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Timor-Leste Asistensia Integradu Saude II (TAIS-II)

FINAL REPORT • SEPTEMBER 2009–SEPTEMBER 2011

TAIS II was a two-year technical assistance project for integrated child health under USAID funding, through BASICS and managed by John Snow, Inc. for and with the Ministry of Health of Timor-Leste.

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LETTER FROM THE PROJECT DIRECTOR

To our Ministry of Health colleagues, valued partners, and our donor, USAID,

I first want to thank all of you for your commitment, hard work, and collaboration to improve the health of children in Timor-Leste. I particularly want to thank the TAIS staff, management, technical and administrative staff, for their dedication and willingness to be flexible and open to learning new ways of working.

This report is the final report for the TAIS II project, which operated for 2 years between 2009 and 2011; but it is the culmination of the work of both TAIS I and TAIS II projects, which gives us the lessons learned, achieving the progress we have since 2005, which are described in this report.

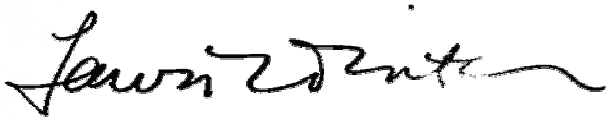
The partnership which TAIS has built with the MOH and districts is the most important success that TAIS achieved. This partnership allowed for developing and implementing together the right interventions to save lives that were adapted to the emerging health care system in Timor-Leste. The journey together in this partnership has been at times exciting and, at times, frustrating, yet ultimately satisfying because we have learned to understand each other. While TAIS can by no means claim that reductions in child, infant, and neonatal mortality were due to its work – many partners and factors contribute to this kind of change – we are happy that we were part of the mix of factors, under the Ministry's leadership, that have seen this progress toward the Millennium Development Goals for children.

I dare not mention individuals by name because one always forgets someone, but from the Minister to the chief suco, from the health care workers, nurses, and midwives who have been the constant backbone in the health care system, to the various partners in the UN agencies and NGOs, and long term consultants—you know who you are—you have all contributed your wisdom and knowledge to the successes in improved child health in Timor-Leste.

A particular note of thanks goes to our colleagues at the United States Agency for International Development (USAID) and through them the American people. Your flexibility and understanding of the needs of this new nation in your technical and financial support to the government of Timor – Leste will ensure a long relationship.

We look forward with enthusiasm to the next years of work to continue to improve maternal and child health. The development process is forward moving for health and the health care system in Timor–Leste. Any mistakes were ours; the successes, so far, are yours.

Sincerely, for the TAIS II Team



Lauri Winter, TAIS II Chief of Party

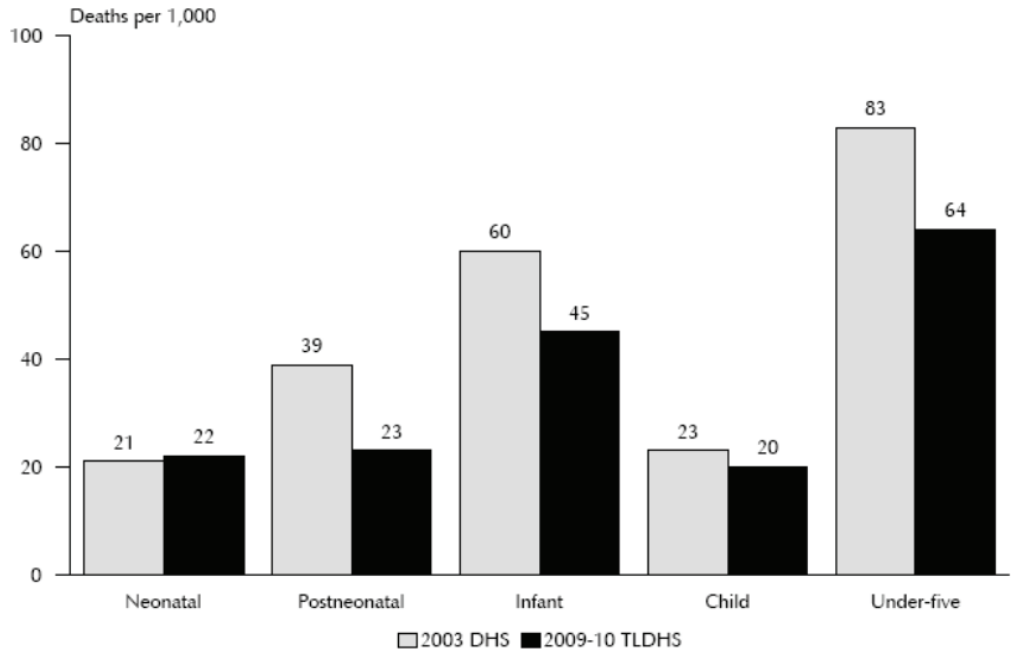
ACRONYM LIST

ANC	Antenatal care
BCC	Behavior change communication
BESIK	Community Water, Sanitation, and Hygiene project
BSP	Basic services package
CCQI	Continuous coverage and quality improvement
CCI	Cultural Change Institute
CCM	Community case management
CCVM	Cold chain and vaccine management
CHC	Community health centers/committees
C-IMCI	Community integrated management of childhood illness
COP	Chief of party
CMAM	Community management of acute malnutrition
CMP	Community mobilization and participation
DCOP	Deputy chief of party
DHS	District health service
DHMTs	District health management teams
DMT	Decision making tool (for family planning)
DPHO	District public health officer
DWASH	District Water Supply, Sanitation and Hygiene Services project
ENC	Essential newborn care
EPI	Expanded program on immunization
FP	Family planning
HAI	Health Alliance International
HMIS	Health management information system
HP	Health promotion
HSSP-SP	Health Sector Strategic Plan – Support Project (World Bank and AusAID)
INS	National Institute of Health
JSI	John Snow, Inc.
IYCF	Infant and young child feeding
KJPS	Village-level Management Committee for Health Program
K1, K4	Indonesian abbreviations for antenatal visits 1 and 4
LAM	Local area monitoring
LLIN	Long-lasting insecticide-treated bed nets
MAEOT	Ministry of State Administration & Territory Planning
MDGs	Millennium Development Goals
MCH	Maternal and child health
MLM	Mid-level managers
MUAC	Mid-upper arm circumference
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
MOU	Memorandum of understanding
MSI	Marie Stopes International
NGO	Nongovernmental organization
NHSP	National Health Sector/Strategic Plan 2011 – 2030
ORT	Oral rehydration therapy
PDS-S	Village Development Plan for Health [formerly the KJPS])
PNC 1	Post-natal care (visit 1)
PRISM	Performance of routine information system management
PSA	Public service announcement
PSF	Promotor Saúde Familiar (community health volunteer)
RSF	Rejistru Saúde Familiar (family health register)
SAMES	Central Autonomous Medical Supply System or Central Medical Supply
SBA	Skilled birth attendant
SEARO	South East Asia Regional Office (for WHO)
SISCa	Integrated Services for Community Health
SS	Supportive supervision
TA	Technical assistance/Technical advisor
TFR	Total fertility rate
TO	Technical officer
TAIS	Timor-Leste Asisténsia Integradu Saúde
TLDHS	Timor-Leste Demographic and Health Survey
ToT	Training-of-trainer
TWG	Technical working group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Timor-Leste is one of the world's newest sovereign nations. Its tumultuous independence was marred by destruction and conflict. In 2003, Timor-Leste's under-five mortality rate was estimated at 83 deaths per 1,000 live births and neonatal mortality at 33 deaths per 1,000 live births.[1] Despite improvements in the under-five, infant, and neonatal mortality rates, as shown in the 2009-2010 Timor-Leste Demographic and Health Survey (TLDHS)[2], continued effort and progress is needed (see Figure 1) Timor-Leste has the second-highest national undernutrition rates in the Asia Pacific region. Approximately half of children under-five are underweight. This figure did not change between the 2003 DHS and 2009-2010 TL-DHS.

Figure 1: Trends in Child, Infant, and Neonatal Mortality in Timor-Leste, 1989-2015



Note: Data for the neonatal mortality and postneonatal mortality rates for the 2003 DHS are unadjusted.

TLDHS 2009/10

1. Ministry of Health and Ministry of Finance of Timor-Leste.2003. Demographic and Health Survey (DHS) 2003.
2. Ministry of Health and Ministry of Finance of Timor-Leste.2010. Demographic and Health Survey (DHS) 2009-10.

Prior to 2004, USAID focused on providing assistance to the Café Timor cooperatives and their health services. Responding to the 2003 DHS data and to the government's priority of decreasing the high maternal and child mortality rates, USAID increased its contributions in the health sector. As part of its bilateral programs, USAID/Timor-Leste awarded a four-year assistance project to two USAID globally-funded projects, BASICS III and IMMUNIZATIONbasics, to provide technical assistance (TA) to the MOH to expand effective, proven newborn and child health interventions throughout the country. In 2005, the two projects merged and became TAIS (Timor-Leste Asisténsia Integradu Saúde).

The project was extended through a task order to BASICS III in 2009, as TAIS II, until the end of September 2011. Both TAIS I and II focused on a limited set of evidence-based interventions that have demonstrated maximum impact in saving children's lives, including:

- Preventive interventions: immunizations, vitamin A, long-lasting insecticide-treated bed nets (LLIN), exclusive breastfeeding and complementary feeding, and healthy timing and spacing of pregnancy (HTSP); and
- Curative interventions: appropriate treatment of pneumonia, malaria, malnutrition, diarrhea and dysentery, and newborn illness through integrated case management.

When TAIS I began, MOH officials were concerned with poor service utilization and significant limitations in coverage and quality in health service delivery. In an effort to address their concerns, TAIS I implemented two primary strategies: continuous coverage and quality improvement (CCQI), and community mobilization and participation (CMP). CCQI was implemented to expand coverage and improve quality of care in health facilities and communities. The approach was to teach district and health facility staff to use HMIS data to identify major gaps in coverage of child health services and to encourage managers to use clear standards of care to identify quality gaps; supervision data and other assessments were not yet available for most of the services. CMP for child health was also implemented to promote appropriate and timely health-seeking behavior and adoption of improved child health practices by families and communities.

Through an iterative and participatory process, TAIS I contributed to a set of complementary and synergistic interventions including policies, strategies, guides and manuals, data management tools, and basic and refresher training packages in child health technical areas, which were used to build capacity at all levels. Supervisory tools and procedures also helped to produce job aids, designed to address poorly performed skills identified during supervision visits. The interventions were developed, adapted, and adopted in collaboration with the MOH, the district health services (DHS), and other partners, such as the UN agencies, non-governmental organizations (NGOs) and other bilateral projects. These interventions were developed to deliver a national basic service package (BSP), which focused on primary health care services aiming to reach the Millennium Development Goals (MDGs).

Utilizing TAIS I's foundation, TAIS II worked with the MOH, UN agencies, and NGOs to improve and institutionalize these interventions and apply the tools and strategies intensively within the management of DHS in targeted districts. The project's goal was to help create a national health system that owns and inte-

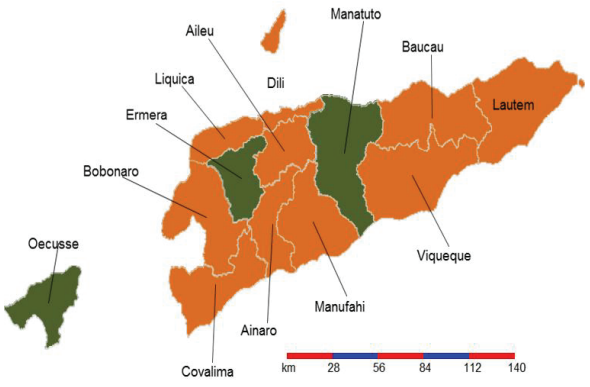
INTRODUCTION (CONT.)

grates new interventions and procedures, and possesses managerial and technical skills that will enable the national health system to be more independent and lead the way to the MOH goal of "One Plan, One Budget" as identified during the health sector mid-term review in 2010.

