the gap in the referral services through a greater emphasis on the message that complications can arise at anytime during pregnancy and both the client and the community need to be ready. This will allow communities to examine which part of the referral chain they need to focus on the most, in order to improve its functioning.

3. Managerial and Administrative Recommendations

1. HAI should provide opportunities for the new USAID Health officer to participate in field visits as much as feasible.
2. HAI should ensure that copies of all reports, briefing memos, summaries of findings from community assessments, etc are shared with the USAID mission to further "tell the story" of HAI's work and program impact in East Timor.
3. HAI needs to hire two more staff at a minimum. There should be a full –time national staff person dedicated to the district expansion and there should be an additional resource for technical input. If the previous technical advisor is available for frequent consultations, that would be an acceptable solution.
4. HAI should hold a staff retreat. The retreat should address dealing with the stress of on-going civil unrest and a small technical update to provide staff with on-the-job training opportunities.
5. Because of the on-going social unrest, HAI headquarters should look at providing stress relief options to its expatriate staff. For example, this could include using overhead to send an additional DHL package with small items.
6. HAI needs to review its budget line items and look at how the under spent line item for small grants can be re-allocated.
7. The HAI Country Director should ensure that at least once a quarter the entire team reviews progress to date against the established work plan and makes any revisions as necessary.

F. RESULTS HIGHLIGHT: CONTRIBUTION TO SCALING UP

In keeping with CSHGP's interest in innovative ideas, the following highlight is presented. It demonstrates how HAI's dedication to community participation has been instrumental in entwining existing cultural practices with better health outcomes. The highlight also demonstrates how HAI has come to personify the strategic partner most trusted by the Maternal and Child Health division of the Ministry of Health. This trust has allowed HAI to have a national impact even though it is working in only seven out of thirteen districts, and contributes to scaling up on the national level.

The primary problem being addressed is how to induce changes in community behaviors so East Timorese access health services for maternal care. The barriers the program faces are low literacy, a suspicion of government services because of many years of political occupation and oppression, and continued strong traditional practices and beliefs surrounding maternal health. The solution HAI proposed was to develop pilot "birth friendly" facilities which honored local cultural traditions yet at the same time provided access to delivery by a skilled attendant. The anticipated magnitude of the intervention was to have these facilities in each of the districts where HAI works, which covers over 50% of the country. However, the MCH division is so pleased with the initial results from the first house, they are considering asking HAI to manage the process for over 65 facilities.

In order to develop birth friendly facilities, HAI began by having all their international staff learn Tetun, the national language. Thus when the program began a series of community consultations, the HAI staff could participate fully in the dialogue. This ability to work in the local language has also been very instrumental in building trust with Ministerial partners. Then the program did a community baseline assessment that inventoried key behaviors surrounding maternal health, designed with input by two anthropologists. They then ranked the behaviors as to whether they were beneficial, neutral or harmful. The technical advisor reviewed the behaviors and identified which ones could be positively modified, allowing women still to practice cultural beliefs but to gain better health care. Armed with this information, the program did a series of community consultations, asking each community to identify what their needs were and how a facility would have to be configured to make it "birth-friendly" in the East Timorese cultural context. To verify the information, more community meetings were held and the public were given an opportunity to validate the findings of the consultations.

Only then did the program begin to renovate the birth friendly facilities. Their deliberate approach attracted sufficient attention that a second donor provided the funds for the rehabilitation. Community members contributed labor and planning support for the facilities. To ensure that they were consistent with local cultural beliefs and practices each facility had, for example, a rope to use during labor, an ample supply of hot water, comfortable space for family members, and privacy. The result was that when the first facility opened it had three deliveries within the first week and two more referrals (more than many health centers see in a month). All of the births were attended by a skilled

provider, either a midwife or a physician. In every case, health center staff were also able to do post-partum support care for breast feeding and clients reported satisfaction with services they received. HAI will continue to use the cultural context to promote better health in all future endeavors, based on this success, and plans a full evaluation of the experience in 2007.

G. GUIDELINES. Guidelines were thorough and defined the evaluation process adequately.

H. OTHER RELEVANT ASPECTS OF THE PROJECT NOT COVERED BY GUIDELINES
Covered in Previous Section D

I. PAPERS PUBLISHED AND PRESENTATIONS
Andrew Bryant, an MPH student at the University of Washington, was seconded to the program for six months in 2005 and 2006 to focus on the community drama work with Bibi Bulak. As a result he wrote a paper entitled "Maternal and Newborn Health Promotion through Community Drama in Timor-Leste." This paper is in its final review and is being submitted to either the journal Health Promotion International and/or The International Journal of Health Communication.

