FINAL MIDTERM REPORT OF TAIS REVIEW

AUGUST 2007

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ACRONYM LIST

BEOC	Basic Emergency Obstetric Care
BSP	Basic Services Package
CCT	Cooperative Café Timor
CCQI	Continuous Coverage and Quality Improvement
CH	Child Health
CHC	Community Health Center
CMP	Community Mobilization and Participation
COP	Chief of Party
DD	Diarrheal Disease
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DPHO	District Public Health Officer
ENA	Essential Nutrition Actions
ENBC	Essential Newborn Care
EPI	Expanded Program on Immunization
FHP	Family Health Promoters (English for PSF)
FGD	Focus Group Discussion
HAI	Health Alliance International
HAST	HIV/AIDS, STI, TB
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ITN	Insecticide Treated Net
LBW	Low Birth Weight
LLIN	Long-lasting Impregnated Bed Net
LQA	Lot Quality Assessment
MDG	Millennium Development Goal
MICS	Multiple Index Cluster Survey
MOH	Ministry of Health
NGO	Non-Governmental Organization
NIP	National Immunization Program
NNT	Neo-natal Tetanus
PSF	Promotor Saúde Familial
RED	Reach Every District (Immunization Approach)
SWAP	Sector Wide Approach
TAIS	Timor-Leste Asisténsia Integradu Saúde
TIPS	Trials of Improved Practices
TOR	Terms of Reference
VVM	Vaccine Vial Monitor

ACKOWLEDGEMENTS

The team wishes to thank the Ministry of Health of Timor Leste for their helpfulness in making this review thorough and transparent. Despite the need to manage a growing program which keeps them very busy, the MOH staff made every effort to be available to the review team to discuss the TAIS project. Partners and donors were equally available, which added to the depth of the review. The USAID Mission met with the team three times and contributed to the discussion among partners on the last day of the review, which was very useful. The reviewers also wish to thank the TAIS team for their excellent organizational, diplomatic, and administrative skills. This was demonstrated in arranging meetings with a comprehensive set of partners and providing phones and transportation, as well as extensive written material, early on. The TAIS team fully engaged with the reviewers and gave extensive and honest answers to difficult questions. Obrigado for your continuing commitment to child health in Timor Leste despite difficult circumstances.

I. EXECUTIVE SUMMARY

TAIS is a four-year child health project funded by USAID that is being implemented across Timor Leste (Timor-Leste). It is focused on a limited set of evidence-based interventions with a proven ability to save the lives of children. Its current approaches and strategies are somewhat different from what was originally envisioned but are responsive to the needs being articulated by the Ministry of Health. In its first two years of implementation, TAIS has contributed significantly to shaping national child health policy in Timor Leste. Concrete results include:

- Introducing evidence-based child health interventions to the Basic Service Package (BSP), which will determine the nature of facility-based and essential community-based health services over the next five years.
- Field-testing Continuous Coverage and Quality Improvement (CCQI), which is a process to improve client satisfaction (such as community, patients, families), improve teamwork in the district for monitoring of child health services and strengthen the sub-district service provision for child health. This process will now be harmonized with the Ministerial performance improvement/district planning approach mandated in the BSP. In contributing to harmonization, TAIS is using its 18 months of field experience in immunization and nutrition services delivery to give the Ministry valuable insights on what systems are working and which need revision. TAIS is also contributing a cadre of trained professionals who can support the district health teams in their implementation of the new process.
- Serving as a lead contributor to the IMCI review in 2006. This resulted in the government and donor agencies renewing their commitment to the principles and practices of IMCI, while at the same time updating policy to align with current global evidence-based practices.
- Using innovated approaches to distribute over 77,000 long-lasting impregnated bed nets (including those for displaced people because of the May 2006 disturbances) in five districts in Timor Leste. This effort included the development of a population-based data set, which was sufficiently comprehensive that the government used it in its application for funding from the Global Fund. This effort also resulted in sustained high use of the nets post-distribution.

TAIS has achieved these gains during a time of unfortunate turmoil in Timor Leste, with staff experiencing personal losses, periodic delays in being able to travel to the field, the need to shift the location of planned activities, the evacuation of the expatriate staff members and constant political tensions. The project also achieved these gains with a very lean national project staff who initially needed mentoring and technical training before they could function fully.

Over the remaining two years of the project, TAIS will re-focus its energies at the district level and also in extending program interventions to more districts. Having completed a thorough investigation into health practices via an extensive community consultation process, TAIS will use the findings to guide its input into promoting positive health behaviors via national campaigns and communication messages. Future TAIS community mobilization efforts will aim to integrate the newly functioning Family Health Promoters into district outreach efforts and to continue support to such civil society groups as the *suco* councils. TAIS pioneered the empowerment of these groups during its bed net distribution and should continue to draw on their strengths for other health interventions, such as using zinc to fight diarrheal disease. TAIS will also continue to contribute to quality and coverage through the harmonization of its CCQI process and the district-based problem-solving approach of the BSP.

The government of Timor Leste, including the new Minister of Health, expects TAIS to continue to function in its next two years as an able technical assistance resource. The government further expects TAIS to follow their lead in delineating the nature and timing of the required technical assistance. Drawing on its relationships with the Maternal Child Health Division of the Ministry, links with UN agencies, and collaboration with international NGOs, TAIS will continue to optimize USAID's investment in the health sector.

TAIS is USAID's largest bilateral investment in health and while drawing on the resources of two global projects, is based on responding to the unique needs of Timor Leste. Although the program started slowly and on a very ambitious scale, it has now begun to consolidate achievements. This investment will move Timor Leste further along in achieving the Millennium Development goal for child health and improve the quality of life for many children under the age of five. Considering that the population of Timor Leste is very young, this will make a lasting investment in the future well-being and strength of the country.

Among the many recommendations provided by the team, the following are key:

- Draw on the current field experience of CCQI to contribute to the new process of problem solving and performance improvement that is mandated under the Basic Service Package.
- Renew the emphasis on the district and sub-district level for interventions since many national policy initiatives are well underway.
- Exploit the extensive community networks that participated in bed net distribution for other child health interventions, such as the distribution of zinc to combat diarrheal disease, harmonizing this with Family Health Promoter program.
- Continue to link the community mobilization approach with the facility based CCQI approach.
- Use the information gathered through the consultative process of the last six months to shape behavior change interventions.
- Review the compensation package for national staff and accelerate filling of existing vacancies.

II. MID-TERM REVIEW

A. Purpose

The purpose of this review was threefold:

- To determine what were the tangible accomplishments of TAIS in its first two years
- To determine how the TAIS project could best support the Ministry of Health's child health interventions over the remaining two years life of project,
- To determine how TAIS has contributed to USAID's strategic objectives in Timor Leste and how the project will continue to contribute to those changing objectives.

The review was structured to assess current accomplishments as a platform for moving forward. The review team looked retrospectively only to understand the contextual history that explained how a series of decisions had been made. In consultation with the USAID mission and BASICS and IMMUNIZATIONbasics headquarters staff, TAIS management developed the terms of reference to lead to qualitative findings, rather than quantitative findings.

B. Methodology

The timing for the review was delayed because of the political and security situation in Timor Leste. It was finally fixed for August, 2007 after the elections were over. In-country preparation activities in support of the review included:

- Completion and distribution of the TAIS mid-term report, with a DVD to all key partners prior to the team's arrival.
- Development of a set of core concerns and questions that the TAIS management team wanted the review team to address.
- Scheduling appointments with over 50 informants within the Ministry, donor agencies, international NGOs and other groups.
- Compiling an electronic register of all the pertinent documents that could be accessed by the review team prior to arrival.

The review team had five members:

1. Lucy Mize, Team Leader, who had recently completed a similar exercise for HAI in Timor Leste,
2. Diana Silimperi, the Basics Technical Director, who had been involved in the original design of TAIS,
3. Allan Bass, an international health systems and immunizations expert,
4. Dr. Sridhar, Basics India team leader, with expertise in nutrition and other child health interventions, and
5. Mike Favin, IMMUNIZATIONbasics Technical Officer, who is providing support to the BCC and community mobilization efforts and who backstops the project with regular visits to Timor Leste and long-distance technical input.

Once assembled, the team worked in-country for two weeks. They made field visits to Manatuto and Aileu (as the field security would allow), held multiple meetings with the key informants, in-depth interviews with the TAIS staff, and group discussions each evening. Preliminary findings were presented at a meeting on August 24th at the MOH. During that meeting, colleagues shared input and comments that refined the findings and validated some of the assumptions the team had made. After field work was completed, the TAIS Chief of Party (COP) went to Jakarta for two more days of consultation with the review team leader. Similarly, the TAIS Technical Director and Dr. Silimperi continued the dialogue at a conference in Bangkok. The draft report was circulated for comment and subsequently significantly revised. This final report contains an extensive series of recommendations, some of which are time-bound, that are a road map for how to move the project forward over the next two years.

III. PROJECT AND TIMOR LESTE BACKGROUND

A. Country Profile

Drawing on data included in the report *Timor Leste: Health Sector Resilience and Performance in a Time of Instability* (2007),[1] the following description is provided of the current Timor Leste health sector profile.

- Infant mortality is in the region of 64 deaths per 1000 live births.
- 136 out of 1000 deliveries will not survive to the age of five.
- Maternal mortality is very high with approximately 420-800 deaths per 100,000 live births.
- Malnutrition is a significant contributing factor to child and infant morbidity and mortality, with almost half of all children below five underweight.
- Recent estimates suggest that 1 in 3 women suffer from chronic malnutrition.
- Almost 50% of the population have no access to clean water.
- Communicable disease accounts for almost 60% of deaths.
- Malaria is endemic with drug resistant P. falciparum thought to be widespread.
- TB is a significant public health problem, 2005 incidence was estimated at 556 cases per 100,000 which was the highest across both the Western Pacific and the Southeast Asian Regions of WHO.
- Acute respiratory infections and diarrheal disease are common and among the leading causes of mortality in children under five.
- Timor Leste has the lowest vaccine coverage rates in the Southeast Asia Region, with DPT 3 at 67% and measles at 64%, half of all children under two have never been immunized.2
- There are 65 community health centers at the district and sub-district level, five regional hospitals and one national referral hospital in Dili.
- There are 181 health posts at the sub-district level staffed in general with a nurse and midwife, the recent deployment of Cuban health staff at the district and sub-district level has changed the human resource position in the health sector.
- Many of these facilities do not have reliable access to water, electricity and communications.

Determinants of USAID Assistance to the Health Sector

When Timor Leste achieved its independence in 2002, similar health sector statistics to those described above painted a very bleak picture of the status of women and children. In response to this, and to the government's established priority of ameliorating its very high maternal and infant mortality rate, USAID conducted a series of health assessments in 2004. The outcome of these assessments was to intensify the existing USAID contributions to the health sector, which at that time were focused on providing support to the Café Timor cooperatives and the health services they provided. As part of its bilateral program, USAID Timor Leste let a four-year assistance award to two USAID global projects, IMMUNIZATIONbasics and BASICS, to provide technical support to the MOH to extend effective, proven newborn and child health interventions throughout the country. At the beginning of 2005, the two projects planned the Timor Leste interventions, and activities started soon after.

B. Initial Project Design

Assumptions of Operating Conditions

TAIS was designed at a time of great optimism in Timor Leste, when there was a heady sense of independence and the belief that all things could be possible. This colored some of the basic assumptions that were the foundation for program design. Among these assumptions were:

[1] Full citation is Pp 49-57 in Zwi AB., Martins J., Grove N.J., Wayte K., Martins N., Kelly P., and Timor-Leste Health Sector Resilience Study Timor-Leste Health Sector Resilience and Performance in a Time of Instability. Sydney, The University of New South Wales, www.sphcm.med.unsw.edu.au/SPHCMWeb.nsf/page/Timor-Leste

[2] It is interesting to note that the newly published resilience study used data from 2005, which are the newest data available.

- TAIS would be responsive to the MOH requests that activities be district focused, with core technical advisors rotating among districts so as not to create an artificial dependency among district health staff on external advisors.
- TAIS national staff would be recruited from an existing pool of available experienced health workers because of the reduced government health service staff after independence. It was expected that they would be able to function independently at professional and technical levels though the project planned on mentoring and on the job training in the most recent child health interventions.
- During the early days of TAIS, the Ministry did not want workshop-based trainings which would take people away from their work. Thus TAIS assumed they would need to use a hands-on approach, onsite learning and support from regional staff with a clinical skill base to mentor the national staff.
- The full extent to which the use of four languages (Portuguese and Tetun as official languages, English and Bahasa Indonesian as the "lingua franca") would be an obstacle to training, communication, and project functioning was not appreciated in general.
- The program did not anticipate such extensive assistance to the Ministry of Health on the revision and clarification of basic national policy frameworks at the central level and expected to immediately work at the district and sub-district level.
- Health service delivery infrastructure was sufficiently developed so that the project would be able to emphasize mentoring health staff within the districts and be able to pay attention to quality issues.
- Staffing the project with both national staff and international team members could be accomplished in a very short time frame and the team would stay fully staffed for virtually the entire life of the project.
- Progress toward project objectives would be able to be captured at a population level and through the use of national survey instruments implemented by partners such as UNICEF. The project also expected to use the national HMIS as part of its monitoring and evaluation efforts.
- There was good coordination and liaison between the various groups operating in the child health sector in Timor Leste.

Child Health Interventions

In late 2004 and early 2005, senior staff from the two projects developed the Scope of Work for the project, in collaboration with the USAID Program Officer, Dr. Chip Oliver, and with input from the Ministry of Health, including the Minister himself. TAIS was designed to do the following:

- Assist the MOH to deliver an integrated package of proven child health interventions tailored to the epidemiology and causes of mortality in Timor Leste (malaria and childhood respiratory infections/pneumonia, diarrhea and malnutrition), delivered through the MOH health facilities in partnership with local community-based organizations.
- Build the capacity of selected, existing local organizations and leaders to reach households with information and advice, and also selected curative interventions, especially in those communities with poor access to formal health services.
- Assist the MOH or NGO partners to strengthen clinic management of common childhood illnesses (IMCI), particularly addressing quality of care and improved referral from the communities to health centers, and from primary health care facilities to first referral-level hospitals.
- Promote the package of proven child and newborn health interventions at the community level.
- Strengthen national policies on malaria treatment and diagnosis (including sponsoring drug-resistance studies to inform policy-makers), as well as expand the distribution of bed nets for young children.
- Establish guidelines for conducting high-coverage, high-quality, integrated fixed, mobile and outreach services for immunization, clearly defining all the roles of the community leaders, promoters and health staff.
- Develop and introduce immunization content into the training of existing and new cadres of managers, health staff and community health promoters.