TAIS II implementation was guided by a three-pronged strategic approach:

- **Improve national child health and nutrition policies and practices** by strengthening the capacity and skills of MOH personnel, supporting policy development and dissemination, and assisting in the creation of a culture of data use that permeates all levels of the system.
- **Strengthen district-level child health services** by improving providers' skills through supervision, on-the-job training, and mentoring, and improving links between health facilities, health workers, and communities.
- **Increase community access to and engagement in quality services** by promoting practical, participatory approaches to facilitate greater community involvement and buy-in of key health messages and practices.

Figure 2: Map of Timor-Leste and TAIS II Focus Districts



TAIS II collaborated with MOH staff to define policies, strategies, and objectives toward established goals. TAIS II posted four international technical advisors (TAs), who worked, at a minimum of 50 percent with MOH staff in the areas of health management information systems (HMIS), health promotion , and maternal and child health (MCH). MCH efforts focused on the expanded program on immunization (EPI), the integrated management of childhood illness (IMCI)/ community case management (CCM), and essential newborn care (ENC) programs. TAs paired with one or two Timorese technical officers (TOs) from TAIS II, who also spent significant time at the MOH working with program managers and department heads. The TAs and TOs also assisted districts nationwide in planning, supervision, and training for BSP delivery, and supervised district-based project teams in the project's three focus districts (Ermera, Oecusse, and Manatuto).

Further, four or five TOs spent 75 percent of working hours providing concentrated support in each focus district to improve district and sub-district capacity in delivering high-impact health services outlined in the BSP. The district-based teams helped with district activities such as monthly coordination meetings, review of supervision results, preparation of routine service reports, and SISCa (integrated services for community Health) implementation. SISCa, a monthly outreach service provision in each Timor-Leste village, had district-based teams that built the capacity of the Family health promoters (PSFs) and suco (village) council members to improve community utilization of government health services and adoption of healthy behaviors. In addition, the district-based teams aimed to strengthen partnerships between government health services and NGOs.

PART ONE: PROJECT MANAGEMENT, IMPLEMENTATION, AND COORDINATION

TAIS II's approach relied on the TA's and TO's continuous support to the MOH (national teams) and the TO's support at district and sub-district levels (district teams). The TAIS II chief of party (COP) and deputy chief of party (DCOP) supported quality assurance and general management, as well as coordination with other partners at both levels.

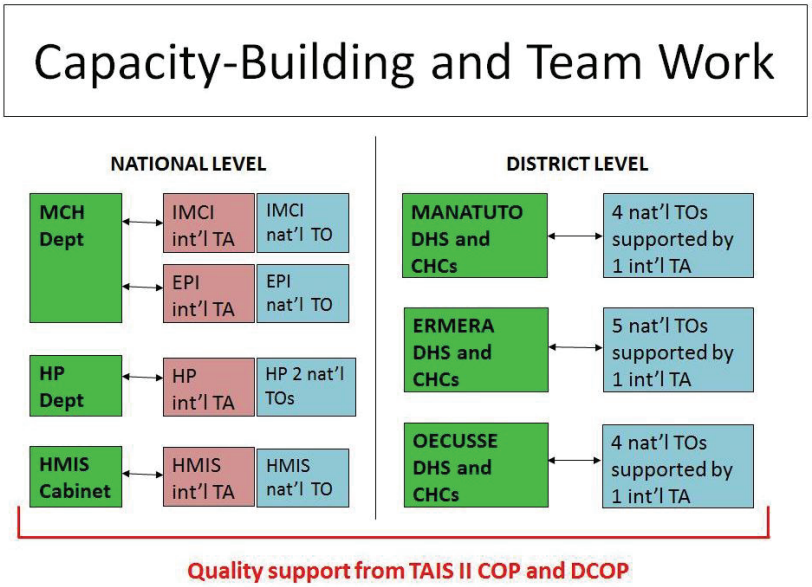
The project's used systems, procedures and tools, provided by its administration team and finance and administration director, were used to demonstrate management practices to MOH counterparts. Although these systems are not usual components of technical assistance, they were illuminated the organization and planning necessary to execute effective activities.

1.1 NATIONAL TEAMS

Time spent with MOH staff varied depending on the each department's needs. TAIS II mentorship and assistance supported the HP SISCa officer, MCH department director, the HP resource center officer, the HMIS unit director, and the IMCI child health program manager. This support had national implications for monitoring and supervision systems as well as district and sub-district capacity building. EPI support focused on district and sub-district levels, while the DCOP helped support the national level through the EPI working group.

With other TAIS II staff, the COP and DCOP supported national technical working groups (WGs) for nutrition, IMCI, newborn, and family planning, as well as various technical sessions for IMCI and community case management (CCM), SISCa, PSFs and HP strategies. The WGs were responsible for developing quarterly and annual plans and coordinating other interested projects and organizations with the MOH technical programs. TAs and TOs helped the MOH develop structured work plans, organize and prepare WG meetings, and improve internal department management.

Figure 3: TAIS Capacity-Building Set-Up



1.2 DISTRICT TEAMS

TAIS II district teams provided technical and logistical support and built capacity of the DHS and community health center (CHC) staff. Composed of TOs responsible for community mobilization, child health and district/facility management, the district teams focused on immunization, IMCI, HP, child spacing, FP, nutrition, newborn health, and HMIS. Team members were experienced in advocacy, facilitation, district planning

PART ONE: PROJECT MANAGEMENT, IMPLEMENTATION, AND COORDINATION

and management, supervision and monitoring, behavior change communication (BCC), and demand creation, which improved implementation. They worked directly with the DHS, CHC and health post staff to plan, manage, and deliver enhanced services. The team also created partnerships with community and faith-based organizations (CBOs and FBOs) and other private-sector partners, which were essential for supporting community-level services, e.g. SISCa.

Three TAIS II TAs from the national level provided consistent and intensive supervision to each district team. Based in the DHS offices three weeks per month, the teams worked as part of district health management teams (DHMTs). This strategy allowed direct support to DHS functions and activities, and subsequently many TAIS II staff developed ongoing, trusting relationship with DHMTs.

TOs routinely provided support to district public health officers (DPHOs) and CHC staff to implement SISCa, including capacity-building of health workers and PSFs, and monitoring in conducting HP activities, such as night events, data collecting, report writing, and conducting supportive supervision (SS) for IMCI, EPI, FP, ENC and nutrition. With support from national-based TAs and TOs, TAIS II district-based TOs, ultimately helped DHMTs improve their capacity in planning, implementing, monitoring, and reporting their activities with a focus on using the HMIS data. TAIS II TOs assisted in conducting regular (usually quarterly) reviews of district activities, assessing progress compared with initial plans, and identifying challenges. The approach also included mentoring supervision and strengthening supply and financial management.

1.3 TAIS II CORE MANAGEMENT

To provide support at both national and district levels, TAIS II needed strong direction to ensure horizontal communication and reflection on activities and tools among district teams, TAIS II technical experts, MOH, and other partner staff at the national level. The COP and DCOP played a key role in ensuring this communication. Periodic meetings with senior technical staff supported TAIS II's input at the national level. The monthly Dili week (when the TAIS II district-based staff came to Dili), provided the opportunity for teams

to share experience and lessons learned with TAIS II and national MOH staff.

With the leadership from the COP and DCOP, TAIS II was instrumental in the review, analysis, and development or updating of policies, strategies, standards of care, guidelines, job aids, and technical tools. TAIS II staff assisted in the development of training modules, materials, and methodologies and co-facilitated trainings-of-trainers (ToT) and staff. The TAIS II staff encouraged increased horizontal communication among MOH units, although there remains a need for improvement in this area.

In addition to regular WG participation, TAIS II leadership was invited to join: the national steering committee for the health sector's national midterm review (2010); the organizing committee for the national reproductive health conference; the director of the community health's national taskforce for national priorities; the local analysis and write-up for the 2009–2010 TL-DHS; BSP reviews; development of tools and protocols for maternal and child death audits; the Village Management Committee for Health Program (KJPS) guidelines; the planning, launch, and implementation of a national nutrition campaign; and orientation for the first group of returning Timorese doctors trained in Cuba.

Key activities and products are discussed throughout this report and summarized in Annex 1.

WAY FORWARD AND RECOMMENDATIONS

TAISII's presence in national and district levels was a strength of the project. The following are national-level recommendations for the future:

- Develop complementary work plans with relevant departments to support the MOH's 'One plan, one budget' goal.
- Develop an efficient mechanism(s) to regularly review plans and implementation progress at all levels.
- Collaboration between MOH and direct counterparts of external advisers and consultants to draft the terms of reference for TAs and TOs.
- Ensure that an MOH counterpart or focal person is assigned to each TA or TO, with defined relationship and mentorship objectives that are monitored and evaluated.

District teams were complementary to national teams, providing direct support to DHS and CHC staff on policies, checklists, and other tools developed at the national level. Complementarily, the district team's field experience informed the national TAs and TOs about the actual conditions and constraints in districts, sub-districts, and communities.

TAIS II recommends that future projects maintain a distinct presence at the national MOH, in addition to strong support at the district, sub-district, and suco levels. Similar to the national-level recommendations, TAIS II encourages the DHMTs to:

- Develop work plans with district and sub-district partners to focus efforts and resources efficiently.
- Support the sub-districts to plan and review implementation with community leaders and partners.
- Use data to identify gaps in services and to monitor and evaluate solutions on effectiveness.

PART TWO: DEVELOPING CAPACITY THROUGH TECHNICAL ASSISTANCE

TAIS II sought to preserve and expand the best TA components from TAIS I through various capacity-building approaches, including mentorship/coaching, modeling of procedures, training, supervision, on-the-job support, and other team-building activities. Five principle practices were distilled from the lessons learned in TAIS II:

- **Maintain a close working relationships with MOH counterparts at national level** by building trust and a collaborative effort to support MOH policies, procedures and approaches. As stated by colleagues in the Ministry, "TAIS II did nothing that was not with and through the Ministry of Health."
- **Improve national (child health and nutrition) policies and practices** by strengthening the capacity and skills of MOH staff, supporting policy and strategy development, revision, and dissemination; development of training materials and the delivery of those trainings using adult education methodologies; and assisting to create a culture of use of data at all levels of the system.
- **Adapt technical assistance to meet national, regional and district needs** by working with national and district managers to adapt and rapidly scale-up promising practices in planning, managing and evaluating program activities and strategies.
- **Strengthen district-level maternal and child health services** by improving provider skills through supervision, on-the-job training and mentoring, and promoting improved linkages among health facilities, health workers, and communities.
- **Provide both institutional and staff capacity-building in key MOH departments** through the technical advisers for EPI, IMCI/CCM and ENC, HP, and HMIS, and in foster sharing of information and lessons learned among MOH departments and partners, and between districts and the central levels.

TAIS's supportive supervision approach improved capacity in all of its intervention areas and also provided for the demonstration of all of the capacity building approaches and lessons listed above. Supportive Supervision (SS) was an effective mechanism for identifying problem areas, improving performance over time, and scaling up promising practices. SS aims to improve health care providers' technical and managerial skills, and ultimately, the quality of care.