Susan Thompson and Mary Anne Mercer presented a poster entitled "Challenges for Maternal And Newborn Care in a Post-Conflict Setting" at the Western Regional International Health Conference, January 2006. Another poster, "Prenatal Care Use in Timor Leste," was presented at the Academy Health Annual Research Meeting, June 2006, Seattle, Washington. Mary Anne Mercer gave an on-line live (Eluminate) presentation, "Post-Conflict Challenges to Maternal And Newborn Health tn Timor-Leste" for the CORE group, March 2006.

Section III. THE ACTION PLAN

At the end of the two-week MTE process in-country, the team leader, Lucy Mize and HAI staff held a meeting for all participants in the MTE, other MOH staff, partners and stakeholders to hear the conclusions and recommendations of the MTE. At that time, and during the past several weeks feedback has been solicited from these key stakeholders regarding the MTE findings. The following action plan includes their feedback and suggestions as the program moves into the final two years of the grant.

Action Plan: Technical Recommendations

Supervision

- Develop forms that integrate ANC, birth and partograph, post partum care, family planning, the health information system, medications and equipment and IMCI.
- Train MCH DPOs in all 13 districts on a new supervision tool and newly integrated forms
- Increase the presence of HAI in the districts, including facilitative supervision visits, with the addition of a new district office in a expansion district, new program and technical staff, and a greater degree of integration between the MNC and the FP program
- Conduct training of MCH DPOs and MWs in productive use of registry data to measure and communicate results resulting in planning their work more effectively

National Level Coordination

- Coordinate work plans on a quarterly basis with the MOH MCH division
- Facilitate a quarterly meeting of the MCH Working Group
- Participate in subgroups for Family Planning and Safe Motherhood
- Participate in the Basic Service Package meetings
- Participate in the review of the Health Information System
- Participate in the national planning process for district strengthening

District Level Coordination

- Advocate for regular a meeting with the district management team to include how the existing registers can be more effectively used in program management.
- Participate in existing meetings such as the quarterly meetings among midwives

Health Information System

- Participate and provide feedback into a review of the HIS expected in January 2007
- Coordinate with private providers not currently reflected in the national registry system (CCT) to more appropriately estimate MNC coverage

Training for PPC and NBC

- Continue to play a key role in the development of training materials for this planned training (PPC and NBC)
- Continue working with MOH MCH division to schedule the training
- Advocate for HAI program district MWs to be trained first

- In collaboration with the MCH division and the Institute for Health Sciences, clarify appropriate roles and responsibilities in the training process
- Following training, integrate PPC and NBC into supervision visits

Drama Groups

- Make changes to drama based upon follow up analysis and support performances in four new start-up districts
- Based upon follow up analysis, incorporate into the BCC drama strategy follow-up community dialogue for improved retention of key messages
- Develop a training module for Community Health Center staff to promote interactive behavior with audiences post drama presentations and work to create links between health center staff and drama groups to facilitate dialogue with audience members following drama presentations
- Consider making a film of Bibi Bulak drama presentation for a more cost-efficient method of wider dissemination in the districts
- In collaboration with the Maryknoll Sisters and their volunteers currently teaching in the high school, develop a plan for a youth group in the district of Aileu which would target adolescents with important messages about reproductive health
- Continue support of the Liquica and Gleno youth drama groups and assist with developing links with the health system and district health staff to conduct interactive discussion with audience following the drama performances
- Investigate possibilities of developing similar youth groups in the districts of Manatuto, Ainaro and Manufahi
- Explore possibilities of other funding to support the work for youth drama groups in the districts

MNC Film

- Develop a plan to show the film in conjunction with a communication campaign that includes opportunities to hold community events and home visits regarding the film's key messages
- Train district health staff on how to use the film as a training tool and opportunity to educate regarding MNC
- Develop a marketing plan that could identify opportunities to screen in regional settings to maximize exposure to the film as a tool for health promotion

Family Health Volunteers

- Continue to be a key player and strong advocate for the appropriate community-based selection and module development in MNC and FP training for Family Health Volunteers in the country through participation in the National Management Committee.
- Provide support through staff who have received Master Training for this effort

Community Training

- Through existing work, such as Birth Friendly Facilities, the MNC film and drama presentations, and future efforts such as the national Family Health Volunteers, advocate for the inclusion of key messages of danger signs for

pregnant mothers and newborns, a birth plan and community transport systems which address community preparedness for complications and emergencies.