The specific set of clinical and public health interventions described included:

- Malaria prevention (ITNs) and treatment
- Nutrition: breastfeeding, complementary feeding, feeding the sick child, micronutrients, growth promotion
- Pneumonia prevention (measles vaccine, vitamin A) and treatment
- Diarrhea prevention (hygiene, sanitation, hand-washing promotion, infant feeding) and treatment (ORT, revitalized ORS and zinc)
- Newborn/neonatal (initially loosely described pending greater collaboration with HAI)
- Primary immunizations

The work was expected to be done at the district and sub-district level, including fielding teams who would be resident in the districts. The original design was based on a phased approach to coverage and planned to start in three or four districts and ultimately reach national coverage by the end of the project.

Summary of Original Strategies and Approaches

Continuous Coverage and Quality Improvement Process (CCQI)

The TAIS team designed CCQI to increase the coverage of the clinical interventions and to improve the quality of services. This is a process by which district and sub district-based health teams can assess their current situation (using mapping, data analysis, records review etc.), analyze the findings, decide on interventions to address the identified problems, implement the interventions, and then re-assess the impact of those interventions on the problem. Each DHS selects its priority area on which to focus on first. Manatuto chose child health nutrition concerns and Baucau focused on immunization. The CCQI process is modeled and facilitated through learning-by-doing at the district and sub district levels; support from TAIS facilitation teams is provided on a routine basis to allow the district and sub district teams to increase their ownership of the process. There are four phases in this process:

1. Introduction: Briefing on the process and purpose of CCQI
2. Situation analysis: Data collection, assembly and analysis,
3. Decision making: Prioritizing problems to tackle based on gap and constraint analysis, idea (solution) generation, standard-setting for solutions, action planning for implementation and monitoring.
4. Implementation: Review and analysis of decisions and results including engaging with communities, and expanding coverage and quality through continuous monitoring

The CCQI process included rapid data collection to review the quality of care for specific child health interventions at the start, and / or used existing data such as from the IMCI Review or other surveys; it did not depend only on the public service statistics. The step of CCQI which would normally have addressed current practices or performance according to the particular child health standard (intervention area) has not yet been implemented – hence the ongoing facility monitoring data collection has not been undertaken, although it is a part of the CCQI process.

Community Mobilization Program

TAIS defined its community mobilization efforts in the following way: "CMP is an information-based strategy that begins with a process for learning with communities about their needs and expectations for health services; it also encompasses current health-seeking practices, preventive actions, and home-based care. Ongoing consultation and dialogue are core components of the CMP strategy so that initiatives are locally defined, do-able and inspire the participation of multiple audiences. To be successful over time, the strategy requires local commitment and leadership as well as the availability of reliable, accessible, quality health care." The strategy involved all the traditional local groups, such as the churches, schools, xefi *suco* and other administrative units found at the sub-district and village level. Once the concept of the Family Health Promoters was legitimized by the Government of Timor Leste as its primary outreach strategy, TAIS has played a role in FHP training and program planning and management.

Tangible Results

USAID and the United States Embassy, along with the Government of Timor Leste were eager to see immediate results from their investment in child health. They supported the distribution of insecticide treated nets (ITNs) as the most tangible way to have impact. The project designed an innovative strategy that linked local administrative units and the community for the distribution of the nets. TAIS also paired up with an international NGO, Catholic Relief Services, to help manage this process. By October, 2005 six months after the project began, teams were already distributing bed nets.

The distribution of ITNs was taken up on a large scale very quickly. An elaborate multi-stakeholder strategy was used for the purpose, and the intervention was implemented as a rolling campaign, completing one district after another, attempting to reach every child less five years of age. This complemented an intervention by the MOH and other development partners to distribute similar bednets to pregnant women. The well-thought out multi-stage strategy involved community volunteers and chiefs of hamlets (*aldeia*), as well as other community leaders, and the District Health System.

Following initial orientation and training, the *aldeia* chiefs and volunteers identified and enumerated households having children in the target age group, and the bednets were supplied to the aldeia chiefs to give to these families. This was accompanied by a wide-ranging behavior change effort that informed communities about malaria, mosquitoes, the control of mosquito breeding and the correct use of bednets, in addition to several topics and "messages" related to child health and nutrition. An inbuilt monitoring system based on a simple questionnaire used by the volunteers and *aldeia* chiefs completed the process. Once a district was completely covered by such a process, TAIS took on fresh district. Currently, of the seven districts for which TAIS had assumed responsibility, ITN distribution has been completed in five, with minor variations in the process followed.

Internally conducted rapid assessments on large, representative samples in two districts (Baucau and Manatuto) have revealed very high levels of use of bednets for children. Field observations by the review team and an examination of the tools used for the surveys suggest that these estimates may include use of bednets other than those distributed by TAIS. These high levels of use need careful documentation to make useful lessons available to other similar ITN distribution programs. The behavior change approach to ITN distribution yielded important lessons for community mobilization that can be applied to other child health behaviors for communities and households.

C. Changes 2004-2007 and Current Project Framework

Globally, development projects undergo a series of iterations and design changes as they are implemented. This is a rational response to changes in the operating environment and to differing levels of success or hardship than originally assumed. TAIS is no exception to this general rule: the current project is different from the one that was originally designed. While the intent is still the same ("to extend technical support to the Ministry of Health and to provide effective, proven newborn and child health interventions throughout the country so as to have a positive impact on child and newborn mortality within a five-year time frame"), the way in which the project has been implemented has changed. Some of the changes include: a more policy oriented focus at the central level for these first two years, working in fewer districts than anticipated, and greater exploration of community based approaches rather than facility-based interventions

In implementing this child health program, TAIS has dealt with changes in its operating environment. Some were unforeseeable, i.e., the arrival of the Cuban Medical Brigade, others were anticipated (e.g. continued progress in the health sector development) but at a pace out of sync with TAIS program planning. The section below discusses the changes over the last two years in the project parameters in greater detail, as well as how the current project framework will serve as a platform for the next two years of activities.

Changes in the Operating Environment

Staffing

The project planned for TAIS national staff to be recruited from the existing pool of experienced health workers. It was expected that they would be able to function independently at a sound professional and technical level. While the essence of the assumption is the same, i.e., that national Timorese staff will deliver most of the technical assistance under the project, the creation of a cadre of staff has proven to be difficult. What was underestimated was the coaching, training and mentoring that would be necessary before the staff could operate at an appropriate level of competency. TAIS has spent consultant time in supporting the technical growth of its line staff, and the technical director has also been responsible for mentoring staff. A longer term intermittent consultant was eventually hired as afield operations support officer to provide more mentoring of the technical teams in the districts.

What was also not adequately anticipated was the difficulty in identifying qualified candidates for the positions and how long it would take for the project to get fully staffed. It was also not anticipated that once the staff were trained, they would leave; at least four technical staff have gone to other posts in the Ministry of Health or to other international agencies. TAIS thought that its original compensation package was equitable in terms of other market opportunities, but now the salaries and compensation package are below market and threaten the project's ability to find and keep good staff.

International Staffing

To get international staff for TAIS was more complicated than expected. The Chief of Party (COP) did not arrive in country until the third quarter of 2005. The Finance and Administration Director arrived a the same time. The Technical Director not until April 2006. Immediately after her arrival, the security situation deteriorated, and the international staff were evacuated for one month. Thus the full complement of international staff has only been in place for little over a year. In addition, because of the need to begin technical work immediately, TAIS had an extensive set of consultants arriving in-country (see Annex One), which made it difficult to establish a sense of continuity with MOH partners. This has been significantly reduced with the arrival of the Technical Director.

Language

Language is more problematic than anticipated. The language of clinical and technical training remains Bahasa Indonesian, with an increasing amount of Tetun. The language of conversations, except at the highest ministerial order is also Tetun or Indonesian. The team's long-term expatriates speak either Portuguese or Bahasa Indonesian, and two of the current long-term local consultants speak Tetun. While senior expatriate project management has made some effort to learn Tetun, overall the language issue has been problematic. It has been difficult to recruit trainers who have the requisite clinical background and who can speak the right languages. It has also been a bit difficult to communicate intra-team. For meetings, workshops, and materials development, extra time and expense have been incurred because of the need for translation. Interesting, now that the Cuban doctors are in place, some of the materials from the Ministry of Health are also being translated into Spanish, although this doesn't affect TAIS.

Data for Project Monitoring

The national HMIS has proven to be too weak to use for project monitoring. There have been at least five consultants (none from TAIS) advising the MOH on the revision of the national data collection program in as many years. The current system has been in place a year, although problems were identified within the system before it was officially adopted and prior to training district staff in its use. While there is now a sensible process in place to re-build the HMIS, the system remains problematic and has certainly affected CCQI, since it relies on regular, reliable data collection. In addition, the data collection schedule for the national level surveys such as MICS and DHS has changed, making the relative evaluative nature of the information less useful to TAIS.

The CCQI process will use facility data, and capitalize upon data already collected for reporting, but may go beyond that in terms of clinical indicators. This process can also be expected to improve the actual reporting and to encourage use of the existing data, which commonly also results in improved reporting.

Both the tools for the rapid assessment of the quality of care and the monitoring tools developed in the CCQI process are adapted from existing program supervision tools.

MOH and National Policy Frameworks

TAIS has spent significant amounts of time over the last two years at the central level in supporting MOH in the revision of key child health policies. This was a very necessary and vital step as policy, strategies, and standards needed to be clarified before the planned work at the district level could begin. It is only now, with the planned roll-out of the Basic Service Package, which incorporates many key child health interventions supported by TAIS that the project will be able to redirect most of its energies to the district and sub-district level, as originally planned.

Collaboration among Partners

While TAIS has collaborated well with the MOH and partners, this has not been seamless. Particularly in the first months, some agencies were very protective of their "territory" and suspicious of the new entrant into the technical assistance arena. The project has had to find alternative and less direct ways to work within the MOH. TAIS has used the concept of an "open door," i.e., when another agency begins an initiative (opens a door), TAIS can then find a way to complement that initiative with some of its own planning and technical assistance. The recently completed Reproductive Health Behavior Change strategy done by UNFPA and the Department of Health Promotion is one example of this. There is now more understanding among key partners on the importance of a BCC strategy. TAIS should be able to use some of the same strategies and frameworks to get out messages for child health. At times, there has been extra energy required by the TAIS team to build the collaborative efforts, especially when they have to clarify that they are not an NGO but a technical assistance project.

Development of the Health Sector

There have been significant developments in the health sector that affected the way TAIS has operated over the last two years of project implementation, such as the introduction of the Cuban physicians. At this mid-term junction, there are many more anticipated changes currently taking place in the very dynamic health sector. Implementation of the Basic Service Package will begin by the close of this year, the first Family Health Promoters are already in the field, and the government is moving towards other macro-changes, including looking at a sector-wide approach in the health sector supported by AusAID and the World Bank. There is also the prospect of further governmental decentralization with the creation of 31to 43 municipalities.

Cuban Medical Brigade

When the project was designed, there was no anticipation of the Cuban Medical Brigade and its impact on basic health services in Timor Leste. The Cuban Medical Brigade provides clinical medical staff to hospitals and health centers throughout the country. Given the coverage of the Cuban Medical Brigade and its initial reluctance to adhere to the established norms of IMCI, there was unanticipated work for TAIS to support the MOH in the institutionalization of IMCI as a national clinical norm. TAIS has also had to alter its community outreach strategies to account for the placement of the physicians in the districts, as they have become an additional resource, although not necessarily one that is fully integrated into the existing MOH initiatives. TAIS now enjoys closer relations with the Cuban Medical Brigade, sharing technical materials in Spanish with them, and they are participating in some of the Ministry technical working groups with TAIS.

Development of the MOH capacity

TAIS had planned on counterparts from the MOH having a greater technical capacity and also being more available. Technically, the capacity of the MOH has been steadily improving over the past two years, as has their authority, as shown by their decisive and strong management of health services during the April/May 2006 crisis and grasp of the Basic Services Package rollout process. However, each key department remains very lean, and TAIS has not been able to draw as much as anticipated on the ministry staff for timely technical decisions and regular updating. One of the reasons is that TAIS is competing for time with many other NGOS, who also need to draw on the same small group of Ministry staff.

One of the primary venues for interaction remains the various technical working groups. The technical working groups include donor technical advisors and act as MOH-operated Inter-agency Coordinating Committees (ICC). Working groups are part of the MOH formal structure under the Health Sector Strategic Plan (HSSP). The review found that the working groups were a key venue for TAIS to contribute to the government goals, policies and strategies and to get the attention and coordination they needed from counterparts to move forward on initiatives.

Roll-out of National Policies and Initiatives

Because Timor Leste is a young country and has received extensive external support, there was more development of key policies and strategies than TAIS originally anticipated. Under the HSSP, the MOH has adopted 57 strategies, prioritizing immediate attention on 32 cross-cutting strategies, of which 17 form an essential core in 10 priority areas of work. These priority areas and related core strategies are intended to be the major focus for action by the MOH and its partners over the next five years: 2008 through 2012.

Of the 10 priority areas defined in the HSSP, the TAIS project has in-country and corporate skill and experience in seven key areas: health services delivery; behavior change/health promotion; quality improvement; human resource development; institutional development; gender equity; and research. These are all within its child health mandate. TAIS had a major role in the development of detailed service and program policies and primary health strategies, including the integrated management of childhood illnesses, nutrition for children and adults, immunization for children and women, health promotion and education, and communicable diseases. These are all now set out in the HSSP.