SS occurred at CHC and HP levels across all districts of Timor-Leste. Visits included direct mentorship on technical, logistical, planning, and managerial best practices (as per BSP standards), debriefing with the facility team, mini-training and facilitation of liaison with the central level. Data entry and analysis for action were also central to SS visits and follow-up.

Whereas SS is not a new concept in international public health, supervision that emphasized a supportive mentorship, rather than fault-finding, was new to Timor-Leste. Most SS visits were carried out by a team of national and district program managers and TAIS technical advisers and/ or officers. TAIS II supported the routine incorporation of SS in several programs, including IMCI, EPI, and nutrition, FP, ENC and HMIS as shown below in a summary of the elements included in supervision checklists.

Table 1: Summary of Supportive Supervision Tools & Categories of Standards Included in the Tool

SS technical area	Categories of technical and managerial standards checked during the supportive supervision visit with the supervision checklist						
	Health Services Organization	Clinical Staff Trained	Quality of Case Management	Document Review	Infection Control	Job Aids and Supplies	Supervision
IMCI	X	Xx	Xx	Xx	Xx	Xx	X
Nutrition	X	X	X	X	X	X	X
FP	X	X	X	X	X	X	X
Safe Motherhood / ENC	X	X	X	X	X	X Death report	X
HMIS	General Information	Data Quality	Registers and forms	Display of Charts	Reporting / Use of data	Filing System	
EPI	Skills Assessment	Attitude Assessment					
		Catchment coverage	Safety	Client support	Recording	Equipment	Work	Community reach

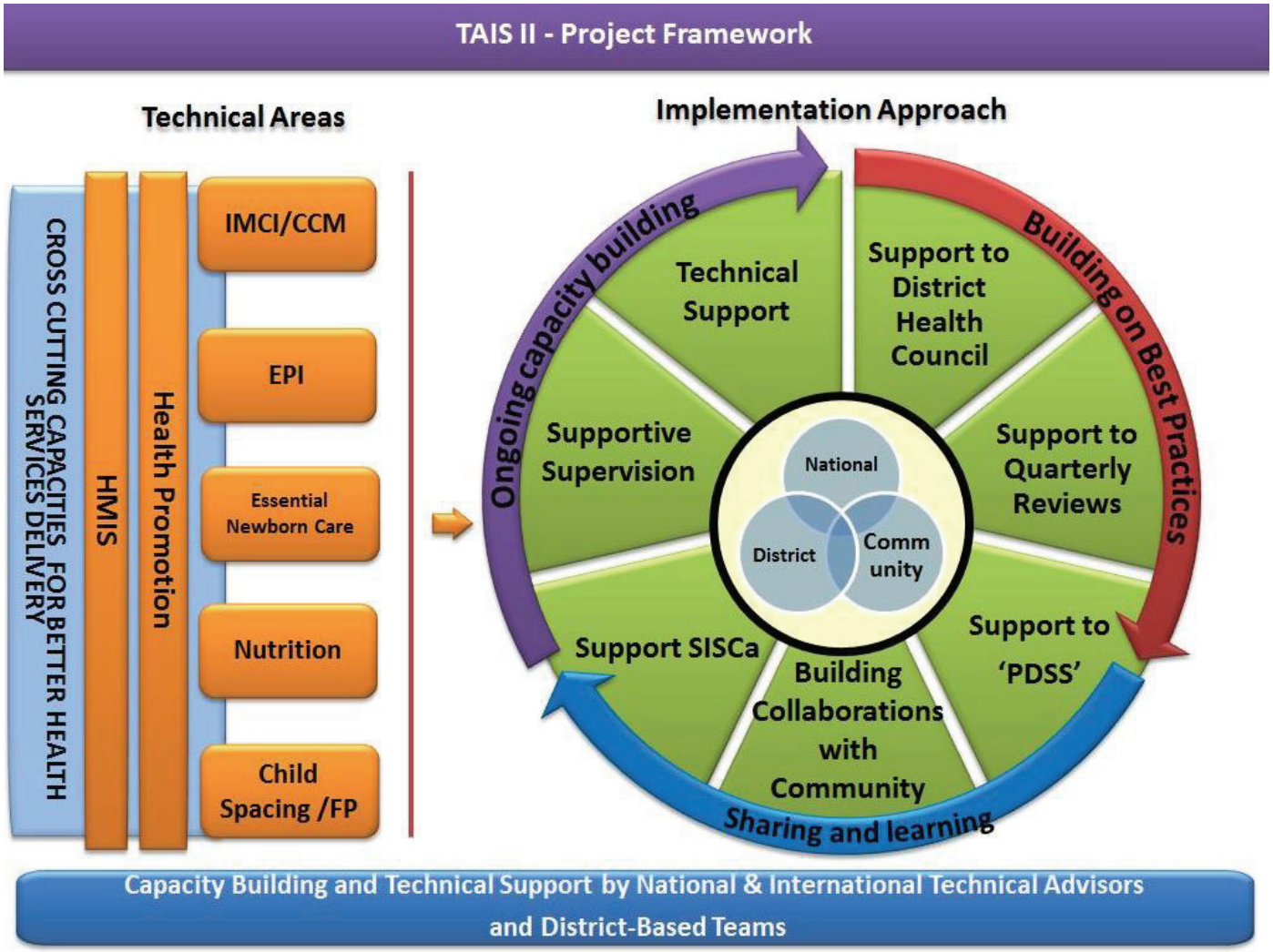
WAY FORWARD AND RECOMMENDATIONS

In the future, the MOH and partners may seek to integrate SS across programs. Currently, SS is not integrated, although as Table 1 shows, TAIS II supported the MOH and DPHOs to apply the same principles and similar tools across all technical health interventions.

- Continue to explore the extent to which integrated SS, which covers both specific programs and cross-cutting areas such as HMIS and HP, is feasible and effective, without losing the required detail needed for effective supervision.
- Develop SS measures for the DHS management roles and responsibilities.
- Develop supervision tools and approaches that reinforce the high-standard planning, budgeting and implementation in an encouraging environment for learning and improved performance.

PART TWO: DEVELOPING CAPACITY THROUGH TECHNICAL ASSISTANCE (CONT.)

Figure 4: TAIS II Project Framework



PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA

This section summarizes TAIS II assistance to the MOH to implement its priorities in multiple MNCH areas, with strong emphases on SS, planning and monitoring and the implementation of the BSP across the national, district and community levels. Based on both achievements and lessons learned, recommendations by technical area are also included.

3.1 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

HIGHLIGHTS

In collaboration with other partners, TAIS II supported the MOH in:

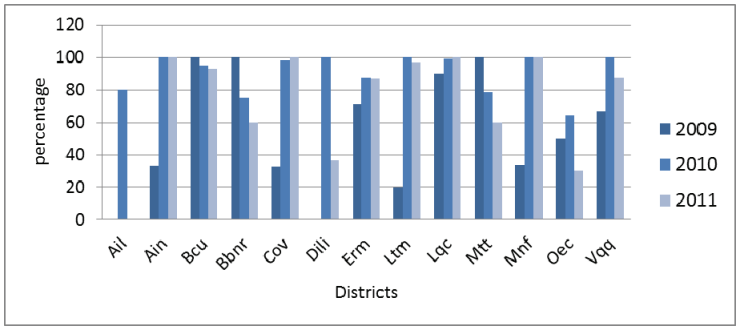
- Developing the national IMCI SS strategy
- Revising the essential drug list, IMCI chart booklet and mothers' card with new treatment protocols
- Conducting the IMCI ToT and multiple basic and refresher trainings
- Developing the CCM Implementation Guide
- Conducting the ToT for the CCM program
- Conducting CCM training for community volunteers
- Assisting in the orientation of the Timorese doctors returning from training in Cuba
- Conducting SS and mentoring district facilitators to become supervisors
- Supporting the organization of various quarterly reviews at national and district levels

3. The National Institute of Health or INS (*Instituto Nacional da Saúde)* provides diploma upgrading training for nurses and midwives and certificate training for auxiliary personnel. It is also responsible for in-service training longer than 3 days.

SUPPORTIVE SUPERVISION (SS)

At the request of the MOH, TAIS II supported quarterly IMCI SS in the three focus districts and nationwide. The number of quarterly SS generally increased from 2009 to 2010. Correct treatments (i.e. zinc, antibiotics and anti-malarial) given to children improved from 2009 to 2010 (see selected results in Table 2 below). TAIS II consistently supported both the national level (directly supported IMCI/child and newborn health manager) and district level (worked with DPHOs-MCH).

Table 2: % Children Needing Antibiotics Receiving Correct Prescription per District 2009-11



TRAINING AND OTHER SUPPORT

Years of capacity development for the use of the IMCI protocol culminated in 2010, when a cadre of skilled IMCI providers were trained as facilitators to ensure enough trainers and supervisors could continue meeting national IMCI training and supervision needs for many years. TAIS II's IMCI TA, the manager of the MOH Child and newborn health unit, and the manager of the in-service training from the National Institute of Health (INS)[3] facilitated training of 18 IMCI trainers. Participants, primarily IMCI DPHOs who had attended

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

Child getting his BCG vaccination (Laubono, Atsabe sub-district).

basic and refresher IMCI trainings in 2008 and 2009, were selected for their excellent skills in SS for IMCI. In addition to their training responsibilities, this group will be involved in reviewing major developments in child health, including CCM guidelines, child health and MCH reviews and ENC training modules.

The primary challenges to sufficient IMCI service coverage and quality include: (1) limited number of health staff trained in IMCI, and the frequent lack of essential drugs in health facilities. Refer to Table 3 below for comprehensive data on trained or untrained staff in IMCI in health facilities in the districts.

In 2010, the malaria and nutrition programs revised their protocols and thus the IMCI chart booklet had to be updated. TAIS II printed a limited quantity to conduct refresher training. Also, TAIS II helped INS revise the curriculum for integrating IMCI into pre-service education.

At both national and district levels, TAIS II encouraged and supported the organization of quarterly reviews and working groups. TAIS II oriented the Timorese doctors, after they returned from their training in Cuba, to the IMCI protocol, as prescribed in the BSP guidelines. TAIS II advocated for these providers to use the referral-level protocols from the WHO blue handbook, Hospital Care for Children, in order to improve the continuity of care and support the doctors in providing quality, standardized care of children in low resource settings.

Table 3: IMCI National Coverage

District	Total # of Health Facilities		Total facilities	Total Health Facilities with IMCI trained providers		Total HF with IMCI trained	% facilities with IMCI trained provider
	CHC	HP		CHC	HP		
Aileu	4	10	**14**	2	7	**9**	64%
Ainaro	4	13	**17**	3	4	7	41%
Baucau	6	25	**31**	6	12	**18**	58%
Bobonaro	6	17	**33**	6	17	23	70%
Covalima	7	13	**20**	7	7	**14**	70%
Dili	6	12	**18**	6	7	13	72%
Ermera	6	20	**26**	6	9	**15**	58%
Lautem	5	19	**24**	5	6	11	46%
Liquica	3	17	**20**	3	14	**17**	85%
Manatuto	6	18	**24**	6	15	21	88%
Manufahi	4	13	**17**	4	6	**10**	59%
Oecusse	4	16	**20**	3	6	9	45%
Viqueque	5	17	**22**	5	8	**13**	59%
National coverage of facilities with IMCI trained provider							**63%**

COMMUNITY CASE MANAGEMENT (CCM)

In 2010, TAIS II assisted in drafting the national CCM strategy, utilizing an outline provided by the national IMCI strategy. TAIS II also helped develop a number of essential complementary materials, including: case recording forms for children and babies, a chart booklet, a form for community follow-up, referral forms for children and babies and a training module. The MOH's MCH department and others, including JSI headquarters technical staff, extensively reviewed the initial drafts. Based on the latest WHO CCM modules, the package includes innovative additions, e.g. ENC, postpartum referral to health centers and SISCa, provision of vitamin A and de-worming tablets, and identification of acute malnutrition with mid-upper arm circumference (MUAC).