General

- Plan an HAI staff retreat for January 2007 as a time for staff to come together to debrief and support on another after what has been a very challenging year with the ongoing civil and political tensions in the country, and also as time to digest the MTE recommendations and plan for the next two years
- As a part of the retreat, create a master training list to include a census of trainings received by MWs and MCH DPOs and HAI staff and those planned for the coming year.
- Drop the plan to conduct maternal and neonatal death audits as part of HAI's program
- Drop the plan to advocate for the purchase of motorbikes for MCH DPOs

Action Plan: Managerial and Administrative

Improve Communication with USAID Mission in Timor-Leste

- USAID mission staff were briefed and participated in the MTE process
- Continue to invite USAID mission staff to participate in community events associated with program activities
- Provide USAID mission with program reports, briefing memos and community assessments

HAI Field Staff Managment

- Post the positions for two national hires for one Health Promotion Assistant and one Technical Program Assistant to respond to current staff shortages
- Explore reallocation of the current approved budget to support the contractual hiring of a Technical Advisor for program-specific areas
- Continue to seek adjunct funding from external sources to augment program activities not covered in the current budget
- Continue to respond to the staff stress that began in April, such as by granting staff "emergency" time off with pay, and continue to be sensitive to ways to reduce stress for all field staff curing these uncertain times.
- Incorporate into regular staff meetings a quarterly review of progress against the established work plan

SECTION IV: ATTACHMENTS

Attachment A.
All analyses of progress to date have been included in the body of the report.

Attachment B.
A KPC survey was not completed for the MTE.

Attachment C. Evaluation Team members and their titles
The core team members consisted of Lucy S. Mize, Team Leader and Susan Thompson, HAI/Seattle East Timor Program Advisor. Ms. Mize had previous experience in East Timor in 2003 and 2004; she conducted a maternal child health assessment for the USAID Mission and she provided technical assistance to the USAID Mission in the design of its health strategic objective. Ms. Thompson has been coming to East Timor since 2002, when she began back-stopping the HAI project in Venilale and assisted in the design of the original Child Survival proposal. Jennifer Hulme, who will be the expansion district coordinator for HAI and who joined the program on Nov 6th, also participated in the evaluation as a way to learn the breadth of the child survival program. HAI national staff, Paul Vasconsuelos, Antonia Mesquita, and Teresinha Sarmento were with the team much of the time and contributed invaluably by illuminating responses from the community and providing their own experience. Ingrid Bucens, the technical advisor, provided input via the internet and telephone calls as she has not yet returned from her maternity leave.

In addition to these core members, Nadine Hoekman , who is the Child Survival Program Manager and who came on most of the field visits, arranged for colleagues to join the team during field visits. In keeping with the inclusive management style of HAI, these other team members included:

• Kiyoe Narita	SHARE Health Coordinator
• Paulino Salsinha Barros	SHARE Community Health Promoter
• Domingas Bernardo	UNICEF National Officer for Child Survival and Maternal Health
• Jose Magno	Head of District Health Service, Aileau District
• Teo Ximenes	Project Management Specialist, Health Program, USAID
• Sue Ndwala	Café Cooperative Timor Maternal and Child Health Coordinator
• Jane Revilla	UNFPA Advisor to the MCH Division, Ministry of Health
• Agapito Da Silva Soares	District Health Head, Manatuto
• Otila Pereira	MCH DPO, Manatuto Ministry of Health
• Appolonia do Santos	MCH DPO, Liquica, Ministry of Health
• Higina Maria	MCH DPO, Ermera, Ministry of Health

Attachment D. Evaluation Assessment methods

The team used document review, field visits, interviews with key informants, and observation as the primary tools for evaluation. Prior to the arrival of the team leader, the Program Manager had contacted all the key counterparts at the Ministry of Health and within the NGO sector and advised them of the dates of the evaluation. This allowed counterparts to participate in field visits with the team and ample time for discussion. In order to have coherent and consistent interviews, draft interview instruments were developed by HAI-Seattle and were reviewed and revised in the field.

On the second day of the evaluation a meeting was scheduled with USAID to explain the process of the evaluation and what issues would be examined. Field visits were conducted to all four of the current program sites and discussions were held with staff who would work in the upcoming districts for year three and four.

The documents we reviewed included not only HAI-generated documents but other pertinent documents such as the 2003 Demographic and Health Survey, the National Reproductive Health Strategy, the WHO report on Training for Neonatal Care for Nurses and monographs developed by other maternal health consultants, such as the EU advisor Arthur Heywood.

The schedule for the evaluation allowed for a meeting with all concerned counterparts at the close of the field work to verify conclusions and share recommendations. After that meeting, the draft report was submitted to HAI headquarters for comments and review. This was returned to the team leader for a final draft, which was then approved by HAI headquarters and submitted to USAID Washington in accordance to the published evaluation guidelines.