The MOH has completed work on the Basic Services Package (BSP), its vehicle for improving standards of care for maternal and child health and HAST (HIV/AIDS, STI, TB) services at all health facilities. Key critical resources will determine the effective implementation of the BSP: health human resources and HR development, supplies and logistics, and the full funding of health worker travel allowances, per diems, and other travel and transport costs. The MOH expects that service delivery improvements and the use of Family Health Promoters will increase utilization rates for antenatal care, Basic Emergency Obstetrical Care (BEOC), deliveries, postnatal care, child health services and reproductive health and family planning. TAIS had a crucial role in defining the BSP child health interventions to meet the MDG4 to reduce child mortality.

According to senior advisors at the MOH, the BSP is “the bible” and will guide all facility and clinical interventions from now on, thus TAIS will need to frame all its activities within the context of the BSP roll-out. It is planned for completion by the end of 2008, with all health care facilities “BSP-ready3” by 2010. A major BSP focus is on strengthening facility-based service delivery; a strategy the review team believes is at odds to reaching vulnerable and remote populations or MDG goals. However, TAIS can, in its advocacy role, promote outreach4 strategies and implementation as a way to reach these underserved populations.

When TAIS first began in 2005, there were very few systems and processes in place at the district level and capacity was limited, thus they were encouraged to begin implementing CCQI at the district level. The review team heard that many senior MOH officers and department heads saw CCQI as overly complex and difficult to understand. However, both the district health management teams (DHMT) using it and the TAIS national team reported on its usefulness. Feedback received during the review included a district manager saying that the CCQI process allowed his staff to independently begin to identify and solve their own problems, rather than always rely on his intervention. When interviewed, TAIS staff noted that they could see visible signs from the use of CCQI, such as coverage maps on display in the health centers.

[3] HSSP MOH Timor Leste, Final, 1 August 2007

[4] Called “mobile clinics” in Timor (TAIS could also promote a broader the definition of outreach as used in other countries – bringing services away from facilities and closer to where people live, by car, boat, bicycle, or on foot.)

Now the government has articulated a similar but different system for performance monitoring and improvement to be put into place under the BSP roll-out. TAIS' job will be to provide its lessons learned from 18 months of implementation to influence the steps under the BSP rollout, and create a harmonization of the approaches. In planning the roll out, the MOH managers decided to institute BSP in different districts to avoid direct interference with parallel activities already being implemented by TAIS. Reportedly, TAIS did not participate in the early planning stages for the roll-out, although invited. TAIS staff acknowledge this was an oversight, which has already been corrected through the review process. TAIS now views the roll-out as an opportunity for TAIS to gain momentum in joining this rapid multi-district expansion in 2008 (and 2009).

Continuous Coverage and Quality Improvement under TAIS shares the same fundamental methods and approaches to improving the management of health systems and the quality and coverage of key interventions as is now proposed under the BSP district team problem solving (DTPS). The review team noted that both approaches are missing some key steps and has made recommendations on what to do to remedy that lack. Harmonization will combine the strengths of both, and use of the TAIS field experience to further refine the proposed processes and will create a much stronger approach or strategy available to the district health teams. CCQI brings an emphasis on sub-district service delivery, rapid clinical assessment and analysis, and clinical standards to the BSP- DTPS process, which is stronger in its emphasis on district planning. Adding quality and standards strengthens district action planning, and expands scope for annual activity, with self assessment at sub-district level.

The MOH considers this CCQI/BSP harmonization as a high priority for the roll-out. As an immediate outcome of the TAIS midterm review, high-level members from the BSP support group met with the TAIS CCQI team and the review team consultants. The outcome from this meeting and others was an agreed-on BSP-CCQI harmonization matrix that includes the value added, benefits, implications, and the agreed steps for implementation (see Annex Two). This harmonization process has been ratified by the full BSP support group, with joint teams set to continue working on the harmonization of tools and processes.

In addition to changes in CCQI, there will also be modifications to the community mobilization efforts. When TAIS was first designed, the Ministry was also just beginning to formulate the Family Health Promoter program. Now that the volunteers are being trained and seem set to be integral to the MOH program, TAIS will need to adapt its community mobilization efforts to include them. TAIS also needs to promote an approach that the local health staff is capable of supporting once TAIS ends and one that is effective in increasing community participation and engagement with health and other services. One key issue is that the FHPs will be limited in numbers, while the TAIS approach has been to mobilize whole networks including civil structures and local social organizations as well as *suco* leadership. TAIS will continue with this over the next two years.

Socio-Political Changes in the Operating Environment

Security

Timor Leste remains a fragile state. After the crisis of April and May 2006, which necessitated the intervention of the Australian Defense Forces and the evacuation of TAIS staff, the country has settled back into an uneasy peace, with frequent small flare-ups and incidents. The impact of this on TAIS has been significant. Among some of the results from the situation are:

- National staff have lost homes and possessions and have at times been unable to account for family members for days at a time. This is understandably reduced their ability to focus on project activities.
- Because of the East/West polarization at the beginning of the civil unrest, some TAIS staff were unable to work in their original sites and had to be shifted.
- The level of insecurity has created a sense of stress and at the same time disrupted the long work hours that would otherwise characterize a project such as TAIS. The office closes early so staff are not out after dark, field work has been disrupted, and activities have been moved to different locations and postponed.

- The key counterparts are also being affected adversely by this situation. Despite the health system's strong showing during the April/May 2006 crisis, the need to respond to the emergency is drawing away resources from routine but essential community health care. During the evaluation, interviews with some Ministry staff had to be repeatedly rescheduled because the officials were being called to emergency meetings on how to handle the needs of the internally displaced persons.
- The COP has had to devote significantly more time to security than anticipated, reducing the time that he can spend on technical support activities. He constantly monitors UN information, checks in with NGO security forces, and keeps the staff informed at all times of potential disruptions and incidents.
- Anecdotal data suggests that the civil disturbances occurring sporadically in 2006 and 2007 did not specifically target health facilities. Civil disturbances do however interfere with access to conflict areas and road travel safety.

Political Changes

The recent elections have resulted in a change of Minister and Vice-Minister in the health sector, as well other macro-political changes in the nature of the Parliament. While Timor Leste has demonstrated innovative management by having the former minister now serve in an advisory capacity, as a WHO consultant, the change-over will necessitate that TAIS re-establish working relationships with top management. In the time since the review team concluded its in-country activities, the Minister has already begun to pursue new initiatives. Thus, TAIS will need to adapt and work at the pace of its counterparts, even if this is different from the desired pace proposed by the two global projects.

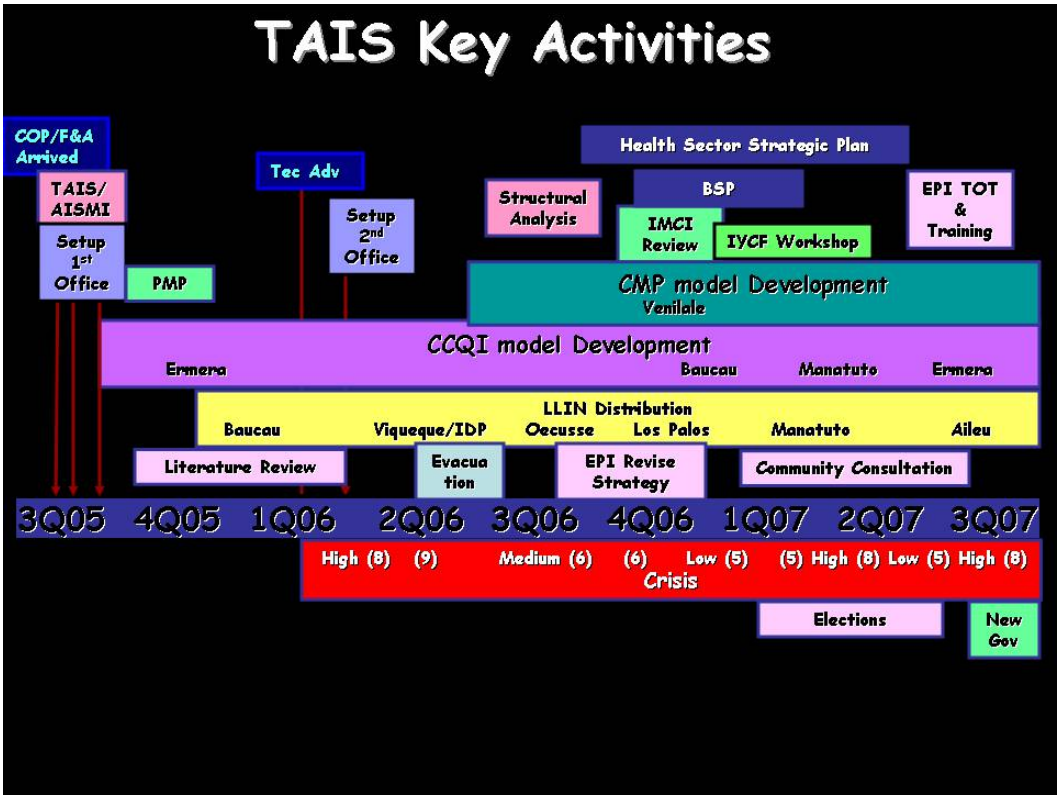
Decentralization

The Government of Timor Leste remains committed to decentralization, and there is a draft plan in place to revise the current administrative units into 31to 43 municipalities, even though its implementation timetable is undetermined. This continued focus on decentralization will mean that TAIS needs to redouble its efforts at the district and sub-district level in order to support capacity development among mostly newly appointed managers who will be working in an environment of greater autonomy. In the context of decentralization, expected to begin in early 2008, local-level administrations will prepare and submit health program plans and budgets for approval to the relevant MOH departments.

Thus TAIS will be implemented over the next two years in a politically fragile state that nonetheless continues to put major resources into the health sector. The MOH is forging ahead with implementing new national strategies to improve health and redress the severest health needs of a largely rural and poor population -- and TAIS will be its partner. Work will now shift from the policy-development phase, with its central-level emphasis, to more concentrated implementation of strategies and approaches at the district and sub-district level.

The TAIS team will draw on its 18 months of project implementation experience to ensure that these future activities continue to promote best practices and proven interventions in child health.

IV. TAIS ACHIEVEMENTS



A. Implementing Evidence-based Technical Interventions

Integrated Management of Childhood Illness (IMCI)
Using the working group for child health as a forum for discussion and relying on the presentation of evidence-based interventions, TAIS has played a major role in assisting the MOH in its IMCI review and in updating the IMCI protocols and associated materials. The national review was a four-month-long process, culminating in the workshop of December 2006. This national review led to a reaffirmation of IMCI within the Basic Services Package and agreement from all parties that health facilities would implement and promote IMCI. The review process was overseen by the IMCI Working Group (of which TAIS is a key member), which did the following:

- Carried out an IMCI health facility assessment (with TAIS staff participation)
- Reviewed existing data on IMCI implementation to date and relevant documents drafted in Timor Leste
- Interviewed key stakeholders
- Synthesized information from the IMCI review meeting group work sessions.

Because of its active participation in the IMCI review, TAIS remains committed to assisting the MOH in implementing the recommendations that emerged. TAIS has facilitated the transformation of the IMCI focus to a broader child survival approach and changed the IMCI working group to a child health technical working group (CHWG). This group, co-chaired by MOH and WHO, is currently undertaking the process of introducing technical updates in child health into the national IMCI program. The group includes several Timorese hospital doctors working in neonatal and child health, as well as the head of the Medical Association of Timor-Leste and a Cuban pediatrician. It is anticipated that this same group

could have a directive role in the future child health interventions proposed. This working group will also advance the importance of tackling the neonatal mortality rate with improved newborn care at all levels.

Another of the outcomes of the review was recognition of the need to continue training and follow-up supervision. As a result, TAIS has been developing the scopes of work necessary to bring on board IMCI trainers to facilitate this. At the end of the August mid-term review, the COP and the Technical Director were exploring regional networks in Indonesia in an effort to identify trainers for this initiative.

In addition to participating in the review, TAIS facilitated the presentation of the evidence and advocated successfully for the addition of zinc in the treatment of childhood diarrhea. The CHWG successfully worked with UNICEF to ensure the purchase of sufficient zinc to initiate that introduction. The first use of zinc is now planned for early 2008.

Recommendations for future activities in this area include:

1. TAIS should ensure that nutritional messages are linked with diarrheal disease messages
2. TAIS should advocate to the Ministry to consider scaling up diarrhea case management (ORT, including zinc) using the combined community and facility approach. Given Ministerial consent, TAIS could plan to implement this throughout the whole country by the end of TAIS.
3. TAIS should collaborate with the filariasis and de-worming distribution of the MOH and WHO to build stronger community networks for such additional interventions such as the distribution of zinc to combat diarrheal disease.

Malaria and ITN distribution

The TAIS approach to ITN distribution integrates community mobilization with health education, empowerment and local capacity building; it has successfully mobilized and coordinated a community-based network of existing volunteers (including FHPs) to focus on ITN distribution and malaria prevention, including education on treatment options. The ITN intervention has been completed as a one-time intervention in five of the seven districts envisaged (Baucau, Los Palos, Viqueque, Manatuto, Oecussi), with Aileu almost complete and Dili to follow. Among the characteristics of this approach are:

- More than a campaign, it reinforced the health system although it did not limit distribution to health centers
- Nearly 77,000 nets distributed for children <5 years
- Documented use rates (for the previous night) of 80-94 percent.

This effort successfully motivated sub-district and *suco* leaders, and activated their role in child health while also empowering them and generating a feeling of ownership of the process. By doing so, TAIS helped to engender local civil accountability for child health. These community networks in the TAIS ITN distribution districts have the potential to take on other CH interventions like diarrhea.

In a follow-up to the distribution, TAIS found high use rates and family understanding of importance of bed net use to prevent malaria. Of all the nets distributed, only 15 were unaccounted for, which is an extremely low loss rate. To capture that level of detail, TAIS used the enumeration data provided by the aldeia chiefs to track the nets by family; this database was so extensive that the Government used it in its Global Fund application process.