To finalize the CCM materials, a four-day workshop was conducted with the MOH, INS, partners (Clinica Café Timor [CCT], Child Fund, Health Alliance International [HAI], TAIS II and UNICEF), and IMCI facilitators from Aileu, Dili, and Oecusse districts. After recommendations were incorporated into the materials, the Directorate of Community Health approved the CCM package, which was produced in Tetun, English and Bahasa. UNICEF funded their printing in November 2010. The CCM providers' training was held in June 2011 in Oecusse (Baocnana) districts and July in Aileu (Lequidoe) district.

WAY FORWARD AND RECOMMENDATIONS

During 2010-2011, SS implementation identified various activities to maintain an effective IMCI program. To do so, the MOH and its partners should:

- Continue IMCI SS visits, with special support to health posts and poor-performing CHCs.
- Ensure that all essential drugs and logistics are available to establish the optimum quality of IMCI care. The Central Medical Supply (*SAMES or Serviço Autónomo de Medicamentos e Equipamentos de Saúde)* was encouraged to purchase and distribute under-stocked essential drugs. All DPHOs-MCH need to keep in touch with the central medical supply and assist the IMCI providers to make proper requisitions on time.
- Continue to work with the surveillance unit and communicable disease control. department to harmonize the way childhood illness visits are recorded and reported through HMIS.
- Health facilities in Covalima, Ermera, Manatuto, Manufahi, and Oecusse need to establish functional ORT corners and ensure safe drinking water in IMCI providers' rooms all year round.
- Provide sufficient funding for DHSs to carry out SS and reviews quarterly.
- Provide SS to CCM providers and continuing education.
- Expand CCM to other districts in Timor-Leste.
- Involve doctors in adapting and adopting standards for referral care of very sick children.

Future training should be focused on health facilities without IMCI-trained staff or doctors. Additional training on IMCI is an ongoing need, particularly as new providers, some returning from overseas training, enter the work force. This will require additional financial support from partners but should be consid-

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

Mothers and children registering at SISCa (Taklela, Ermera Vila sub-district).

ered part of the longer term design of review and updating of standards for in-service and continuing education.

It is important to provide SS to recently trained CCM providers in Lequidoe and Baocnana and learn from this experience before expanding CCM to other sub-districts in Timor-Leste as planned in the CCM strategy. The MOH should analyze data from SS and the HMIS to assess the effectiveness of CCM and hold bi-annual review meeting to discuss and plan improvements in the program. Continued efforts at national, district, and facility levels are needed to ensure a reliable supply of CCM drugs and logistics.

3.2 ESSENTIAL NEWBORN CARE

TRAINING

After three years of consensus building, the ENC program was initiated in early 2010 with a five-day ToT facilitated by HAI, INS, TAIS II, and UNICEF. ENC training modules for participants and facilitators, including the case recording form and other job aids, were then revised to be consistent with the existing chart booklet and with national IMCI protocols. Following the ToT, ENC trainings were conducted as per the national training plan. All districts now have health workers trained in ENC.

SUPPORTIVE SUPERVISION

TAIS II, in collaboration with HAI, supported the MCH department in development of an integrated SS checklist for Safe Motherhood and ENC. Following pre-testing and MOH approval of the checklist, SS was initiated in several districts. TAIS II supported SS for the ENC component in the three focus districts.

WAY FORWARD AND RECOMMENDATIONS

- Substantial support of ENC is needed throughout the MOH system.
- An ENC training plan needs to be developed and implemented and all future midwives need to receive this training during pre-service training.
- The low level of SS needs to be increased.
- An HMIS for ENC needs to be developed and implemented.

3.3 HEALTHY TIMING AND SPACING OF PREGNANCY

FAMILY PLANNING- MATERNAL, NEONATAL & CHILD HEALTH CONFERENCE IN BANGKOK

TAIS II sponsored MOH, INS, and project staff to attend the USAID- sponsored FP-MNCH conference in Bangkok in March 2010. This conference was an update of the 2007 Bangkok conference, at which the ENC plan had been developed.

The 2010 conference yielded important outcomes, which included team building with key MOH staff and partners, and development of a country plan for implementing best practices in FP, ensuring privacy in FP counseling areas at SISCa and a trained cadre of FP volunteers to provide information the importance of child spacing and on variety of FP methods available and making referrals to health centers. An implementation taskforce was established to review progress, assess existing FP BCC materials, and create and disseminate new materials. A revitalized FP Working Group, with updated terms of reference, adopted the 'Bangkok Plan'. The WG reviewed partners' work plans to identify how to integrate this into the national plans and encourage harmonization of approaches. Regularly held WG meetings began in 2010.

HAI, TAIS,CCT and Marie Stopes International (MSI) participated in the MOH-facilitated discussion on establishing a cadre of FP community volunteers through the FP Working Group. In 2011, the United Nations Population Fund (UNFPA) provided funding which enabled a FP counselors' pilot program to be implemented in Oecusse and Ermera. The impact of this pilot program will be evaluated in the near future.

FP COUNSELING

In 2010, TAIS II provided training on FP counseling with the use of the Decision-Making Tool (DMT) to MOH staff and DPHOs-MCH. HAI and MSI further worked with midwives to promote this tool. In 2011, TAIS II translated the tool into Tetun.

SUPPORTIVE SUPERVISION

In 2010, TAIS II supported the MOH FP Officer in developing a SS tool for FP. Following approval, TAIS II facilitated an orientation on the tool for MOH staff and DPHOs-MCH. TAIS II subsequently supported SS in the three focus districts. The visits were conducted in collaboration with HAI and the DHS.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

OTHER SUPPORT TO THE FP PROGRAM

Following TAIS II participation in USAID training on FP compliance regulations in 2010, TAIS developed a draft monitoring and evaluation plan per USAID regulations for internal use. Because of the reduction in TAIS staffing during extension periods, support to FP was limited to SS and ensuring the display of posters in Tetun with the advantages and disadvantages of all methods.

WAY FORWARD AND RECOMMENDATIONS

Despite the significant drop in the total fertility rate from around 7.8 to 5.7 per woman (TLDHS 2009/10), there remains a large unmet need of approximately 50% for family planning in the country.

- The MOH should continue to expand the reach and improve the quality of its FP information and promotion, in coordination with supportive partners such as MSI, UNFPA, and HAI.
- Continued dialogue with church officials is needed to achieve their acceptance of the program.
- It is also recommended that the MOH and partners conduct an evaluation of the FP counselors program in Oecusse and plan for expansion if appropriate. They should also implement other activities from the Bangkok plan.

Difficulty with reporting on FP is due to varying interpretations of the definitions of such indicators as "new acceptors". There has never been a concrete participatory discussion about family planning indicators – what does the MOH want and need to measure, and understanding how to measure each indicator. This must be undertaken in a very pragmatic and sensitive way in the near future.

3.4 EXPANDED PROGRAM ON IMMUNIZATION (EPI)

HIGHLIGHTS

In collaboration with other partners, TAIS II supported the MOH in:

- Developing and disseminating technical guidelines for vaccinators.
- Revising SS checklists, conducting SS, and discussing findings at quarterly meetings.
- Drafting and disseminating a Q&A booklet for community leaders and groups.
- Drafting and disseminating multiple job aids as reminders and to facilitate recommended practices.
- Providing inputs into plans for new vaccine introduction (Hib vaccine).
- Supporting campaigns (MNTE, H1N1 and measles catch-up), in planning, logistics, training, monitoring and implementation.
- Conducting cold chain and vaccine management (CCVM) training with INS.
- Conducting refresher training on basic immunization for six national hospitals.
- Adapting the EPI mid-level managers' training modules and supportive materials.
- Reinforcing the use of coverage data through district review meetings.

TAIS I and II's cross-cutting assistance to the EPI was a major focus of to its assistance to the MOH. When TAIS I began in 2005, DPT3 and measles coverage were around 50%. Program quality was sub-optimal, as five different vaccination schedules were found, some with mistakes. A small TAIS I study in 2006 found that many vaccinators could not make the correct decision about which vaccines a particular child was eligible to receive. Significant deficiencies existed in cold chain management, the collection and use of data, and community participation. Many isolated communities had difficulty accessing routine immunization services, and many facilities had insufficient health personnel to provide both daily vaccinations and community outreach sessions.

SUPPORTIVE SUPERVISION & JOB AIDS

Since 2007, when TAIS began working with the MOH on EPI SS, a majority of the 68 CHCs and five hospitals have been visited on multiple occasions. Utilizing a 40-item checklist, observations, data review, and questioning, supervisors met with the facility staff to discuss findings and give immediate training and orientation. Following the checklist, supervisors would prepare a record with priority steps that need to be implemented.

During the project's years, national and district levels MOH staff have undertaken greater responsibility. The SS findings are presented at DPHOs-EPI quarterly meetings and highlighted in national working group meetings and monthly district coordination meetings. The results, in addition to the job aids, have also generated numerous in-service trainings, particularly for hospital staff. In 2007, supervision assessments of EPI skills and attitudes of facility based health care providers averaged 56 percent and 41percent, respectively. After SS implementation and additional support, scores averaged 94 percent and 88 percent in 2010.

CHC staff preparing children for measles campaign (Manatuto District).

Development and use of job aids completed the effort to improve health staff technical knowledge and skills as well as program performance. Additionally, some job aids and reference materials have been translated into in Spanish for the large contingent of Cuban medical professionals in the country. Figure 5 below presents the job aids.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

Figure 5: EPI Materials Developed with TAIS Assistance

- An **immunization schedule** designed to help vaccinators determine the potentially difficult decision of which vaccinations children should receive, based on age & vaccination history.
- A **'late for immunization' card**, which assists vaccinators in determining what immunizations to give for a child presenting late. It clarifies how to record the immunization correctly, which was identified as a major problem area.
- A **weekly vaccination calendar** to calculate both children's eligibility for vaccinations, by calculating the child's age (in weeks) and the number of weeks since a previous vaccination.
- A **basic contingency plan** for power outages with components for facility staff to complete based on local circumstances, because supervisors found that virtually no health facilities devised their own plans.
- A **multi-dose vaccine policy (MDVP) sticker** to encourage compliance with the national MDVP policy for outreach. Stickers are designed to be placed on cold boxes and refrigerators. This issue remains one of the most difficult health worker practices to improve.
- The **MOH's official contraindications policy**, which describes conditions in which children should or should not be vaccinated related to illness, previous side effects, etc.

TRAINING AND COORDINATION

Through the national EPI Working Group, TAIS II collaborated with the MOH, the INS, UNICEF, and WHO to improve immunization coverage and quality. TAIS I contributed to the revision of the national EPI policy and strategy; the planning and implementation of the national multi-intervention maternal and neonatal tetanus elimination campaigns (2008-2009); pandemic influenza vaccination campaign; pre-service and immunization refresher training for health staff; the national measles catch-up vaccination in 201; and the preparation of several reference materials for health staff, including the finalization of the mid-level managers (MLM) training course, based on WHO global materials.

Finally, in 2009 TAIS I worked closely with WHO and the EPI unit to submit a successful proposal to WHO South-East Asia Regional Office (SEARO), which was subsequently provided with 120,000 doses of H1N1 vaccine and supplemental financial support for vaccine deployment. By the end of campaign, approximately 50 percent of the target population was reached – a respectable coverage compared to those in other countries in the region.