The overall process for the evaluation took five weeks, of which thirteen days were spent in the field and the rest of the time was spent in drafting and editing the report.

Attachment E. Persons interviewed and contacted

Health Sector Colleagues

1. Sarah Sullivan, UNICEF Midwife Evaluation Team Member
2. Kiyoe Narita, SHARE Health Coordinator
3. Paulino Salsinha Barros, SHARE Community Health Promoter
4. Six Cuban Physicians[1]
5. Domingas Bernardo, UNICEF National Officer for Child Survival and Maternal Health
6. Sue Ndwala, Maternal Child Health Director, Café Cooperative Timor
7. Jennifer Barak, Project Officer Child Survival and Maternal Health, UNICEF
8. Jennifer Graves, Alola Foundation Maternal and Child Survival Coordinator
9. Laurie Winter,TAIS Program Technical Director
10. Jane Revilla, Reproductive Health Advisor to the MCH Head, UNFPA
11. Sister Dorothy, Maryknoll- Uma Ita Nian Sister
12. Sister Susan, Maryknoll- Uma Ita Nian Sister

Ministry of Health Colleagues

1. Ana Isabel de Fatima Sousa Soares, Director of Health Services, MOH
2. Filomeno de Oliveira dos Santos, Head, District Health Services, Liquica
3. Hernania de Fatima, Midwife, Liquica
4. Apolonia Dos Santos, MCH District Program Officer, Liquica
5. Angelino Araijo da Silva, Manager of the Lete Foho Community Health Center
6. Erling Larssen, Senior Health Advisor, Ministry of Health
7. Carlos B. Gilman, Head District Health Services, Ermera
8. Rosa Pinto Soares, Midwife, Laleia Community Health Center
9. Otila J.A. M. Pereira-MCH DPO, Manatuto
10. Agapito de Silva Soares, Head District Health Services, Manatuto
11. Manuel de Jesus, Head of Remexio Health Center
12. Jose dos Rui Magno, Head District Health Services, Aileu
13. Amalia de Araujo, MCH DPO, Aileu
14. Natalia de Araujo, Director of Maternal and Child Health Services, MOH

Community Members

1. Victoria Suarez, mother who delivered at the new HAI Birth Friendly Facility
2. Carlos, wife died in childbirth one year ago, volunteered to do water systems for the new HAI Birth Friendly Facility.
3. Domingas Salsinha, Caritas Health Volunteer
4. Tenesa Fatima Maia, Caritas Health Volunteer
5. Maria Lucia, Caritas Health Volunteer
6. Eugevio Aleino Maia, Caritas Health Volunteer
7. Ernesto de Deus, Caritas Health Volunteer
8. Isabel Si Menes, Laleia- Community Health Center client, newly delivered
9. Antonio da Silva Martins, Liquica Youth Group Member

[1] For reasons of political sensitivity, the Cuban physicians are not listed by name or by district but they were generous in sharing their time and their experience with the HAI evaluation team.

10. Lucia da Conceicao Soares Liquica Youth Group Member
11. Manuel dos Santos Liquica Youth Group Member
12. Inez da Costa Pires Liquica Youth Group Member
13. Agustinha M dos Santos Liquica Youth Group Member
14. Luciana de Jesus, ANC Client, Remexio
15. Domingo Soares, Acumau Village Head
16. Annie Sloman, Bibi Bulak

USAID Staff

1. Flynn Fuller, USAID Representative to Timor-Leste
2. Brian Frantz, Program Officer
3. Teodulo Ximenes, Health Officer

HAI Staff

1. Nadine Hoekman, Country Director
2. Ingrid Bucens (via skype) Technical Consultant
3. Sarah Moon, Family Planning Program Manager
4. Celio Alves, Officer Manager
5. Emelita Guteres, Book Keeper
6. Paul Vasconselos, Health Promotion Assistant
7. Antonia Mesquita, Health Program Assistant, FP
8. Theresinha Sarmento, Health Promotion Assistant, CS
9. Jennifer Hulme, Expansion District Office Coordinator

Attachment F. CD with electronic copy of the report in MS WORD 2000 – enclosed

Attachment G. Special reports:

Attachment G.1	**Key Messages for MNC in Timor-Leste**
Attachment G.2	**Cultural Practices and Beliefs Analysis**
Attachment G.3	**Summary of Evaluation of MNC Drama**
Attachment G.4	**Interviews with Cuban Physicians**

Attachment H. Project Data Sheet form – updated version

Because a midterm community survey was not conducted, the project is not reporting on the Rapid Catch indicators at midterm. Even had it been planned, the security situation in the country would not have allowed for a community-based survey to be conducted.