Despite this success, TAIS did not fully exploit this community mobilization approach for ITNs. The distribution was not effectively linked with the health facility component of treatment; e.g. community mobilization for ITNs could have been used to spearhead more awareness of where to go for treatment and malaria danger signs. If CCQI had focused on malaria case management at community health centers (CHC) and health posts in those districts where ITN distribution took place (rather than addressing other interventions such as EPI in those districts), then there could have been better bridging between community and facility.

Recommendations for this area:

1. TAIS should conduct a careful assessment and documentation of this distribution effort since it is sufficiently ground-breaking, particularly as it is the only intervention with clear large-scale community-level outcome in the TAIS program to date. This assessment would lead to understanding of program impact and how best to document the process. This should be evaluated soon; otherwise it may be difficult to document the exact nature of the TAIS inputs, particularly since ITN distribution may be overtaken by other initiatives from other players.
2. TAIS should contribute to USAID-sponsored publications so the Timor Leste experience could be studied and used in other districts and countries.
3. TAIS should better link the remaining distribution efforts of bed nets with the health facility component of treatment, using the newly integrated quality and coverage process coming from the BSP roll-out and harmonization.
4. TAIS should study epidemiology (malaria incidence in <5 years old) to capture impact of ITN use or monitor malaria incidence in children under five years to assess impact of ITN use.

Essential New Born Care

Perhaps the most important contribution of TAIS to Essential Newborn Care (ENBC) to date is its efforts on the inclusion of newborn care interventions in the BSP and the contributions made in the MCH working group. A community consultation exercise taken up by TAIS in the first half of 2007 has provided a wide range of detailed information related to newborn care practices in the communities, which should help inform a behavior communication strategy for enhancing home-based newborn care.

TAIS has been a contributor, along with HAI and WHO, to strengthening newborn care in facilities, including participation in the first training of MCH Coordinators and facility midwives in essential newborn care. TAIS coordinates very closely with HAI for interventions in the newborn health, including using the same expert consultant, which contributes to the coordination and integration of project activities to overall MCH activities.

In the near future, TAIS, working together with the MOH, Timorese medical staff, the Cuban Medical Brigade and other child health working group members, proposes to facilitate a process of quality improvement for pediatric care in referral hospitals and other smaller health facilities with pediatric inpatients throughout Timor-Leste. The process will be consistent with the current directives of the MOH as outlined in the HSSP and Basic Services Package. TAIS has already started this process through procuring consultant services and developing a proposal that included consultation with all key members of the national health team.

The review team noted that there does not appear to be a clear and comprehensive operational strategy for combating neonatal mortality within the BSP or TAIS. The community-based treatment of neonatal sepsis is one proven strategy to rapidly reduce neonatal mortality in high-mortality situations, but there does not appear to be enthusiasm for community-based workers taking on the treatment of illnesses.

Recommendations for Essential Newborn Care include:

1. TAIS should consider assisting the MOH with regional WHO offices (such as Indonesia) to improve the quality of case management in district hospitals, especially for newborns.
2. TAIS can and should contribute to an acceleration of strengthening institutions, including health posts, so that they can handle birthing as well as the care of premature/LBW and sick neonates. Skilled birthing and immediate postnatal/neonatal care can go a long way in reducing neonatal mortality.
3. TAIS should promote essential newborn care for babies born at home. Such care is simple and includes, at the minimum, the preparation of the family when the mother is pregnant, followed by close support at home at and immediately after birth. If the identification and extra care (or referral) of the premature/LBW, as well as the diagnosis and referral/treatment of sick babies can be added on, the "yield" would be substantial.
4. TAIS should work to develop clarity on the role of the FHP in reducing newborn mortality. Until such time the BSP reaches its goal of the majority of births being at facilities, it will be necessary

to simultaneously reach out to homes where births are taking place (with at least sound information and advice), and to potential referral centers (to strengthen services). The current assumption appears to be that the FHP will be responsible for any outreach care to families, but there is little clarity about how this is linked to the health infrastructure. Potential candidates for delivering these services at home are the nurse or midwife at the health post (who can take care of births occurring in at least the closest *aldeias*), and the FHP (who are more likely to be close to woman in labor in an *aldeia* that is far from the health post).

5. Advocate for specific changes in potentially harmful policies, such as the non-acceptance of skilled attendance for home births and the recommended postnatal visit at seven weeks, which is one week before the baby is eligible for several vaccinations.
6. TAIS should consider exploiting the volunteer network of the kind used for ITN distribution to promote support for ENBC. ENBC would provide an excellent opportunity to test the ability of such networks to provide ongoing and timely support.
7. After a limited time period of trying these various alternatives, TAIS should provide recommendations to the Ministry on which of these community mobilization efforts and use of FHP are most effective in promoting essential newborn care.
8. TAIS should work with HAI to promote the active management of the third stage of labor as an element in any midwifery training, particularly since Timor Leste has already begun to include this in its training courses. With the arrival of the new nursing and midwifery staff to work with the European Union project in curriculum development and review basic standards, this could potentially be an opportune time to promote an excellent quality-driven intervention in health facilities.

Nutrition

A number of efforts have been made by TAIS in preparing to take on the challenge of implementing the Infant and Young Child Feeding (IYCF) components of the Essential Nutrition Actions in Timor Leste. The clear recognition of the importance of combating malnutrition in the BSP was a result of the advocacy efforts of TAIS. TAIS has also been a key member of the nutrition working group of the MOH since the time TAIS began operations. The project seeks to particularly focus on behavior change for improved infant and young child feeding (exclusive breastfeeding and complementary feeding) and greater coverage of vitamin A supplements and growth monitoring. By design, the CMP approach is to be used for the former and the CCQI for the latter. In the last eight months, the team noted that activities have lagged in this sector, in part because there is so much to do in each and every sector of child health.

In early January, 2007, TAIS facilitated the national IYCF workshop which set the stage for refining IYCF guidelines and norms. Following the national IYCF workshop the nutrition working group, with the help of the newly arrived nutrition advisor, developed a short list of priority nutrition messages. A recently concluded community consultation exercise explored the roots of behavior related to these messages, and has yielded substantial information about current infant feeding practices. This can and will inform a comprehensive behavior change communication strategy. The TAIS team recognizes that paying attention to operational detail will be crucial in improving infant feeding practices. What is crucial in changing child feeding practices is timely, responsive interactions with the family on a one-to-one basis. Other channels of communication can supplement but not replace this approach, except perhaps after substantial improvements have occurred in communities.

During field visits, the review team observed community based growth promotion (CBGP). They noted health staff making errors in interpretation of growth charts in an otherwise excellently run health post in Manatuto. The monthly growth monitoring session presents an obvious opportunity to strengthen growth promotion but there are real dangers of such exercises deteriorating into weighing sessions for merely detecting malnutrition (for the sake of reporting a task done). Since the quality and frequency of EBF and CF appears to be almost universally poor, and malnutrition rates uniformly high, there may not be much point in trying to detect children who falter in growth and therefore need attention: most likely, all children need attention. The IMCI and EPI standards of care have been updated and are clear, but the Essential Nutrition Actions including IYCF standards need to be clarified at national level for implementation in sub-districts and communities.

In terms of vitamin A distribution, the review team noted that currently, while well-designed service registers (such as the immunization register) do exist in at least some health posts, apparently vitamin A doses are not recorded in registers, but in tally sheets. This makes it impossible to tell what proportion of the target population received vitamin A. What is also lacking is any census of families at the health post to provide the confidence that the denominator is indeed fully captured, even in immunization registers. However the MOH has made efforts to provide good population estimates from the National Directorate of Statistics and the HMIS has calculated the estimates for the sub-districts.

Recommendations for essential nutrition actions are:

1. To better sustain community-based growth promotion, TAIS should address barriers to behavior change. While FHP or volunteer networks can be communicators, they may not be reliable when much specificity is expected and a combination of efforts by the nurse/midwife and volunteers (guided and supported/supervised by the nurse) may be a practical solution.
2. TAIS should focus on the rationale for growth promotion so sub-district staff understand that counseling on feeding practices is essential. Insights from the community consultation should be very helpful in preparing job aids and training on nutritional counseling and negotiation. To get this, staff need to think of finding the best environment in which to have a quiet conversation with the mother about feeding, away from the crowded central location of the weighing session.
3. TAIS should work with the HMIS consultants to ensure that there is a strong monitoring system capable of tracking feeding behaviors and the tasks planned to change such behaviors. This needs to be carefully developed and integrated with the BSP.
4. To maximize the efficacy of vitamin A distribution, TAIS needs to advocate to district health teams to ensure the capture of all existing children in the service register at the health post (the denominator), and to ensure the dosing of all eligible children on the scheduled day.

Immunization

Table 1: Key Immunization Indicators in Timor Leste

Indicator	2006	2005	2004	2003	2002
Measles cases	90	203	41	94	
Measles coverage	64%	48%	55%	55%	39%
BCG coverage	72%	70%	72%	72%	66%
DTP1 coverage	75%	64%	65%	65%	62%
DTP3 coverage	67%	55%	57%	57%	44%
Reported NNT cases		6	0		0
Protected at birth (TT2 coverge)		45%	40%	37%	35%

Source: WHO/UNICEF August 2007

Immunization services are an integral part of the child health services provided by 65 health centers and some of the 181 health posts in districts and have been since the inception of the TAIS project. The Health Sector Strategic Plan for the Ministry of Health establishes the immunization policy framework for the next five years 2008-2012 and will frame the future assistance that TAIS will contribute. The HSSP targets include a national DPT3 immunization coverage of 85% and the elimination of maternal and neonatal tetanus by 2008. The MOH has specified immunization as priority MDG4 intervention for implementation in the Basic Services Package - integrated with other linked interventions. In the BSP and decentralization roll-outs now taking place, immunization remains a key intervention and will continue to be a focus for TAIS. In Baucau in 2006, and in Manatuto in 2007, immunization was self identified as a priority problem area to be addressed in the district through use of the TAIS CCQI process

The TAIS project has had a role in the development of the Timor Leste National Immunization Program (NIP) since the earliest days of the project. TAIS project consultants identified and detailed poor health worker practices, and limited outreach service provision, inaccurate interpretation of multiple

immunization schedules, poor vaccine cold chain and waste management, and inadequate recording, monitoring and reporting of immunization as key problems for immunization provision. This early work informed the development of EPI training material by UNICEF. TAIS is providing continuing TA to conduct, support and assist the training process and its evaluation. TAIS has collaborated with UNICEF and WHO on the development of tools for better estimating immunization coverage, job aids and decision making tools for health workers. TAIS also contributed to the Reach Every District (RED) strategy training. Despite this long input, the review team noted that the TAIS national and district technical officers still have basic technical knowledge and skills deficits in immunization quality and services. The review team was pleased to note their EPI technical skills are currently being upgraded by the national EPI training for trainers.

The NIP engages with donors and partners through an informal EPI Working Group (EPIWG) that meets irregularly with MOH, WHO, UNICEF, TAIS, and the Institute of Health Sciences participation. Cooperation and collaboration with the TAIS project team was reported to be close and effective. One issue facing the NIP now is the proposed three rounds of supplemental immunization activities targeting 222, 500 women 12-45 years of age with tetanus toxoid vaccine to raise TT2 coverage sufficiently to eliminate maternal and neonatal tetanus by 2009. Senior MOH advisors are concerned that campaigns of this nature divert human and material resources away from routine immunization, with possible damage to the current effort to strengthen routine services. TAIS can have a role in ensuring that supplementary immunization activities are used to strengthen routine immunization and other outreach services through a RED approach. The NIP is also planning to apply for GAVI funding for New and Underused Vaccine Support, Health Systems Strengthening, and possible Immunization Services Support

Recommendations for the TAIS Immunization efforts:

1. Continue to provide TA for the development of national-level immunization policy, including the immunization schedule and new vaccine introduction, injection safety and waste management. TAIS should try to improve the capacity of the national immunization program manager to provide technical and operational support to district activity.
2. At the district level, TAIS should facilitate the replication of the existing TAIS/UNICEF/MOH EPI training activity to all districts as part of a cyclical district training package of key child survival interventions within the BSP and CCQI roll-out framework.
3. TAIS should support the identification, recruitment and training of national EPI trainers to deliver training courses for district and sub-district health workers in all districts by 2009. This assumes that it is possible for local in-district recruitment via churches (CRS method) and NGO poaching and then training in upcoming training events. Prior to this, TAIS should review the training material in late 2007 and propose revisions based on lessons learned.
4. TAIS should assist the NIP to strengthen routine immunization services through selective support to supplementary immunization activities, such as the proposed MNT campaigns, collaborating with partners and targeting support to enhance routine service delivery and links to other CS interventions.
5. TAIS should facilitate and support the re-activation of outreach child survival services in districts as for delivering immunization services and other linked interventions to underserved and remote populations.
6. Based on the lessons learned in ITN distribution, TAIS should engage district administrations with advocacy, informal coordination, and information to facilitate the engagement with civil society networks to support immunization activities, particularly for outreach to underserved populations.
7. TAIS, through the EPI Working Group, should provide TA to support the NIP GAVI Fund application processes.
8. TAIS should participate in technical discussions on adding a birth dose of hepatitis B and defining the tetanus elimination strategy.
9. TAIS, as part of its project closedown strategy, should consider providing financial and technical support for an immunization coverage survey in late 2008 to help measure progress in the absence of an accurate or timely HMIS. Alternatively facility-based registry surveys may be useful for measuring immunization activity.

B. Implementing Strategies for the TAIS Project

CCQI

CCQI is one of two key strategies implemented by TAIS to improve the coverage of child health interventions and the quality of the services. It has been started in three districts to date: Ermera, Manatuto and Baucau. The work in Ermera was interrupted because of the civil unrest while the work in the other two districts has continued and is now in Phase 4 of the process when solution monitoring and progress review are implemented.