ADDITIONAL EPI SUPPORT

TAIS I and II helped address the demand for immunization. In 2007, the project's formative research on child health found that most families were open and receptive to immunization, although their knowledge and understanding of immunizations were limited. In response, TAIS developed a question-and-answer immunization booklet and other materials (e.g. church health messages booklet and a short film), which was distributed to local government officials, community leaders and to PSFs. The other materials are described in the HP section of this report. In addition, TAIS and other partners worked with SAMES to begin strengthening EPI supply management system, including vaccine storage and tracking systems.

WAY FORWARD AND RECOMMENDATIONS

During the last five to six years, Timor-Leste has had noteworthy improvements in both quality and coverage of immunization. While the improvement is encouraging, further work remains. Recommendations include:

- Strengthening the MOH's responsibility for SS and devolving primary supervision responsibility at the district level.
- Analyzing and addressing the arrival of vaccines at CHCs near expiration dates.
- Systematizing local-level data collection and analysis to enable staff to identify and address gap.
- Continuing SS to improve performance of facilities and staff that score poorly.
- Improving access for remote and under-served populations in each district, sub-district, and suco.
- Increasing improvement of management skills and practices in the supervision, including human resources, budget execution and planning.
- Applying data on services, population, and coverage to guide efficient time and location of vaccination services in both facilities and outreach settings to sustainably reach the large number of children who have not received immunizations.

The award of a Millennium Challenge Corporation immunization project to USAID's MCHIP project – Imunizasaun Proteje Labarik–should facilitate continued progress in these areas.

3.5 HEALTH PROMOTION / BEHAVIOR CHANGE COMMUNICATION

A family health promoter cuts a baby's nails for hygiene promotion at SISCa (Aubeon, Natarbora sub-district).

HIGHLIGHTS

In collaboration with other partners, TAIS II supported the MOH in:

- Developing and printing the National HP Strategy 2011-2015, as well as annual and five-year work plans
- Finalizing the Child Health BCC Strategy
- Developing the guidelines and training suco council members in developing Suco Development Plans for Health (PDS-S)
- Drafting the HP chapter of the Draft National Health Strategic Plan 2011-2030
- Developing, training and utilizing in the field the monitoring tool for SISCa

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

- Implementing the church health messages booklet
- Drafting a job description for DPHOs-HP
- Conducting various PSF trainings and refresher trainings
- Producing various BCC materials on child health and nutrition

HP STRATEGIES

At the request of the MOH, TAIS II coordinated the drafting of the National HP Strategy 2011-2015. After conducting a workshop with partners, TAIS II prepared a first draft and, after several rounds of discussions between HP department and the Health Policy Cabinet, the MOH approved the National HP Strategy in May 2011.TAIS II provided funding for printing the document for countrywide distribution. The MOH will develop a dissemination strategy to encourage use of the approaches and interventions.

TAIS I led the effort to develop the MOH's BCC Strategy for Child Health, as well as various BCC materials proposed in the Strategy (see below). TAIS II also supported the drafting of the HP chapter of the draft MOH National Strategic Plan 2010-2020 and the action plan (including indicators for monitoring expected results).

BCC MATERIALS

In addition to developing new materials, TAIS II and partners assisted the HP department in creating a comprehensive BCC materials management system, including: development and approval procedures, a central database, and request and stock management forms to request tools at all levels from the national warehouse to the CHCs. The HP department is using the materials development procedures, yet not currently implemented by all partners. The materials management system was established, but has not yet been implemented by the HP department.

Table 4: TAIS II BCC Materials

Type of material	Topic	Use
PSA	Nutrition	TVTL and community
Short film	Hygiene	Community
Short film	Immunization	Community
Short film	ENBC	Community
PSA	IMCI	TVTL and community
Flipchart in Tetum	Family planning	Health facilities
Counseling cards	Nutrition	Health facilities and community
Short film	Nutrition counseling	Training
Booklet	Child health	Churches and FBOs

Child health films: TAIS II helped develop several short films on child health; topics include EPI, hygiene, birth preparedness and ENC, and awareness of danger signs. Complementary radio dramas were also produced. All materials were reviewed by the respective MOH program managers, and the final products were distributed to districts in 2010 for use in SISCa and other HP activities. Two of the films (hygiene and

ENC) were translated into Baikeno and distributed to local NGOs in Oecusse. The original IMCI film was not used due to lack of clarity of the messages, but TAIS II supported the production of another IMCI film, which was broadcasted on national television in July 2011.

Nutrition: At the end of 2010, a small working group composed of the MOH Nutrition and HP departments, UNICEF, Alola Foundation and TAIS II, started adapting the global UNICEF Infant and Young Child Feeding (IYCF) Counseling Package. TAIS II advocated for the addition of assessment questions and key IYCF practices, barriers and enablers listed on the back of the cards to help the counselors negotiate behavior change. This information was based on the Community Consultation carried out during TAIS I and on a nutrition counseling package previously developed (but not used) by TAIS II. TAIS II also supported the design (including several photos) and pre-test of the cards. In addition, TAIS II supported the translation of a Guatemalan film, teaching community health volunteers the recommended five steps of effective counseling on feeding young children. The MOH will use the film for the counseling cards training in late 2011.

Family Planning: After training DPHOs-MCH on the Indonesian version of the Decision Making Tool (DMT) for FP, the MOH asked that TAIS II prepared a Tetum version of the tool, which UNFPA will print. Similar to other new tools, the field follow-up led to additional reinforcement with health care workers. Further encouragement of counseling attitudes and the Tetun translation is expected to assist health care workers counsel clients more effectively.

DHS and TAIS II staff conducting family planning supportive supervision at a health post (Cairui, Laleia sub-district).

WORKING WITH THE CATHOLIC CHURCH

The Catholic Church has an important role in Timor-Leste. In recognition of this, the MOH and TAIS I collaborated on an initiative in 2007 to disseminate key information on child health during weekly mass in churches and chapels. The initiative was developed because of large attendance at churches, wherein they could potentially reach a greater number of people than existing health facility and outreach encounters. For this initiative, the MOH and TAIS I developed a booklet comprising 12monthly themes (e.g. malaria, immunization, pregnancy, nutrition), in which were divided into four weekly messages to be delivered by priests or catechists after mass. After an extensive technical review by the MOH and intensive pre-testing with catechists, nuns and priests, the booklet was approved by the two bishops.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

TAIS II focused on disseminating the booklet and training the catechists on its use in the following districts and parishes:

Baucau District	**Dili District**	**Manatutu District**	**Ermera District**
Vermasse	Comoro	Manatutokota	Hatolia
Venilale	Catedral	Laclubar	Ermera
Fatumaca			
Baucau			
Laga			

In June and July 2010, TAIS II and the MOH facilitated a monitoring study of the initiative. The overall findings were:

- For various reasons, the messages did not reach the number of people intended.
- Priests were a major gatekeeper for facilitating or impeding message announcements.
- There was high interest in the information and people felt that the church was an appropriate venue for the messages.
- Community members reported changed practices and/or willingness to change practices.
- The issues of ownership and management of the initiative were noted, particularly with the end of TAIS II approaching.

The Church Health Messages Booklet monitoring report was translated into Tetun and provided to the MOH. Following the delivery of the report, a meeting between TAIS II, other partners and MOH was held and several suggestions were presented, e.g. expanding the use of the booklet inside of and external to the Catholic institution.

Selected suggestions are presented below:

- Encourage CHC staff to communicate better with catechists.
- With the DPHOs-HP from the 13 districts, implement use of the booklet in their districts.
- Conduct a follow-up meeting with bishops, as they officially approved and signed the booklet. They should be asked to send a letter to all parishes requesting regular implementation of the readings. The bishops (including the new one in Maliana) should receive the monitoring findings and a copy of the report to learn about implementation challenges.
- Prepare a budget for implementation, including incentives to catechists.
- Add the Malian bishop's signature to the booklet.
- Expand use of the booklet to other settings, e.g. schools, SISCa's, suco councils, literacy programs and other organizations, e.g. women and youth groups.

NUTRITION CAMPAIGN

TAIS II provided technical and financial support to the National Nutrition Advocacy Workshop held during March 2011 in Dili, which launched a national nutrition campaign aimed to: 1) raise awareness of high-level decision-makers; 2) advocate for resource allocation; 3) engage media and stakeholders in a year-long campaign; and 4) improve community's knowledge, attitudes and practices. TAIS II directly supported the following main activities: drafting of the workshop design, developing PowerPoint presentations and group

discussion templates; review of the presentations and templates with the technical team (composed of MOH, UNICEF, Alola Foundation and TAIS II); logistics (e.g. invitees, agenda, room setting, food, banners); and collaborating with the Nutrition Officers to draft the workshop report.

Community watching a health education film (Taklela, Ermera Vila sub-district).

Through the nutrition working group of stakeholders, TAIS II supported the following actions:

- Collection of all BCC materials from partners.
- Development of the campaign's key messages and photos, which were pre-tested and used as the foundation for local leaders' advocacy materials.
- Design of a brochure with the key messages for leaders.
- Support during the campaign launch and implementation in TAIS II focus districts.

ADDITIONAL HP PROGRAM SUPPORT

TAIS II worked closely with the Head of the HP department to strengthen the internal organization and procedures. The project strongly advocated for and supported the organization of HP quarterly meetings, DPHOs-HP and partners from the 13 districts. The meetings allowed for review of new tools (e.g. the SISCa tools described below), new trainings (e.g. the BCC trainings for PSFs supported by the Bee, Saneamentu, no Ijieneiha Komunidade – BESIK and CDC programs), new programs (e.g. previous work with suco councils), among additional review. At the meetings, district representatives shared experiences and reinforced the need for partners to support the HP programs in the district, rather than implement uncoordinated activities.

TAIS II initiated several meetings between the HP and HMIS departments in order to revise the HMIS formats for HP, which were unclear and not gathering information on the four HP programs (only a format for the "thematic" program is developed, but not used). SISCa, PSFs and thematic programs have been revised; however, the school health still needs to be analyzed. The HMIS Department will propose registers and reporting formats to HP. In addition, TAIS II coordinated the drafting of a job description for DPHOs-HP.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

WAY FORWARD AND RECOMMENDATIONS

- Since the HP Strategy has been distributed to all districts, the MOH and partners should disseminate the document and the five-year HP plan to all HP in-charge staff (e.g. MOH, DHS, CHCs, and partners).
- The child health films have been primarily featured at night events preceding SISCa and attracted great interest. The films should be used in smaller groups, where discussions are more effective for behavior change.
- Meetings with priests should be conducted to improve their understanding and involvement in the dissemination of health messages through the Catholic Church. Local NGOs should be involved to implement regular monitoring of the church messages. The partnership between CHC staff, parish staff, DHS and the Catholic Church should be strengthened. The booklet's use should be expanded inside and outside the Catholic Church.
- The MOH should encourage its network (health facilities, SISCa, collaborating NGOs) to address the monthly themes in the Church Health Booklet in all health promotion opportunities during the same months the messages are delivered at churches.
- For the nutrition counseling initiative to be effective, the MOH and partners should ensure thorough training, with extensive practice in counseling skills, followed by mentoring and supportive supervision of the volunteer counselors.

3.6 INVOLVING COMMUNITIES IN THEIR HEALTH

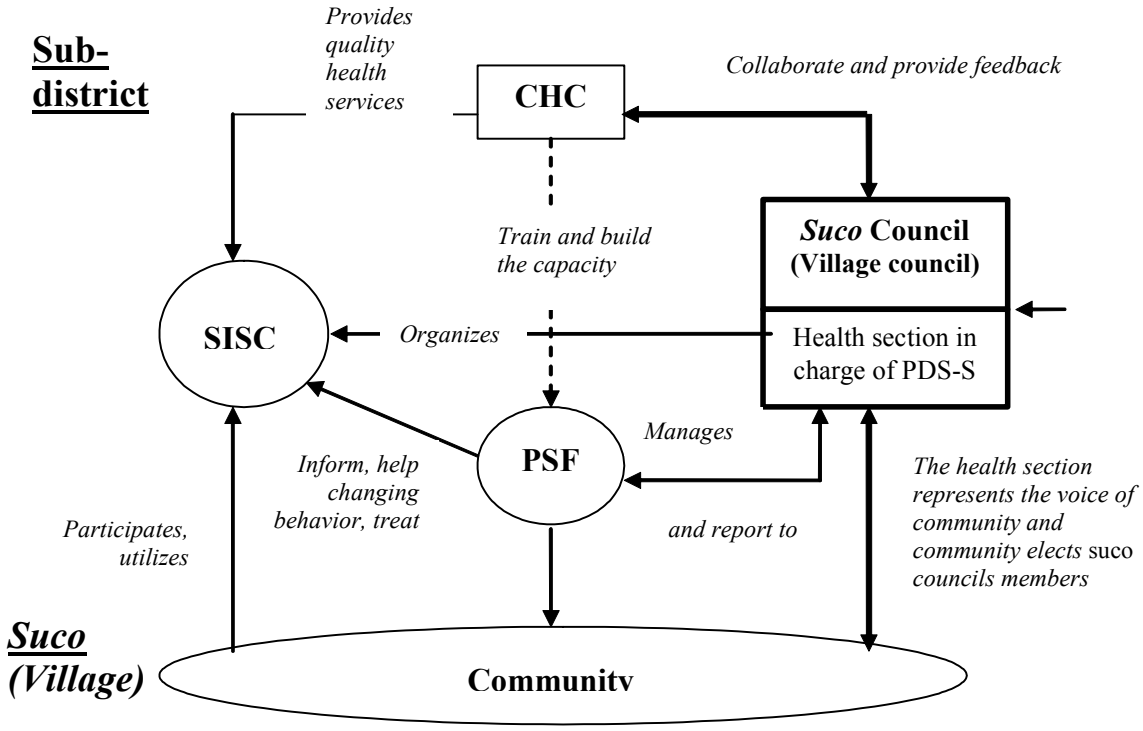
During 2006-2007, TAIS I attempted promoting community participation and mobilization in Venilale, intending to lead to communities developing their own action plans through listening exercises. These activities showed potential, but were too human resource-intensive for the MOH to manage and sustain after TAIS I ended, TAIS II and the MOH examined other community participation approaches more appropriate to the country's context. One concept emerged directly from two important MOH guidelines, the PSF Guidelines[4] and the SISCa Guide[5], both of which recommend the creation of KJPS as the village-level PSF support group and SISCa management committee. Both recommend including influential people in the committee, e.g. the suco and aldeia heads.

Using a bottom-up approach to establish and encourage community ownership, the HP Department and TAIS II facilitated establishment of committees in TAIS II focus districts. The approach consisted of training community facilitators to lead group discussions in selected aldeias, disseminating the results to the community at the committee's inaugural meeting, and, finally, developing an action plan to address health issues identified by the community.

4. Ministry of Health of the Democratic Republic of Timor-Leste. 2005. Family Health Promoters Program (FHPP) Guidelines.

5. Ministry of Health of the Democratic Republic of Timor-Leste. 2008. SISCa implementation guide.

Figure 6: Management Commission for Village Programs-Relations between Health Services, Community, and Suco (Village) Councils



Although simplified from the Venilale activities during TAIS I, the approach was again found very human-resource intensive, chiefly because of lack of personnel at the CHC level for establishing and supporting a new group in each village. Therefore, the concept evolved towards working with the suco council, an existing village structure, supplemented by PSFs.

To revise the approach, the HP Department and TAIS II utilized the same bottom-up approach, and the action plans developed in the pilot sucos are included into Planu Dezenvolvementu Suco (PDS) [Suco Development Plan]. The PDS is a national program implemented by Ministério da Administração Estatal e Ordenamentu Territorial (MAEOT) [Ministry of State Administration and Territory Planning]. To better define the collaboration between the CHCs and suco councils, the HP department is currently creating a working group with MAEOT to better define the capacity-building needed to enable suco councils develop appropriate PDS-Saúde (PDS-S) [PDS for Health].

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

A Memorandum of Understanding (MOU) is being drafted and revised by different MOH departments.

TAIS II's support incorporated both national and local levels, especially with DPHOs-HP and CHCs. By mid-2011, TAIS II supported the development of three PDS-S: Poetete (Ermera Vila sub-district), Cairui (Laleia sub-district) and Aubeon (Natarbora sub-district), and supported the process in other sucos. In Oecusse, TAISII worked with the USAID-funded local governance project implemented the Asia Foundation to develop suco council capacity for developing health plans.

From March to September 2010, TAIS II work with local government officials and partners in three sucos to develop their training and action plans and another four sucos to disseminate locally collected data to the community.

Poetete village head announcing the creation of the village council's health section to the community (Taklela, Ermera Vila sub-district).

WAY FORWARD AND RECOMMENDATIONS

- The MOH and MAEOT should negotiate and sign an MOU. Afterwards, the draft KJPS Guidelines should be updated to guide other sectors to support and increase suco councils' capacity to develop and implement improvement plans for community health.
- As with most HP and community interventions, NGOs are critical to support the HP department in increasing community participation. Overtime, HP staff are needed at CHC because, in their absence, work with communities is difficult unless an NGO takes the initiative.
- The PDS-S, which officially replaces the KJPS, should be developed with the support of community groups working in health, e.g. mothers' support groups, local NGOs, FBOs, water and sanitation groups, etc.

3.7 INTEGRATED SERVICES FOR COMMUNITY HEALTH (SISCA)

DISTRICT-LEVEL SUPPORT

Both TAIS I and TAIS II intensively supported the CHCs to monitor SISCa. TAIS I supported Aileu district to monitor 11 SISCas. This short "pilot" experience was intended to improve health workers and PSFs' skills, as well as increase community participation by monthly supporting the same SISCas . TAIS II district teams and DHSs agreed to monthly support selected CHCs and SISCas. TAIS II consistently supported SISCas in several sub-districts of each of the

three focus districts. At each SISCa visit, the TAIS II team:

- Prepared materials, equipment and medicines with CHC staff.
- Participated in supporting PSFs or health staff complete growth charts and counsel, FP counseling, hygiene and sanitation promotion and general HP.
- Facilitated debrief meetings with health staff and PSFs after each SISCa about the monitoring results (using the SISCa Monitoring and Stratification format described below).

As a results of TAIS's important support to the CHCs in transport, human resources, linkages with community leaders, PSFs' capacity-building, active HP (and night events), among other support, approximately all SISCa's supported by TAIS were "functioning" (with a minimum score of "B"). However, most SISCa's still require support in areas, e.g. capacity building of PSFs to conduct HP; counseling for health staff and PSFs; better organization of SISCa (preparing materials, improving patient flow, etc.); improved planning and management to avoid drug and materials/equipment shortages (i.e. an improved requisition system); more effective use and distribution of BCC materials; and data use and analysis, specifically the number of participants compared to target groups.

NATIONAL-LEVEL SUPPORT

Support at the national-level was strengthened during TAIS II with the simplification of the SISCa Monitoring and Stratification format (see Annex 2). It was disseminated across all districts and TAIS II built the capacity of the MOH SISCa Officer in compiling and disseminating monitoring results to the 13 DPHOs-HP. TAIS II's presence at the national level also facilitated the organization of extraordinary meetings, including, SISCa working group meetings, and HP quarterly meetings with DPHOs-HP in order to ensure that SISCa monitoring was done the same way in all 13 districts. The meetings involved partners whose support is crucial to SISCa, especially in HP and BCC. After one year of compiling district reports, the national level saw a substantial improvement in the quality and timeliness of the reporting from the districts.

WAY FORWARD AND RECOMMENDATIONS

- Continued intense support and frequent visits are necessary to improve SISCa functioning and impact, as well as PSFs and health staff's skills and community involvement.
- Due to the cost of conducting refresher trainings at the sub-district level for PSFs and the limited MOH budget, informal skills-building prior to or after SISCa is vital to quality and impact of SISCa.
- NGO and partners support to DPHOs-HP and SISCa is crucial to improve transport issues and human resources shortages (especially in HP), BCC and links with communities and community leaders.
- Strong support and capacity-building for the national SISCa Officer is necessary to monitor SISCa functioning and maintain needed communication with DPHOs-HP.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

- While there is a good tool for monitoring the functioning of SISCa, the data collected needs to be used for problem solving to improve functioning of SISCa
- Data collected on services provided at SISCa must be harmonized with the regular HMIS program reporting. The current age groups used in SISCa reporting are not the same as those used in HMIS reporting.

3.8 COMMUNITY HEALTH VOLUNTEER (PSF) PROGRAM

In 2009, TAIS I supported the PSF program evaluation, which resulted in specific recommendations on the selection, training, roles and supervision of PSFs. TAIS II sought to address some of the recommendations through its community mobilization officers based at DHS and national MOH levels.

DISTRICT-LEVEL SUPPORT

Communication between health staff and community leaders was enhanced through collaboration with suco councils. CHC personnel were given the opportunity to inform suco council members about the health condition in the village and the PSFs' role at SISCa and during home visits. TAISII teams assisted the CHC staff to facilitate on-the-job training and mentoring for PSFs at 37 – 46 SISCa per month, primarily on basic skills, e.g. weighing, completing the growth chart, and conducting HP. Monthly monitoring of PSFs led to refresher trainings in identified weak areas. A total of 102 refresher trainings for PSFs were conducted in Soibada, Natarbora and Ermera Vila on nutrition (weighing, growth chart and counseling) and IPC/BCC focusing on nutrition.

CCM volunteers being trained in Oecusse (Nitibe sub-district).

NATIONAL-LEVEL SUPPORT

At the national level, TAISII officers trained as Master Trainer of Trainers (MTTs), supporting the HP department in training District Trainer of Trainers (DTTs) in IPC skills and BCC. TAIS II also reorganized the PSF database, which currently includes all trainings attended by PSFs. As working group meetings were difficult to organize regularly during TAIS I, TAIS II used the quarterly DPHOs-HP meetings to discuss and improve the PSF program.

TAIS II developed an internal MOH survey on PSFs' expectations for programs within the Directorate of Community Health, and then helped facilitate a PSF program coordination meeting. The coordination meeting identified each program's plans regarding: PSF training in 2010 and 2011; needs for home visits by

PSFs; status of home visit reporting formats; and commitment to use an integrated home visit format. Key issues identified led to various recommendations including: hiring an additional HP staff member, managing the PSF database at the district level, building the capacity of DPHOs-HP to coordinate PSF activities, and updating the job description for PSFs and the PSF guidelines. Following these findings, TAIS II advocated for a meeting on the revision of the PSF Guidelines, which is scheduled for late September 2011.

WAY FORWARD AND RECOMMENDATIONS

The MOH should work with partners to address the health staff shortages at the CHC level to monitor and mentor PSFs. This initiative should include revising the program guidelines for volunteers and their role in health service delivery and referral. NGOs and their field staff can play a major role in filling this gap by visiting families identified as problematic during SISCa or who are not attending SISCa. Many PSFs remain incapable of conducting effective HP during SISCa. Therefore, the new IPC/BCC training module from the HP department should be utilized by all partners doing refresher trainings for PSFs. Training needs supplemented by supportive supervision and mentoring.