Over time there have been changes in both the language and the actual process of CCQI in response to feedback from the District Health Teams that were implementing it. District managers seem to be fluent in its concepts and there is evidence of greater use as a tool at the district level, particularly in Baucau. Despite evidence from the field that CCQI was appreciated and used, the review team found that it retains a reputation at the national level of being overly complex and difficult. The review team also found that some of the key components of the quality improvement process, such as root cause analysis for an identified problem, had not been emphasized to a verifiable and measurable level in the district analysis. This cause analysis step has been added to the sub-district level problem solving process. As TAIS has nearly two years of experience with district and sub-district problem-solving because of its implementation of CCQI (at least applied to child health components of BSP), the review team finds that this experience and field-testing of the related learning-by-doing process and materials will be invaluable to ongoing BSP implementation process.

Given the importance of CCQI and the harmonization with BSP, extensive recommendations are:

1. TAIS should carefully document its CCQI lessons learned in capacity development, use of tools and actual changes/results in performance of EPI and nutrition and apply findings to harmonization and strengthening of problem-solving approach and tools to implement BSP.
2. As a continuation of the process that started at the close of the mid-term review, TAIS should join the BSP team and contribute to the harmonization of the CCQI and District Team Problem Solving processes into one common process, with common implementing terminology, tools and methods for application in Manatuto and Alieu.
3. TAIS and WHO should work jointly to harmonize and agree on common framework, process, terminology and materials for district roll-out of BPS to assist the MOH in the process, initially in Alieu and Manatuto.
4. TAIS should assist the MOH in the development of the training approaches for the Technical Support teams for the BSP, with special focus on the child health interventions.
5. TAIS should also continue work in the remaining four districts within which it has been working and apply the harmonized method to initiate improved performance in child health components of BSP, ideally using a “twinning” approach to promote horizontal learning between paired districts.
6. TAIS should develop its own detailed BSP roll-out plan for the six districts in which it plan to work during the next two years, but also include within the plan, the initial transfer and facilitation of early implementation in the remaining seven districts after 2009, if that is congruent with the decided upon geographic scope.
7. TAIS should use the BSP roll-out of common tools and processes for district problem solving, quality and coverage improvement as an opportunity for rapid multi-district expansion in 2008 and 2009.
8. TAIS should use the district planning activity to focus attention and training for improvement on the key child survival interventions that have a direct impact on morbidity and mortality.

CMP

The primary achievement to date in community mobilization has been the activation of community networks to assist in the distribution of bed-nets. The behavior change approach to ITN distribution

yielded important lessons for community mobilization that can be applied to other child health behaviors for communities and households and to linking them with health facilities.

In late 2006 and early 2007, a consultant and TAIS's CMP team worked with local organizations and officials in Venilale sub-district of Baucau district to pilot a community listening exercise, in which local organizations and community member collected and analyzed information on breastfeeding and immunization. This demonstration activity encountered difficulties due to prolonged discussions over expected compensation for what were to be "volunteer" activities, an all too frequent issue in Timor Leste. The TAIS community team also elaborated the concept of community contracting to stimulate community involvement without the traditional individual incentives. While both of these ideas have much potential, on reflection it was felt that they were too human resource-intensive to be managed and sustained once TAIS ends. Thus, the CMP team is now examining other approaches and strategies more attuned to the reality of Timor Leste.

Another major TAIS effort in this sector has been the design and implementation of the community consultation and articulating those findings for future intensive behavior change. This process was a particularly rich source of information which will be used when crafting behavior-change child-health communication messages over the next two years.

In 2006, TAIS undertook an assessment of known information on 24 family and health-worker behaviors that have a major influence on child health. TAIS reviewed published and unpublished documents, and asked MOH, development-agency, and NGO staff to comment on a draft document. The assessment document listed each key behavior, essential sub-behaviors, and what is known about current practices, motivations and barriers, as well as important gaps in existing information. It also summarized known information on cross-cutting issues that comprise the context for behavior change in families and communities.

This initial step was followed up in 2007 by formative research on 13 of the key child health behaviors. This "community consultation" consisted of eight focus group discussions on the context of behavior change (mothers' tasks, schedules, independence, as well as a bit about the nature of communities and communication opportunities) in five districts, followed by in-depth interviews and trials of improved practices (TIPs) in 13 communities in Ermera and Bobonaro districts. In the TIPs, mothers were asked to try out new, improved practices for a trial period, after which the interviewers returned to get feedback on what people did, their perceived benefits and difficulties, etc. The findings were reported back to health and other officials in the two districts in July 2007, and the final report was ready for distribution in September. A series of dissemination meetings and discussions are planned.

TAIS also supports a staff person within the Health Promotion Department of the MOH. Her role is less that of an advisor in the technical realm and more of a line staff member. This role has not been as well defined as it should have been and while her services are well appreciated at the MOH, it is not immediately clear how she contributes to the day to day functioning of TAIS' work in behavior change. TAIS has also provided input into other behavior-change efforts being implemented by other organizations, for example providing extensive information and feedback to the long-term consultant from UNFPA who was preparing the MOH's BCC strategy for reproductive health. TAIS expertise (and access to BCC expertise and materials through TAIS partner organizations) is a resource for national health promotion department.

TAIS supported and accompanied the implementation of the pilot demonstration of the community health volunteer program, the FHPP. TAIS is considered a technical support resource for MOH in its on-going development of the FHP program, though the exact roles and tasks of the volunteers and how they will relate to the community networks of volunteers and civil organizations is not clear. The first FHPs started work in selected sub-districts in 2007 and six TAIS staff were involved in the early training. Planned training for the FHP in newborn skills was in the 2007 work plan but has not yet happened, and so far the planned TAIS training and interaction with them has been delayed. Currently, TAIS is examining how it can engage *suco* councils and community-level committees to serve as the spearhead for future

community mobilization, giving local people responsibility for their local area. TAIS feels it can play a role in supporting the village health committees, who in turn would create the bridge between communities, their FHPs and the health facilities.

TAIS plans to contribute to the development of national messages and BCC materials over the next two years. TAIS would also like to assist the districts in reactivating the concept of the village health committee and ensure that representatives from outside the health sector are adequately represented. Current plans for the next two years include dissemination and use of the community consultation findings, continued input into the child health messages and discussions with HAI on how TAIS can use the film developed by HAI to further awareness on neonatal health behaviors.

Recommendations in this sector include:

1. The community mobilization approach should be included in the harmonized framework of problem solving and BSP implementation.
2. TAIS should assist the MOH in determining the optimal relationship between FHPs and community networks that can be used for child health promotion and prevention.
3. TAIS should develop materials and methods to help institutionalize the role and contribution of the *suco* councils in child health and strengthen the link between civil society and the health system.
4. TAIS should explore using other strong civil or religious organizations to promote child health (health-promoting behaviors or practices) within families and communities (e.g. C-IMCI).
5. Use findings from community consultation to develop BCC messages for specific child health areas.
6. Develop operational links between BCC/community mobilization approach and the facility-focused quality improvement process to capture synergies between the two processes to maximize impact on child health status.

Policy development and advocacy

The original design for TAIS did not envision significant input into policy at the national level. However, the evolving policy environment in Timor Leste made it necessary to contribute to health policies that reflect both international best practices and national realities. This contribution has been one of the primary tasks of the technical team within these first two years of implementation. TAIS leadership also had the necessary ability and presence of mind to respond to policy needs when opportunities presented. The team found that TAIS' strong communication links with the highest MOH levels have contributed to its effectiveness in advocacy and policy dialogue.

TAIS has contributed significantly to the review of IMCI, the definition of national child health interventions, which are now codified with the Basic Service Package, and also to the review of infant and young child feeding practices and review and revision of the national immunization policy and guidelines. TAIS is also using a consultant to look at the role of hospitals in newborn care, which will affect national policy.

The process for many of these activities has been lengthy as it involves the presentation of evidence in support of proposed interventions, dialogue at the working-group level, interaction with counterparts from the European Union (which is charged with many of the policy initiatives in Timor Leste), interactions with department heads to obtain their buy-in, rewriting existing policy, socialization at the district health office level, and then, finally, the culmination of presentations at a national workshop. The results are worthwhile, however, as Timor Leste has officially adopted many of the most up-to-date policies on child health.

Recommendations:

1. TAIS should try to review the current policy insistence on facility-based birth (the Basic Service Package policy is to "discourage home deliveries, even if no apparent complications") since it ignores a potentially useful interim step of assisting home births with skilled attendants, which

can positively impact maternal mortality, and which is more feasible for most women in the Timor Leste.

2. TAIS should continue to track the changes in the newborn policy and work closely with counterparts at the Ministry to provide inputs.
3. TAIS should also ensure under the BSP roll-out, that sufficient attention is paid to sharing policies with district level staff so they understand the appropriate parameters for intervention.

Capacity development

One of the truisms frequently expressed in Timor Leste is that the capacity of the national staff, both within the TAIS program and the Ministry of Health, is less developed than expected and needed to implement TAIS' initial strategy. Be that as it may, TAIS project staff have developed significant capacity since the beginning of the program. During the review, the team found that there is an appreciation at the Ministry for TAIS contribution to capacity development over the last two years.

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TAIS has accomplished these improvements through trial and error in the field, through on-the job training provided by the technical director, through mentoring and through working with key MOH staff. The review team found that TAIS staff themselves do not fully appreciate their own contributions and successes in CCQI and in national staff/capacity development. In addition to the development of its own staff, TAIS has supported capacity development through training in the following ways:

- Finding a trainer consultant to adapt the immunization modules for Timor Leste and providing its staff as trainers for a nation-wide EPI training.
- Contributing to the training of the first 16 service providers in ENBC through job aid development and other training material production
- Sending midwives and doctors to Dhaka for regional ENBC training
- Sponsoring key MOH personnel to be part of the regional technical update for MNCH/FP workshop in Bangkok in September 2007
- Giving a two-day course on the basics of EPI to selected TAIS staff and others
- Providing staff training on immunization in November 2006 and in nutrition in February 2007.

What TAIS did not do yet was to integrate its overall training efforts with the national Institute for Health Sciences, which has recently consolidated its mandate as the lead agency for all health-related training in Timor Leste. However, there is still ample time over the next two years for this to happen.

Recommendations:

1. Create a training plan for the year and share it with the Institute for Health Sciences
2. Respond to the invitation from the IHS to provide input into their curriculum and coursework, including have consultants give guest lectures if appropriate.
3. Identify more opportunities for on the job training, mentoring and use of other adult learning skills to diversify training experiences away from workshops alone.
4. TAIS should include in every scope of work for visiting staff and consultants in-service technical training of a half-day to provide ongoing support for technical growth.
5. TAIS should evaluate whether the Gates Leadership training program available in Indonesia is a suitable resource for team members or counterparts.

C. Performance Monitoring and Work Plan

Performance Monitoring Plan

TAIS has a performance monitoring plan (PMP) that has been approved by the Mission. However, the data that TAIS are being asked to use to measure progress and the actual project activities that are having an impact in Timor Leste do not match. One of the contributing factors to this mismatch is that over time, communication from the USAID/Dili Mission appears to be inconsistent on three distinct issues:

1. The number of indicators on which the project will be evaluated has moved from many (in the original performance plan) to two (only ITN and DPT3), and back to six, according to the

conversation the review team leader had with the Mission, a change that the TAIS team had not focused on

2. Whether internal monitoring data alone will be acceptable for an end-line evaluation
3. Whether there is a clear ban on conducting independent surveys, or is it just a preference indicated, where available data should be used where appropriate, but a survey may be permitted if appropriate data are not available.

There is an urgent need to get clarity from the USAID/Dili Mission about the three issues mentioned above through substantive discussions. Discussion is also needed on the establishment of baseline data that are more germane to the existing situation in Timor Leste. The mid-term review concluded that existing "baseline" data are possibly not aligned with the indicators that TAIS will need to report against in 2009. Some of the issues around baseline include:

- There are apparently serious problems with at least some of the indicator estimates currently taken to be "baseline" (DHS 2003/MICS 2002 limitations).
- The fact that the project activities to date have focused much more national-level policy work and not on the originally envisioned district-level child health interventions (other than ITN distribution) makes the use of 2002/3 data as baseline less desirable.
- There are disagreements among indicator estimates among different sources of data (DHS, MICS, WHO cluster surveys, etc.) that might be potential baselines for a TAIS evaluation, in the absence of a separate project baseline estimate. This will have to be kept in mind when designing any assessment using these as baselines.
- If a valid baseline is not quickly established, it may become impossible to draw any clear conclusions about the contribution of TAIS to outcomes at the community level when the project is evaluated in 2009.

The review team was pursuing the idea of a survey (please see Annex Five for a greater discussion on this) but notes that there are many conditions particular to Timor Leste that might make a survey difficult to implement. However, the review team finds that at mid-term, there are not sufficient systems in place that will allow TAIS to have quantitative measures by project end and that is problematic. The possibility of the use of LQA methodology for assessments is being seriously considered by the country leadership, and possibly by USAID/Washington. It is necessary to understand the strengths and limitations of this method before agreeing to use what may be mistakenly seen as a low-cost replacement for any full-sample survey.

The review team noted that the current PMP does not capture all the efforts of the project. Some of the most seminal contributions of TAIS to Timor Leste may be the policy/advocacy work at the national and district levels, as well as the establishment of traditions of causal, evidence-based thinking and action at the district and sub-district levels. While some of this will be reflected within the next two years in the IR-level outcomes, these outcomes alone are insufficient to capture the process impact of this support. Additional, qualitative assessments will need to be planned for this purpose. The MOH has expressed interest in the development and use of a set of process indicators that will capture the impact of such interventions, so that the worth of the considerable amount of investment by different agencies in health in Timor Leste can be assessed. The review team believes that TAIS will need to take the following points into consideration when constructing this revised indicator or indicators:

- The indicators to be developed should be able to effectively assess changes in causal thinking of the kind engendered by CCQI.
- The most credible use of such indicators will be in prospective documentation efforts, where, say, a "baseline" score for such indicators is first established in a new district, before the CCQI/BSP roll out, and a repeat assessment some months or years later that captures change. While this can be done retrospectively, it is usually less powerful, and more subject to bias.
- Keeping this assessment independent of project implementers is even more important than in the case of the quantitative assessment surveys in order to provide unbiased information to the government.