The PSF database is one management issue for the community volunteers program. Completing and maintaining the national PSF database is very difficult because information changes at the district and sub-district levels (e.g. drop-out of PSFs, trainings), which is often not transmitted to the HP department. The best way forward appears to be establishing district databases of PSFs directly managed by the DPHOs-HP, who should annually update the national level. An accurate database will allow each department to better target its trainings and avoid overloading PSFs.

The SISCa/PSF working group was difficult to organize because of lack of involvement from HP staff. Therefore, TAIS-II included SISCa and PSFs topics in the quarterly national DPHOs-HP meetings. As a result, MOH, DHS, and partner staff made concrete decisions. The quarterly HP meetings at district and national levels should be continued and include at least a half day for discussion and planning actions to improve the functioning of SISCa and PSFs.

3.9 HEALTH MANAGEMENT INFORMATION SYSTEM

DISTRICT-LEVEL SUPPORT

Assessment of HMIS and training of health staff: In collaboration with the MOH's HMIS department, TAIS supported a workshop to strengthen HMIS capacity at the national, district and health-facility levels and establish a collaborative HMIS team within the district by building on experience, methods and tools from Timor-Leste "best practices" in HMIS management. The Performance of Routine Information System Management (PRISM) framework and tools were used to help district and health-facility managers identify the system's strengths and weaknesses and develop interventions for strengthening HMIS. The workshop was conducted in Ermera, Manatutu, Ainaro and Oecusse. Data collection and recording, management and quality, and analysis and display of results were covered in the training.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

Supportive supervision and suco-level data: With a focus on improving quality of HIS data and providing on-the-job training, TAIS II assisted the national HMIS department in developing a SS process for HMIS in early 2010. The SS process focused on CHCs and health posts. With involvement of a national staff, TAIS II developed an SS checklist, and subsequently, all national and district staff were oriented on using the tool to improve data quality and use. The national level conducted SS, with support from TAIS, in Ermera, Manatutu, Oecusse, Lospalos, Liquiça, Same and Viqueque. During the supervision process, discrepancies between registers and reports were identified. Refer to Annex 3 for a selection of HMIS SS results and recommendations. Also, as part of the process, health staff were provided on-the-job training on completing the different programs' HMIS formats and creating and using tally sheets for transferring data from registers to HMIS formats.

Suco-level data analysis: Information in the cohort registers for from the Safe Motherhood program and suco-level data analysis conducted by WHO, indicated coverage of health services varied by sub-district and suco. TAIS II integrated the approach of analyzing data by suco-level for vaccination, antenatal care and FP. Along with the HMIS department, TAIS II promoted creation of registers according to sucos. This facilitated analysis of coverage by different sucos and identified of pockets with low coverage. The suco analysis of HMIS data was useful in organizing PDSS discussions about coverage of health services, challenges, and areas for improvement.

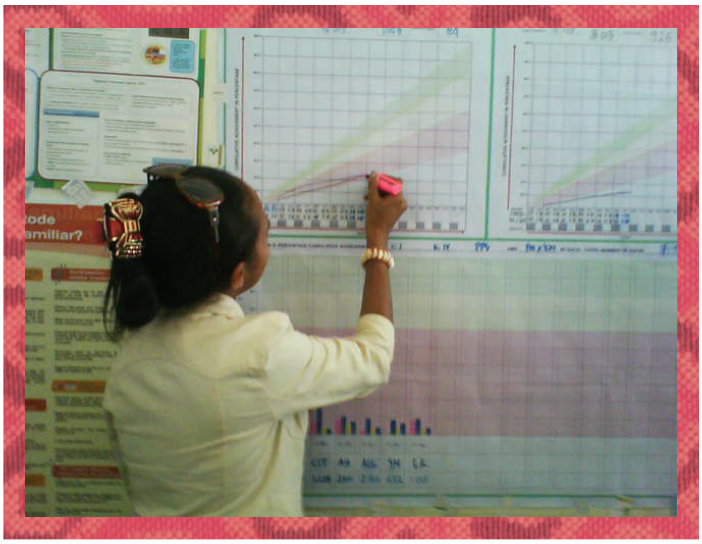
To assist data analysis and visualization by suco level, a wall chart was designed and health facility staff were trained on utilizing the chart. The wall chart is divided into three colors to provide easy interpretation of program performance. If the indicator level is in the "green zone," the program is performing well and if continues similar efforts, will achieve its target. If the indicator is in the "yellow zone," it signifies an average -performing area and improvement is necessary to achieve targets. Lastly, if an indicator level is in "red zone, "it signifies that the program is performing below average and requires special efforts to achieve targets.

The charts were first introduced in Ermera district. Currently, DPHOMCH -FP Ermera has taken the lead by working with the health facility in analyzing and plotting data on the graph. The graph allows plotting four indicators at the CHC level and also at the suco level within the CHC catchment area. For example, for MCH , the program can use K1, K4, SBAs and PNC1 visits which are helpful in following the continuum of care starting from registration of a pregnant woman to child birth and first visit after child birth.

Moreover, the charts are helpful in monitoring program performance monthly at the CHC level. It also allows the CHC staff to plot coverage against targets by different sucos. The graph pictured (to the right), and the graph at the bottom allows staff to plot coverage by different sucos within the catchment area and identify sucos with and maintaining low coverage.

HMIS database: An HMIS database was designed with support from TAIS II to input individual health facility reports and enable preliminary analysis of monthly data. District and national level health staff gave suggestions on the database design. TAIS II helped Ermera district staff sort their reports for 2011 and in-

put all data from CHCs. This "pilot" was completed in September and the MOH plans to scale-up the program at the national level.



DPHO-MCH teaching health staff on how to monitor coverage on graphs hung on CHC walls (Ermera Vila CHC).

NATIONAL-LEVEL SUPPORT

HMIS guidelines: TAIS II drafted HMIS guidelines, which were reviewed with individual programs and the HMIS department. The guidelines included data collection steps, basic understanding of target populations, and the calculation and use of indicators in order for health services coverage to be determined for sucos, sub-district or districts. The guidelines were approved during the first quarter of 2011 and translated to Indonesian and Tetum.

Support to the national HMIS "think tank" and national meetings: TAIS provided technical support to the HMIS 'think tank, 'established by the MOH, to address two key priorities – the MOH website and the Rejistru Saúde Familiar (RSF) [Family Health Register]. Involving representatives from the MOH, HAI, WHO, AusAID, the World Bank, UNICEF and TAIS II, the think tank helped the MOH to design their website and refine the process for updating the RSF and use of the data locally.

MOH website: TAIS II hired a short-term consultant to design the MOH website and train the MOH Protocol Officer to regularly update it. Website design and content were presented to and approved by the Council of Directors. The website went live in July 2011.

Registu Saúde Familiar: In 2008, the MOH launched the RSF to collect local-level data about families. This data was needed to help correct the estimated denominators from the 2004 census, providing the more accurate population numbers for the health services. PSFs and CHC staff used the data aiming to ensure that SISCa's were reaching all people needing care. However, the data were not collected systematically and not felt to be accurate enough to be useful.

In effort to better understand the issues regarding the RSF implementation, the think tank members visited Covalima, Liquiça, Bazartete CHC, Comoro CHC and Dili DHS to interview the district-level implementers for the first round of data collection for the RSF. Challenges identified through data collection, include: lack of guidelines and registers, poorly defined responsibilities, low capacity levels, unclear payment processes, inadequate supervision, coordination issues and electricity problems.

PART THREE: ACTIVITIES AND ACHIEVEMENTS BY TECHNICAL AREA (CONT.)

The MOH HMIS unit and TAIS II organized a RSF review meeting in Ermera to assess a functional RSF's challenges and different approaches; which identified areas needing focus. While UNICEF plans to provide financial support for printing and supporting the new registers, TAIS II has been closely involved with the HMIS unit in charting the RSF data collection and updating data use processes. TAIS II proposed to use RSF data collected to develop bottom-up micro-planning at the sub-district level; which was being implemented in Ermera when the project ended.

OTHER NATIONAL-LEVEL SUPPORT

In 2010,TAIS II helped the HMIS department organize a three-day national HMIS coordination meeting, in which HMIS SS's results were presented. All HMIS-DPHOs and DHS directors participated in the meeting. Discussions about these results and other issues contributed to development of a HMIS resolution, which was signed by all districts.

WAY FORWARD AND RECOMMENDATIONS

- Assist the MOH develop an overall health information strategy that includes the monitoring and evaluation requirements of the National Health Sector Plan 2011-2030.
- Develop a more comprehensive HMIS, including data on human resources, training, equipment, availability of transport and community involvement.
- Clarify the roles and responsibilities for HMIS at various levels of the health system.
- Streamline and standardize health management information at all levels of health system (e.g. SISCa, health posts, private clinics, CHCs and hospitals) to reduce the burden of data collection and reporting at all levels.
- Train health staff on HMIS formats, processes and systems
- Build on this capacity through regular review processes that utilize the HMIS for planning and decision-making.
- Conduct routine data quality audits to identify gaps and generate quality data.
- Improve collaboration and the communication of feedback loop from data analysis both within and outside the MOH.

PART FOUR: CHALLENGES, OPPORTUNITIES, AND RECOMMENDATIONS

4.1 CHALLENGES AND OPPORTUNITIES

NATIONAL LEVEL

- Donor and partner coordination issues continue to merit attention. The health sector midterm review identified the theme of "One Plan, One Budget" as a priority area. Since the National Health Sector Plan 2011-2030 was disseminated; the MOH annual plan originating from this strategic plan can serve as the foundation for all UN agencies and partners to build on and into which they can integrate their support.
- Unreliable availability of equipment and essential drugs at health facility level is a major barrier to improving services. TAIS II and the MOH IMCI program manager strive to present at the newly-organized SAMES coordination meetings to provide inputs from the field, in which TAIS has previously attended.
- There are similar issues with expiration dates and storage with vaccines and EPI supplies. TAIS II found nearly expired vaccines and vaccines delivered that are nearly at the discard point due to heat exposure. SAMES reported problems with 22% of its donated stock, which is often too close to expiration.
- The MOH, Alola Foundation, UNICEF and TAIS II have collaboratively developed nutrition counseling cards for PSF and health workers. These materials may potentially support good counseling and healthful new practices by mothers; however, these actions require quality of training on counseling and using the cards, and sufficient follow-up support and supervision of the counselors.
- Coordination of support for the HMIS has been difficult. Yet, the health information 'think tank' is a good opportunity to further develop the Family Health Register and website. Broader and strategic HMIS issues have been able to be dealt with following the "think tank" progress, such as the development of an HMIS guideline and a simple computerized database for CHCs.

DISTRICT LEVEL

While decentralization to the district level has been promised for several years, the process has been minimally implemented, and community-level health services remain centrally-driven. TAIS worked with individual MOH departments that are open to explore innovative approaches in their programs. CCM development and suco-level data analysis in TAIS districts are excellent examples of the MOH's openness to new approaches. Also, the planned placement of district-level management advisers will be an opportunity to improve service support from the district level.

COMMUNITY LEVEL

The PDSS establishment is a process vulnerable to being moved forward too quickly. Specifically, the entire process is predicated on implementing a bottom-up approach, which takes time/is essential to creating community ownership and sustainability. TAIS aimed to ensure that the HP department communicates with partners about this critical consideration of wanting to promote expanded suco council involvement in health.

PART FOUR: CHALLENGES, OPPORTUNITIES, AND RECOMMENDATIONS (CONT.)

TAIS's monthly support to the standardization of IEC health topics will help capitalize opportunities for health promotion and education at SISCa. The HP department's tools for tracking dissemination and stocks of HP materials will also be important in this regard.