- Examine whether process indicators, such as numbers of people trained, workshops held, numeric improvements in the numbers of children getting immunized with Measles etc would be helpful.

While any final evaluation of TAIS will need to draw program-level conclusions for certain donor-related purposes, there are good reasons for assessing performance in individual districts: this will be more meaningful to individual district health programs of the MOH and will permit a clearer analysis of what worked and under what circumstances. Such district-wide lessons are likely to be more useful than a single project-wide assessment purely from the TAIS perspective. Generating and using district-wide estimates will have cost considerations, however.

Recommendations:
1. Work with the Timor Leste USAID Mission and finalize indicators for the expected PMP as soon as possible, including any final surveys etc.
2. Work with the MOH and USAID and develop the desired indicator that captures all the policy and advocacy work, as well as the changes in causal thinking.
3. Coordinate with UN agencies and other partners to determine the scheduling of any other population-based surveys in Timor Leste in which TAIS could participate (i.e., get some of its questions asked without doing the survey independently.)

Work Plan
TAIS has submitted annual work plans as per the terms of its award. However, it appeared to the review team that the work plan and the actual work performed were sometimes far apart. This was because of frequent ad hoc requests from the government that were not anticipated and also because the security situation changed rapidly, which resulted in cancellation of activities. In addition, the workplan appeared to be a separate tool from those used by the MOH and could have perhaps benefited from greater alignment. As a result of these findings, the team recommends:
1. The project should redo its current work plan during the month of November. The existing work plan does not sufficiently capture the work of harmonization between BSP and the CCQI, and it contains outdated information on the FHP. The work plan will need to reflect those changes suggested for the PMP. It will also need to be aligned with the MCH work planning done at the MOH. Possible assistance for revising the work plan could be obtained from the BASICS project coordinator, who is currently on a long-term assignment in Indonesia and who could be seconded to Timor Leste for a few weeks to complete this process.

Geographic scope
Clearly, one measure of impact is to what extent all the child health interventions are being applied across Timor Leste. TAIS to date has worked intensely in three districts and was unable to work in the fourth because of the civil unrest. At the same time, its contributions to national level policy and the BSP have had a national level impact and it should rightly claim this national level impact among its accomplishments. Under its ITN distribution, it has had an impact in five districts, soon to be seven.

Given the importance of coverage and scale-up as a measure of success for USAID, and given the changes from the initial design, TAIS at this point needs to determine exactly where it will work (with all the usual caveats of security etc being applied) and in what sectors of child health it will work for the next two years.

Recommendations include:
1. The project should work with the intent of having many of its interventions being implemented in most of the districts, achieving national coverage. However, there are certain caveats. Oecussi is difficult to reach because of its enclave status, paradoxically because of this isolation, many other organizations are implementing activities there. Thus, TAIS should make Oecussi the lowest priority for interventions.

2. As soon as possible, TAIS should have a definitive plan for geographic scope, in particular because it will be a determinant in how to obtain data needed.
3. The project needs to determine if a TAIS expansion – limited to 6 districts with direct support and 4-6 with indirect (supporting partners) with focus on MCH component of BSP -- is feasible given the current staffing configuration.
4. TAIS should consider focusing on expanding impact coverage through combined CMP/CCQI efforts in pneumonia and diarrheal disease control – two neglected areas across continuum of child health in the three existing districts.

V. TAIS AND ITS PARTNERS—OUTCOME OF RELATIONSHIPS

A. MOH

During the review, the team consistently heard that TAIS had excellent relationships with senior members of the Ministry of Health and with most agency heads among donors and UN agencies. However, TAIS was less successful in building mid-level relationships that would serve to support day-to-day activities and interventions. There were some critical comments about the efficiency of the team approach, i.e., sending three or more professionals to the field for activities, and about TAIS' ability to follow through after initiating requested activities. TAIS leadership does appear to be over-committed; there is recognition among the larger community of the value-added they bring to the technical field and thus a constant demand for their participation. This leaves them little time to follow-up and mid-level TAIS staff still need mentoring in order to independently follow through. At the same time, however, all TAIS staff are being asked to do much more than was originally envisioned. Because of limited personnel resources MOH colleagues often request TAIS staff for different activities such as the PSF training at district level, national EPI training, IMCI assessment, BSP roll-out, general secretarial support to working groups, etc.…Despite the oft times distracting nature of these activites TAIS recognizes this type of support is essential to moving the child health agenda forward. During the review, MOH members asked that TAIS continue to second staff to the Ministry, particularly in Health Promotion and the Maternal and Child Health division. As a measure of trust, the current TAIS staff member who is placed at the MOH in the Health Promotion division is relied on to represent the Ministry at some functions. While understanding how this benefits the program, it has also made professional life difficult for the staff person. She has found it impossible to fully carry out her multiple MOH responsibilities as well as her TAIS responsibilities.

B. Donors, Bilaterals, UN agencies

TAIS staff have enjoyed very good relations with the UN agencies in particular. They have coordinated with UNICEF on a number of immunization initiatives, more so now that representation has changed at UNICEF, and there is a warmer climate of collaboration. This relationship is both based on the technical skills that the TAIS team has and on the strong personal relationships that the team has been able to foster, which contribute to positive working relationships. One other area of intersection between TAIS and the UN agencies is within the working groups sponsored by the MOH.

UNFPA and TAIS do not have a very large overlap in program areas, but the UNFPA BCC consultant drew extensively on TAIS guidance and knowledge in the course of preparing the reproductive health behavior-change strategy. The current UNFPA team has signaled they would like to have a more active collaboration with TAIS particularly in the area of newborn health and this certainly should be followed up. The TAIS team is exploring using the same UNFPA consultant for its future BCC work, which would foster inter-agency ties as well as providing consistent technical assistance in the MOH. TAIS already benefits this way, as the newborn expert they have as a long-term consultant previously worked for WHO and HAI in a consultant capacity and thus is able to share her institutional knowledge of the different programs and initiatives.

TAIS has more limited interactions with the World Bank and with AusAID, another important bilateral donor in health. This does not appear to have hampered the work of the TAIS team, nor are they particularly missing any opportunities for leveraging resources. AusAID will support the SWAP that the World Bank is examining and will not be providing funds to smaller projects, in a departure from their previous manner of working in Timor Leste.

TAIS appears to have good working relationships with USAID. The Mission has been on field visits to TAIS sites and reported they get adequate and timely communications from the TAIS team. TAIS and HAI, a USAID-funded NGO, share information and efforts on many different aspects, although their closest technical collaboration remains mostly in newborn care. HAI facilitates TAIS's relationships in

some of the joint districts because of its extensive experience at the district level. HAI made the interesting observation that implementing health programs in Timor Leste is about "sowing seeds of change, not getting the fruit", which is an apt metaphor. Clinica Café Timor (CCT), which also draws a small amount of funding from USAID, continues to collaborate with TAIS, particularly in training initiatives.

C. International NGOs and Local NGOs

TAIS draws on consultants who also have working relationships with other NGOs in Timor Leste and thus is able to foster intra-institutional coordination. One of TAIS' community consultation consultants has taken a staff position at the Alola Foundation. Staff from one international NGO and one local NGO served as interviewers for the community consultation, and other local NGOs helped organize participants for the focus group discussions. TAIS has also joined with Catholic Relief Services in the distribution of bed nets. Because TAIS is a time-limited project and not an NGO, it does not have access to some of the NGO groups that have been established to foster collaboration and sharing of information, at least according to informants from CARE. TAIS does, however, benefit from the extensive security information provided by the international NGOs. TAIS is also planning to explore some of the psycho-social supports for its national staff that international NGOs suggested in the course of this review.

D. Civil Society and District Health Teams

Civil society has a key role to play in achieving the MDG health goals. The key lesson to be learned from TAIS project experience with ITN distribution is that engaging and harnessing civil society drove coverage and utilization beyond that achievable by routine facility-based health services and appropriate utilization of the nets beyond what is achieved through traditional campaigns.

For some 25 years, in pre-independence Timor, the Indonesian government used the "*posyandu*" system, operated and organized by community-based volunteers, who hosted mobile health team visits to villages once a month to deliver a package of family health services. TAIS with CRS mobilized this existing network of volunteers in its ITN distribution program. District-based churches and church networks, school-based parent teacher associations, and civic, political, professional and commercial organizations, dedicated health NGOs and some international NGOs operate in districts and are capable of supporting health activities. In some districts, health councils, including community members, are being established by the district administration, providing an additional point of civil society engagement. TAIS is keenly interested in supporting these councils and is already examining what would be the best way to reinforce their capacity.

The Timor Leste MOH has chosen to create and train a cadre of Family Health Promoters (FHP) to deliver health promotion and behavior change messages and specifically to promote the appropriate utilization of preventive and curative services at health facilities. The FHP program is being implemented in two *suco*s of all sub-districts of the four pilot districts, with support from UNICEF, HAI and TAIS. The FHPs will be supported, supervised, and coordinated by the DHMT, and more locally by staff at sub-district health centers and health posts. The review team noted that different agencies have different understandings on exactly how this supervision is to unfold. Some groups say that such rigid inclusion in the health service hierarchy would undermine the FHP mobilization role, while others feel that interface with the health system will support their legitimacy in the eyes of the community. All agencies agree that the FHPs' role is ensure that all remote communities have regular access to the BSP through health facilities and mobile clinics or other outreach mechanisms.

It remains to be seen how and whether the FHPs will interact with the existing volunteer networks, such as TAIS used for its ITN distribution. The DHMT has a crucial role in providing support and coordination for FHP activities and will, in the context of the BSP roll-out, have the opportunity to include civil society in implementing district health plans. TAIS will play an important role in monitoring how this program unfolds and recommending needed adjustments.

Recommendations in this area are:

1. Identify district champions, both individuals and institutions, outside of TAIS, to develop and use for sub-district coverage and quality improvement, probably with the BSP rollout process.
2. Strengthen the onsite mentoring approach using (trilingual) experts – to focus on clinical content of IMCI refresher and quality improvement (similar to EPI TOT just done).
3. Although TAIS' focus should shift to district and sub-district implementation, it can show ongoing support to central level MOH capacity development, and strengthen relationships with department-level leadership by assigning one advisor each to IMCI and Health Promotion.
4. Identify opportunities for more exposure to the mid-level department staff to build and improve those relationships.
5. Provide briefing notes on child and newborn health to the new Minister as requested and required.
6. Continued collaboration with the UN agencies, particularly capitalizing on UNFPA's interest in newborn care.
7. Because of the collaboration with HAI on newborn issues, TAIS should ensure adequate opportunity for HAI to participate in work planning.
8. TAIS should also ensure that they give due credit to any and all partners because the gains in child health are not done alone but as part of the extensive effort including the MOH, other NGOs and other UN agencies.

VI. MANAGEMENT ISSUES

A. Staffing

TAIS is understaffed both in expatriate and national staff. There are currently four vacant positions for national staff due to staff resignations and moves to other institutions. The Finance and Administration section of the project is the most adequately staffed but that situation in precarious, as it is widely known that other organizations are tendering offers and trying to "poach" TAIS administrative staff, because of their capacity. The TAIS Technical Director is working to maximum capacity but still cannot meet all of the demands on her time, so is not always able to follow up issues in as timely a manner as she would like. The COP, who is focusing on developing the project data bases, external relations and other coordination activities, also spends substantial time on security issues, which impedes his ability to provide inputs into as many of the technical initiatives as he would like. TAIS currently has four long-term expatriate consultants who are resident in Timor Leste. These staff are very helpful in moving forward the technical agenda, but because they are working on specific tasks, they are not able to also contribute to the overall technical management.

Because of the delay in fielding long-term expatriate staff, there was an early reliance on consultants. While many of the consultants worked at the district level and were critical to getting activities up and running, the USAID Mission questioned this extensive reliance on short-term help. Once the Technical Director was in place, there was a drop-off in the number of external consultants brought in. However, from the review team perspective, this use of consultants is symptomatic of the excessively lean management structure in place within country and points to the need to create better in-country capacity.

TAIS has gotten very good backing stopping in the behavior change efforts. Their Washington backstop in this area has been out to Timor Leste four times in the last two years. This contribution is significant, not only for the technical contributions but also because his knowledge of the program allows him to be an advocate for TAIS back at headquarters and explain field reality to staff who have not been able to travel out. However, there remains need for BASICS and IMMUNIZATIONbasics headquarters to provide more support and technical inputs on a routine basis, while at the same time respecting budget expenditures.

TAIS national staff appear to be underpaid compared to other east timorese working both within the Ministry of Health and UN agencies. They also do not have a clear idea of all the benefits such as severance pay, as the personnel manuals are in English only rather than in Tetun or Bahasa Indonesian. While TAIS staff are given sufficient opportunity to apply for internal vacancies, and many of the staff have been able to add to their skill base over the last two years, they have not been given commensurate opportunity to increase their salary levels or benefits.

Recommendations to address these findings include:

1. The project should perform a job function analysis to ensure that the staff are being used to take full advantage of their abilities. Staff should be promoted or redeployed based on the findings of the study. All existing vacancies should be filled as soon as possible.
2. The project should access any existing wage surveys done by the UN to use as a reference point for its own compensation package. TAIS should also immediately do a market survey if none have been done recently as inputs into the compensation decision. Lastly, TAIS should review the Foreign Service National scale as another data point. These three inputs should then be evaluated and used to raise salaries, if warranted.
3. Recruit expatriate staff with facility in English and Tetun and knowledge of public health to work directly with Technical Director and assume responsibility for some of the key functions. These staff should be responsible for representing TAIS on various technical working groups and for pushing forward activities in these specific technical areas (such as EPI and nutrition).

4. TAIS focus must shift to district implementation during the next two years, with capacity building and implementation at district and sub-district level receiving most staff time and technical input. This shift should also be reflected in the staffing pattern and assignments.
5. TAIS should give serious attention to the possibility of basing staff in districts for extended periods of time to work more closely with DHS teams and health centers. Given the renewed district focus, the project needs to look at how it can recruit staff to be district-based rather than Dili-based. One way to do this is to recruit experienced people already living in the districts. Such people are reportedly there, having worked for the MOH during Indonesian times.
6. In order to ensure expanded district implementation, TAIS will need to develop a cadre of technical mentors/facilitators who can address technical content of child health components in the BSP. This cadre need not be full time TAIS staff, or reside all the time in Timor Leste, but they must be available and able to spend concentrated time in the districts, developing the technical skill base at district and health center levels – ideally leaving a repository of district-based mentors/child health "champions." Skill areas for this cadre include IMCI, EPI, and nutrition at PHC and district-hospital levels.
7. TAIS should investigate local stress-reduction activities such as a team retreat, counseling by local resources, and increased time off of work with pay, to mitigate some of the stress from the current situation.
8. TAIS should finish the terms of reference for the team-building process for late October, 2007 and include some discussion of leadership qualities wanted to develop in the team.

B. Security Situation Impact on Well-being

The security situation has had an ongoing negative effect on the well-being of all TAIS staff. The international staff have more options, e.g. being able to pay to get away to Bali or other places of perceived safety, but they don't have the counseling and steady support necessary to deal with continued assaults that the uncertain situation inflicts on their physical and mental health. The national staff are doubly afflicted, having no place to go to and also losing possessions as a result of the various disturbances. At various times over the last fifteen months, staff have lived in the IDP camps, have not known where their family members are, have witnessed violence in Dili, and have not been able to get to the districts because of disturbances on the road. Staff also had to address internal team dynamics that mirrored the initial geographic division of East vs. West but have been able to overcome that. However, at the height of the crisis, staff had to change positions because it was not safe for someone who was perceived to be from the east to work in a western district.

TAIS management and their U.S.-based projects, while recognizing that this is a difficult environment, have not done enough to ameliorate the stress. At present, TAIS staff are not using the available counseling service, although there are other groups that have accessed such services in Dili, nor have there been innovative stress management solutions offered such as group outings, work schedule options, etc. The team did ask for a facilitator and have tried to write the scope of work for such an exercise but have not been able to complete that task, although it is now tentatively scheduled for late October.

Recommendations:
1. Connect with NGOs and determine what are options for counseling, provide this information to TAIS staff as soon as possible.
2. Continue to follow a liberal leave policy for all staff as response to security threats or stresses.
3. Provide time during the Staff meetings to discuss how staff are feeling (if culturally appropriate).
4. Investigate whether social outings as a team or the provision of after-hours yoga classes would be of use or interest to the staff as a stress reduction effort.

C. Headquarters

TAIS managers have worked very hard to present a singular face to the MOH and have clearly succeeded, as the project is known only by its name TAIS and not as a consortium between BASICS and IMMUNIZATIONbasics. This branding as one project was also what the USAID Mission wanted, and

they are pleased that TAIS has been able to create a presence in Timor Leste as an integrated project. However, the intrinsic nature of the partnership has not always contributed to this seamless presentation. The team was struck by the following:

- Initially, before TAIS was constituted, BASICS and IMMUNIZATIONbasics prepared separate, although quite compatible, strategies for work in Timor Leste.
- The financial reporting of the project remains onerous with the Finance and Administration Officer having to prepare two separate sets of records to comply with internal procedures of each project.
- Although the two offices are located a few miles from each other in the Washington, D.C area, they do not have regular joint discussions and or coordination, and thus ludicrous situations occasionally arise in which one organization or the other is asking TAIS to DHL information to them at a cost, when it is readily available just down the road.
- The separate contracting mechanisms issued by USAID, a cooperative agreement grant and a contract, also have differing capabilities, which contributes to the disjuncture, i.e. it is easier to hire consultants under the cooperative agreement than the contract.

To address these management findings, the team recommends:

1. The two projects need to coordinate carefully on the close-down of TAIS, as IMMUNIZATIONbasics is schedule to end in July 2009, before BASICS is scheduled to end.
2. Regular, scheduled coordination of communication, including video conferences or other electronic “staff meeting” functions.
3. Better coordination between the BASICS staff coming to Indonesia and the technical needs of Timor Leste to take advantage of regional presence.

VII. SUMMARY OF RECOMMENDATIONS – THE WAY FORWARD, BEYOND 2009

The technical recommendations from the review have been embedded in the text and will not be repeated here. In sum, TAIS should continue its child health interventions in Timor Leste. It should be guided by the BSP and other government mandated frameworks. It should use its considerable experience to inform the BSP roll-out tools and process. . It should remain an active member of working groups and should ensure that as many of the child health interventions as feasible are adapted and used at the facility and community level. It should revise its staffing pattern to help it accomplish this, including adding more expatriate staff. It should update its performance monitoring plan so it can provide USAID with salient evidence of its impact on child health. Beyond this, and beyond the project end of 2009, the team recommends:

- TAIS should develop multiple scenarios for USAID funding, including the current scenario of no additional funding for FY2008 but funds for FY2009, or additional funds for FY2009. These scenarios will provide the Mission and the MOH options to pursue interventions which will contribute to reaching the established goals.
- TAIS should confer with other donors such as the World Bank and AusAID to determine if there is a role for its technical assistance under the SWAP and whether the MOH would welcome their participation.
- TAIS should explore what aspects of child health under future paradigms need to be developed over the next years and how could the institutions behind TAIS support that
- TAIS should confer with the MOH and develop a manpower plan for the placement of TAIS staff in positions that would be most beneficial to the MOH after the project closes in order to not lose the developed technical competence.

VIII. ANNEXES

ANNEX 1: **Table of Consultant Services 2005-2007**

ANNEX 2: **MOH and TAIS Harmonization Table**

ANNEX 3: **List of People Consulted**

ANNEX 4: **TAIS Organizational Structure**

ANNEX 5: **Pending Technical Issues**

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ANNEX 1: List of consultant services used in TAIS since December 2004 to August 2007

Name		Status	Organization	Task	Main Component	Number of Visits	Notes
Carl	Hasselblad	Con	IB	EPI	CCQI	2	
Steve	Saphiere	Con	BASICS	M&E	CCQI	4	
George	Greer	Staff	BASICS	Mal	CCQI	2	
Robert	Steinglass	Staff	IB	EPI		3	
Diana	Silimperi	Staff	BASICS	IMCI		2	Mid Term Review
Tom	Shaetzel	Staff	BASICS	IYCF		2	
Indira	Nayaranan	Staff	BASICS	NB		1	
Mike	Favin	Staff	IB	BCC		4	Mid Term Review
Vuthy	Keo	Con	IB		CMP	3	
Dotty	Foote	Con	IB	BCC		2	
Mark		Con	IB	EPI	CCQI	1	
Elvira	Beracochea	Con	BASICS		CCQI	1	
Shamin		Con	BASICS	IYCF		2	
Joan	Shubert	Staff	BASICS	ITN	CMP	2	
Paul		Con	IB	EPI		1	
Lucy	Mize	Con	BASICS			1	Mid Term Review
Allan	Bass	Con	IB			1	Mid Term Review
Sara		TAIS	BASICS	BCC			
Tanya		Con	BASICS	BCC		1	
Cudjoe		TAIS	BASICS	ITN			
Swandari		TAIS	IB		CCQI		
Sridhar		Con	BASICS			1	Mid Term Review
Ingrid	Bucens	Con	BASICS	NB		1	
Caroline		Con	BASICS	IMCI		2	
Paul	Crystal	Staff	BASICS			1	

Annex 2: Matrix – Harmonization of BSP and CCQI tools, 27 August 2007

Steps	BSP	CCQI	Value Added	Benefit	Implications	Steps to address implication
Goal	• Reduce the morbidity and mortality	• Reduce morbidity and mortality				
Objectives	• Improve performance and quality of services under BSP • Strengthen district management capacity • Strengthen district management system	• Improve the quality and coverage of child health services under BSP • Improve client satisfaction (such as: community, patients, families) • Improve teamwork in the district for monitoring of child health services • Strengthen the subdistrict service provision for child health • Increase the integration and continuum care of child health services				
Focus of process	• District and subdistrict	• District and subdistrict	Subdistrict ++			
Responsible	• District team • Facilitated by BSP supporting team	• District team • Facilitated by TAIS field team				
Situation Analysis	**Focus:** All services under BSP **Source of data:** • Secondary data (Quantitative and qualitative)	Child Health • Secondary data (performance EPI, Nut, IMCI)	• Epidemiological analysis • Rapid assessment	More complete understanding about the health situation, quality of care,	• Better informed planning process • Additional	• Establish team • Define the timeline to improve the tools

Steps	BSP	CCQI	Value Added	Benefit	Implications	Steps to address implication
	Scope of analysis: • Performance +++ • Epidemiological +++ • Quality + (results of supervision) • HR, infrastructure and equipment **Approach:** • District team will do the analysis • Mentoring by BSP supporting team **Lessons learned:** • District/subdistrict not clearly	• Primer (rapid Assessment • Catchment area, • Traditional practitioner – to cover wider coverage • NGO (activities for possible collaboration). Analysis is not yet integrated at the district level • HR district and sbdistrict Coverage/performance Quality +++ HR and infrastructure for chilld health. Infrastructure: equipment, medicine and medical supplies). Data already collected but not yet analyzed • District team • Supporting team • Mentoring by CCQI national team		support system in the district More information on quality of the process, sometimes the standard is not always available Immediate feedback to the subdistrict Socialize the expected standard or performance Peer assessment will increase the ability of district and sd staff to implement and understanding about heath problem	resources (HR, logistic) funding and skill staffing • Design/improve appropriate assessment tools • Increase the amount of time to visit all subdistrict • Informal training	• Setting standard in consultation with programme manager • Consultation with district • Socialize the expected standards

Steps	BSP	CCQI	Value Added	Benefit	Implications	Steps to address implication
	understand the objectives of the program • National indicator some services are not clear • Different reporting format • Capacity of the district and subdistrict on data management, analysis, and interpretation need to be improved					
Identification of priority service area	• Analyze the gap of performance • Prioritization based on poor coverage performance and quality	• Analyze performance gaps across three services and prioritize services • Prioritization based on coverage and quality	More specific Quality of Care data	More specific behaviour to improve at the provider level **Ex.** IMCI. Assess how people treating according IMCI protocol. Observation of the process such as count respiration Motivate the provider to perform better including time management	Need of skilled facilitators	Training for facilitators
Resource analysis (HR, Infrastructure and Gaps)	• Identify the gap of resources to implement priority services	• See situation analysis				
Setting Objectives	• Performance – district target • Constraint reduction is done after the constraint analysis and problem solution	• Performance – programme national standard • Quality of care and programme management at the subdisdistrict level	Quality of care according to national clinical care			

Steps	BSP	CCQI	Value Added	Benefit	Implications	Steps to address implication
				Improve client satisfaction		
Problem analysis	• Identification of root causes • Prioritizing root causes to be solved • Identification of solutions	• Identification of root causes • Prioritizing root causes to be solved • Identification of solutions				
Development of action plan	• District action (implementation) plan: o Activities o Budget o Timeline o Responsibility	• Indicator for specific improvement				
Development of Monitoring and evaluation plan	• Performance • Quality • Responsible: o District team o Some SD staff o Support from National	• Performance • Quality • Self assessment • Responsible: o District Team o SD level	• Performance • Quality • Self assessment of quality and coverage and quality • Responsible o District team o SD level			

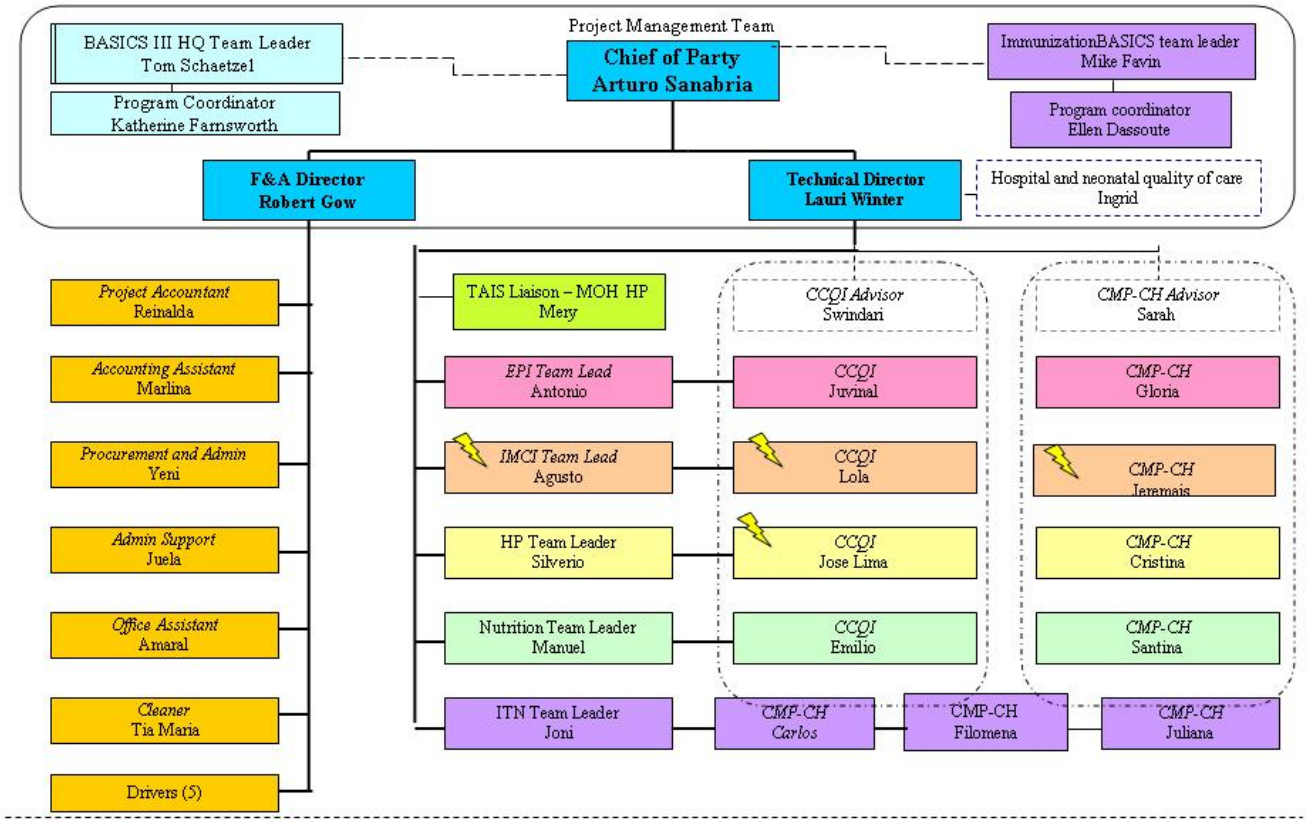
LIST OF PERSONS INTERVIEWED FOR TAIS MID-TERM REVIEW - clustered by organisation

Surname	Name	Organization	Employer	Position
Brown	Tanya	Alola Foundation	Alola Foundation	Maternal and Child Survival Coordinator
Gusmao	Arminda	Ausaid	Ausaid	Program Officer
Banskota	Dih	CARE	CARE	Health program Director
Fransisco	Diane	CARE	CARE	Acting Country director
Belanger	Jason	CRS	CRS	Country Director
Viegas	Manuel	CRS	CRS	Administrator
Rignak	Alberto	Cuban Medical Brigade	Cuban Medical Brigade	Country Director
Belo	Cristiano	DHS Baucau	MOH	Deputy public health officer - nutrition and HP
Leonel	Guteres	DHS Baucau - CHC Keli kai	MOH	CHC director Kelikai
Smith	Euan	E U-- SISHIP	E U-- SISHIP	Project Manager
Lloyd	Peter	EU -SISHIP	EU -SISHIP	Human resources advisor
Greer	Anna	HAI	HAI	BCC consultant
Hoekman	Nadine	HAI	HAI	Director
Hulme	Jennifer	HAI	HAI	Extension of services coordinator
Moon	Sarah	HAI	HAI	Birth spacing program coordinator
Viera	Francisco	Healthnet	Healthnet	Director
Camnahas	Lorenzo	Institute for health sciences (ICS)	Institute for health sciences (ICS)	Director
England	Sue	Café Cooperative Timor	Café Cooperative Timor	MCH program coordinator
Canisio	Pedro	Ministry of Health	Ministry of Health	Director of Health Promotion
Araujo	Natalia	Ministry of Health	Ministry of Health	Director of Maternal and Child health services
Bosco	Jhoni	Ministry of Health	Ministry of Health	Program manager - Malaria
Celina	Aurea	Ministry of Health	Ministry of Health	Program manager --Family planning

Surname	Name	Organization	Employer	Position
Cunha	Mateus	Ministry of Health	Ministry of Health	Program Manager - EPI
Dignan	Cecily	Ministry of Health	Ausaid	Technical adviser - Nutrition
Jacobsen	Rick	Ministry of Health	Global fund	Technical adviser - Health Promotion
Soares	Ana	Ministry of Health	Ministry of Health	Director of Health Services
Soares	Dirce	Ministry of Health	Ministry of Health	Program manager - Nutrition
Soares	Agapito	Ministry of Health	Ministry of Health	Director of District Health Services - Manatutu
Vital	Misliza	Ministry of Health	Ministry of Health	Program Manager - IMCI/Newborn
Ximenes	Duarte	Ministry of Health	Ministry of Health	Director of policy and planning
Ximenes	Jose	Ministry of Health	Ministry of Health	Directors of District Health Services -Baucau
Bonito	Antonio	TAIS	TAIS	National Technical Officer - focal point EPI
Bucens	Ingrid	TAIS	TAIS	Intermittent long term consultant - IMCI neonatal and pediatric hospital care
Carvalho	Filomena	TAIS	TAIS	District Community Mobilization Officer
da Costa	Cristiana	TAIS	TAIS	District Technical Officer
da Cruz	Santina	TAIS	TAIS	District Community Mobilization Officer
Ernelia	Yuliana	TAIS	TAIS	District Community Mobilization Officer
Fernandes	Joao	TAIS	TAIS	National Technical Officer - Community Mobilization for ITN
Glorita	Maria	TAIS	TAIS	District Community Mobilization Officer
Gow	Robert	TAIS	TAIS	Finance & Admin Manager
Laot	Mery	TAIS	TAIS	TAIS MOH - national liaison and HP
Lay	Yeni	TAIS	TAIS	Administrator Field Coordinator

Surname	Name	Organization	Employer	Position
Mausiry	Manuel	TAIS	TAIS	National Technical Officer - focal Point Nutrition
Meyanathan	Sarah	TAIS	TAIS	Intermittent long term consultant - Community mobilization and participation (formative research)
Pinto	Agusto	TAIS	TAIS	National Technical Officer of Community Mobilization - focal point IMCI
Sarmento	Carlos	TAIS	TAIS	District Community Mobilization Officer
Soares	Silverio	TAIS	TAIS	National Technical Officer - focal point HP
Tilman	Emilio	TAIS	TAIS	District Technical Officer
Xavier	Juvinal	TAIS	TAIS	District Technical Officer
Yuwono	Swandari	TAIS	TAIS	Intermittent long term consultant - field support officer (CCQI)
Bernardo	Domingos	UNFPA	UNFPA	Senior program officer
Bismarc	Angela	UNFPA	UNFPA	Technical advisor - Family Planning
Mosquera	Mario	UNFPA	UNFPA	BCC Consultant
Gonzalez	Alejandro	UNICEF	UNICEF	Health Programs Director
Aung	Yin Yin	UNICEF	UNICEF	EPI officer
Sarmento	Noeno	UNICEF	UNICEF	Program assistant - MCH community health
Frantz	Brian	USAID	USAID	Program Development Officer
Ximenes	Teodulo	USAID	USAID	Health Officer
Araujo	Rui	WHO	WHO	Senior Management consultant
Larson	Erling	WHO	WHO	Senior Management consultant
Shidarta	Yuwono	WHO	WHO	CDC Officer (seconded for

Surname	Name	Organization	Employer	Position
				BSP)



CCQI = Continuous Coverage and Quality Improvement
CMP-CH= Community Mobilization and Participation for Child Health
= resigned

ANNEX 5: Pending Technical Issues

In the course of the review, a few key technical issues were raised and discussed but without the review team coming to a final consensus or plan. As part of the post-review planning process and in conjunction with the MOH and USAID, TAIS will need to address these pending issues. One of the most urgent is the community based management (CCM) of common killer conditions, such as childhood pneumonia and perhaps malaria. The review team understands the following about this issue:

- Evidence from around the world indicates that community based treatment of child hood illnesses is effective and can reduce mortality. The two global projects that support TAIS are currently using this approach in other countries.
- WHO raised the consideration of this approach with the MOH in the last few years but did not receive official support or sanction and therefore has not pursued it.
- A senior advisor to the MOH stated that he is not sure this is an appropriate time to initiate a new approaches, he suggested waiting until after the new minister has set his agenda and priorities.
- The TAIS team does not feel that there are sufficient resources or staff available to undertake the implementation of this approach, except on a pilot basis and only with approval of the MOH.
- Some considerations surrounding a pilot would be to limit implementation of this to communities with high prevalence of the specified childhood illnesses or mortality.

Ultimately, if TAIS does choose to pursue the pilot of community case management of certain childhood illnesses, in keeping with the current evidence and literature, then they should initiate discussions with the MOH as soon as possible. They should also take into account the recommendations suggested by the review team, listed below:

- Strengthen TAIS' relationship with the malaria program and work through them to pilot home-based management of fever which will lay the foundation for CCM of childhood illnesses in Timor Leste.
- TAIS should develop and implement an advocacy strategy to gain approval for trial of CCM of pneumonia in remote areas during next 1-2 years.
- Among its advocacy efforts for CCM, TAIS should use evidence for how the use of CCM will support Timor Leste reaching its MDG 4 goal.
- TAIS should advocate to the Ministry to consider scaling up diarrhea case management (ORT, including zinc) using the combined community and facility approach. Given ministerial consent, TAIS could plan to implement this throughout the whole country by the end of TAIS.

A second technical issue raised was the validity of baseline data and whether surveys could be appropriate as a measurement tool. Among issues identified by the review team include the following:

- Overall, despite plans and efforts, the likelihood of already having made measurable impact on most population level outcomes is low; the potential exception is ITN distribution, where nearly all children under five years of age in 5-6 districts have been reached with ITNs, following a rolling campaign.
- By all current estimates, it is highly unlikely that TAIS will have uniformly intensive interventions likely to affect all of the agreed-upon SO/IR-level indicators across all districts in the country; in fact, TAIS may not have a "full package" going in more than 6 of the 13 districts at the most by the end-line. Nonetheless, the review team thinks that TAIS interventions will still have the potential to impact population-level estimates of the six USAID indicators (and more) by 2009, given a reasonable implementation environment. Thus, a decision to assess the program on six indicators should be acceptable to TAIS.
- A well-defined geographic scope will also be crucial if TAIS is to measure impact of its interventions. Thus, to realistically implement the program, and implement baseline surveys, the absolute geographic scope of the program must be quickly negotiated and determined.
- The most likely scenario appears to be that there will be two domains of the influence of TAIS:
  - a limited number of districts (current thinking ranges from 3 to 6) where a "full package" of interventions is implemented using the harmonized CCQI/BSP approach, and where it will be appropriate to expect population-level impact on all or most IR level indicators.

  - a national domain (including all or most districts of ET) where TAIS' influence will be felt at least at district planning and monitoring (process) levels, but where it will not be possible to predict (or for TAIS to commit to) population-level impact.
- It is unlikely that a national "baseline" estimate from 2002/3 will be considered appropriate for comparing with an end-line survey in < six (TAIS) districts in 2009. It is equally unlikely that the next DHS and/or MICS, even if timed to coincide with TAIS end-line in 2009 and comparable to the 2002/3 surveys, will be considered appropriate to assess the contribution of TAIS in six districts; the multitude of players in the ET context will make attribution to TAIS almost meaningless if the evaluation were based on such surveys.5
- There will be a need for special assessment of the ITN effort, taking into account the differences in ITN implementation approaches in some districts, which could potentially affect the choice of districts to be assessed.

The review team raised the issue of surveys as part of the discussion on the PMP and obtaining reliable and verifiable data on impact to provide to USAID and the MOH. The team recognizes that the current state of data collection stems from the historical fact USAID and the MOH would not permit TAIS to gather baseline data when it started. This refusal was less a reaction to TAIS' data needs and more a response to the fact there had been significant data collection already done in the country, which was disrupting services and was very costly. The review team also recognizes the following are factors in doing surveys in Timor Leste:

- Research in ET is much harder and more expensive than in most places. There needs to be a tremendous effort put into explaining and winning over local officials. Does TAIS have the budget for this?
- Families will all expect some compensation for responding, does this conform to TAIS policy?
- The security situation in ET has several potential implications on assessments:
  - Physical dangers for field teams involved in the surveys
  - Resistance to surveys, either from the community or the government, fearing misuse of data to endanger people's security, particularly if the surveys include enumeration to generate sampling frames, or if the information collected includes information perceived to be sensitive
  - Distortion of estimates due to large-scale migration.
- The MOH has lately been hesitant in permitting surveys and has had varying policies concerning surveys in the past. They might not be supportive of TAIS requesting this survey. At the same time, with the roll-out of the BSP, the MOH may find it useful to lay down a baseline.
- Since the review team left, another population based survey on "living standards" has been done and is almost finished, it may have useful indicators for TAIS and the Technical director will review.
- There is a very strong tendency to tell interviewers the "right" rather than the "real" answers, thus will the data be truly reliable?.
- Will a survey actually be able to tease out the impact that TAIS alone has had on the child health program? Since there is so much going on in health in Timor Leste now, it will be very hard to separate out the results of TAIS input in particular.
- A proper survey, with useful accuracy and statistical significance, will take a long time for planning and approvals, implementation, analysis and reporting, an anticipated 3 to 6 months. The TAIS team needs to determine if this is an appropriate use of time and resources, particularly for the COP or if there are other methods that can be used to satisfy the need for reliable, quantitative data.

Bearing all these caveats in mind, it is unlikely that the TAIS team will do a survey. However, if conditions change and they do undertake a survey, then they should consider the following recommendations from the team.

Comment [AGB2]: the section that follows seems to be too complicated and wordy.

[5] DHS and MICS may be able to provide reasonably robust estimates for 2-3 regions in the country, but none of the regions is likely to correspond to the cluster of TAIS districts; and neither survey will have sample sizes large enough to provide district-level estimates.

- It will be wise to have an independent end-line survey. Unless there is certainty of MICS or DHS being conducted sometime in mid-2009 and of the data being available by the time of the end-line TAIS evaluation (before the end of 2009), it would be unwise to leave this to chance, since, if the timing of either of these surveys goes wrong (either earlier or later than desired), it would be of limited use for the TAIS evaluation.
- The program should preferably be assessed at district level as well as at the aggregate project level. This has several advantages: besides permitting the assessment of any variations in approaches among districts, it will provide flexibility of accommodating differential implementation intensities that are a real possibility, considering the current security scenario.
- The LQA method is less likely to work for evaluation purposes, but is certainly worth utilizing for monitoring purposes.
- It is recommended that baseline and end-line surveys be based on samples of adequate size to provide reasonably robust point estimates of indicators, and not simply decision rules, which carry a much higher risk of showing "no difference" in assessments over time.
- It is recommended that the end-line surveys be managed by individuals and agencies that are visibly independent of TAIS/BASICS /IMMUNIZATIONbasics and the Timor Leste MOH. This will enhance credibility and ownership of results and findings. However, the TOR for the surveys must be laid down in close consultation with TAIS and MOH.
- It will be necessary to negotiate with the MOH at the earliest to determine which of the following assessment options is more feasible:

Comment [K3]: It looks like something is missing here?

It will be important to ensure that the tools for these surveys are developed and administered carefully, ensuring comparability to internationally accepted indicator definitions such as from the DHS.