4.2 CONCLUSION AND RECOMMENDATIONS

Since the TAIS project began working in Timor-Leste in 2005, many basic health indicators have improved considerably. While TAIS played an influential role in these improvements, the project's contributions cannot be assessed precisely because the project worked from within MOH structures at all levels. During the same period, there have been many clear improvements in the management and functioning of the MOH, although important health system weaknesses remain; e.g. an over-dependence on donor funding, understaffing, lack of operational funding -- amongst others.

The effectiveness of TAIS II was enhanced by the restructuring its technical staff, with teams of both public health technical officers and community mobilization officers based in three focus districts; and the placement of four technical advisers in relevant MOH programs or departments. This reorganization enabled TAIS II to coordinate and integrate management and quality-of-care improvements better with the MOH at national and districts levels. The embedded TAs and the improved coordination and communication among programs facilitated new ways of combining programs to achieve better results.

The four national advisers helped generate concrete planning and development of several policy/strategy revisions and develop specifically targeted trainings for identified gaps in knowledge for HMIS, EPI, IMCI, and newborn care. Through supportive supervision, TAIS introduced a truly collaborative and supportive approach to improving capacity. TAIS fostered communication among departments, the MOH and partners, and provided opportunities to propose new formats and management concepts to facilitate the MOH's work. Supervision and the requisite tools for measuring progress in improving quality of care were a major contribution of TAIS II for child health services. The best recognition of the impact of this support has been the district-led review meetings using their supervision data to solve problems.

Close collaboration with MOH counterparts and TAIS II's willingness and ability to flexibly respond to MOH requests improved the project's ability to support system strengthening and increased the project's credibility within the MOH. TAIS helped on several key MOH initiatives beyond the direct technical assistance areas, e.g. designing tools for a task force to follow-up on national priorities indicators, supporting the monthly NGO forum with the MOH, the Health Information think tank and the steering committee for the Sector Mid Term Review, developing the management and leadership training course, and the orientation of the newly graduated Cuban- trained doctors to the Timor -Leste health care system and protocols.

Coordination with other donors has occasionally been difficult, despite the increased activity of the technical working groups. For example, the plan for improving nutrition counseling tools and skills was delayed while

different partners negotiated a common approach and collaboration. The adaptation of tools requires TAIS II and partners to collaborate closely to ensure that the technical assistance support is not overwhelming MOH central and district colleagues with multiple tools and approaches that have not been developed through processes that ensure MOH ownership.

Through their activities, the TAIS II team identified a number of recommendations for how other NGOs and donor health projects may best support the MOH, districts, and community-health leaders. The project proposed an orientation workshop that the MOH may use with its partners to harmonize inputs to health services at all levels, as outlined in Figure 6.

Final recommendations based on the TAIS team's experience follow:

- Follow training (on any topic, technical/managerial) with focused SS to improve coverage and quality.
- Introduce a facility-focused quality- improvement process based on SS and HMIS data that maximizes impact on the mother and child health status.
- Improve performance of SISCa and health facilities through better planning and monitoring from CHC and with partners.
- Strengthen a community-level information system through the RSF for improved planning.
- Improve the HMIS by including management indicators for all levels.
- Regularly review data for evidence-based decision making.

Figure 7: Orientation on Mechanisms of Support to District Health Services/District Health Management Teams

Objectives:

- To introduce and understand existing mechanisms of coordination and support from international and national agencies to the DHS
- To explore ways to scale up these support mechanisms in all districts
- To introduce and understand key national processes and tools for achieving quality and coverage targets
- To accomplish the health objectives of the Ministry and reach the MDGs

Topics and tools

- District Health Council (DHC) meetings
- Resource sharing and management/ coordination: people, transport and budgets
- National priorities and SISCa monitoring format
- National standards, tools for supervision and schedule for supportive supervision
- Suco-level data analysis or Local Area Monitoring
- HMIS database –data entry and use
- Community participation through PDSS

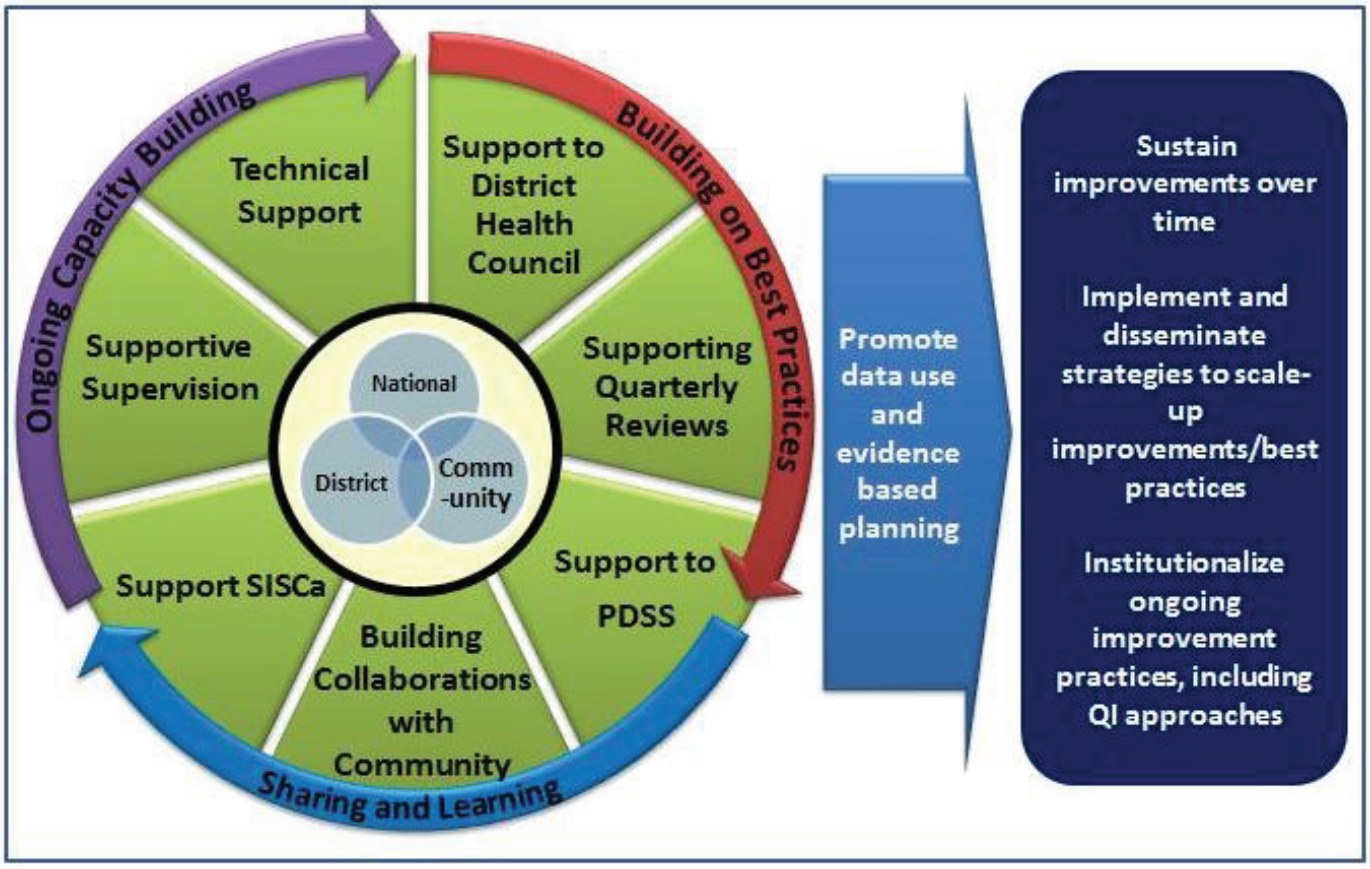
- Encourage community involvement through PDSS to help improve service delivery.
- Strengthen PSFs skills and their support structure for health promotion and prevention.
- Strengthen the links between civil society and the health system through the regular Ministry's monthly NGO sharing meetings.
- Continue to link with all partners and analyze the NHSP 2011-2030 objectives to prioritize strategic activities.

PART FOUR: CHALLENGES, OPPORTUNITIES, AND RECOMMENDATIONS (CONT.)

- Continue to evolve the supportive supervision process to become more integrated and reflective of the BSP intentions.
- Reinforce the regularity of monthly sub-district and district coordination meetings and the quarterly reviews of SS data for technical implementation improvements.

While these selected recommendations may seem simple they are built on a gradual understanding of the needs and expanding capacities of the Timorese health services delivery system and will need vigilant monitoring and dogged reinforcement. They are not glamorous, but they are important. They build on the progress realized by the MOH and district staff—that collecting and analyzing their own data are crucial to achieving a strengthened health system that can continue to deliver the right health services to the Timorese people into the future.

Figure 8: Next Steps



Acknowledgements:

TAIS II worked in partnership with the Ministry of Health in Timor-Leste and with many district and local health workers. The project would like to thank these partners for embracing new systems and allowing our project team to work alongside you.

We would like to thank our staff, who devoted countless hours with the goal of improving health services in Timor-Leste.

A particular note of thanks goes to our colleagues and friends at the United States Agency for International Development (USAID), and through them, the American people. You have supported TAIS's efforts technically and financially all along the way.

ANNEXES

Annex 1: Technical Inputs and Support from TAIS II between 2009 and 2011: technical strategies, guidelines and tools developed with and for the MOH, and, in collaboration with other health sector partners

Intervention area	Development of Strategies, Guidelines and tools	Training, Monitoring, and Supervision Assistance
EPI	- Technical guideline handbook for health workers (in Bhasa Indonesian) - Q & A booklet for community leaders and groups - SS checklists revised - Multiple job aids – particularly for CCVM in this phase – updated the weekly calendar for calculating age of child - Inputs into plans for new vaccine introduction (e. g. Hib vaccine),	- Cold Chain and Vaccine Management training (with the Institute of Health Sciences) - Refresher EPI and CCVM training for six national hospitals - Maternal and neonatal tetanus campaign, measles campaign, etc. - Regular participation in the EPI WG initiatives and plans - H1N1 vaccination campaign - Adaptation of training modules and supportive materials for Mid-Level Managers (MLMs) and district-led SS for MLMs - Dozens of SS visits, 2009 -11 - Measles catch-up 'campaign' (2011)
Child health – IMCI and newborn care	- National IMCI SS strategy - CCM Implementation Guide: - Revised essential drug list for IMCI/newborn - Training materials and tools for PSF to implement CCM - Updated and revised 'buku bagan' – IMCI chart booklet - Final newborn care training modules	- Training of Trainers (ToT) IMCI - Multiple IMCI basic trainings - ToT CCM - CCM for community volunteers - ToT ENC - Regular participation in the child health review meetings - Supervision visits to all districts for IMCI
Nutrition	- Nutrition counseling cards for PSF training focused on IYCF messages - Drafted cohort register and proposed a card to be kept at the CHC level to track children - Developed the agenda and presentations for the National nutrition advocacy campaign launch workshop - Participated in 5 district level advocacy campaign launches and SISCa level activity in 2 focus district	- Regular participation in the nutrition WG - Refresher trainings for PSFs in basic nutrition growth monitoring
Family Planning	- FP supportive supervision Checklist - Tetum translation of the Decision –	- Orientation of MCH DPHO on use of SS checklist and DMT

Intervention area	Development of Strategies, Guidelines and tools	Training, Monitoring, and Supervision Assistance
	Making Tool (for client counseling for FP method choice)	
HP and Community level services and involvement	- SISCa monitoring checklist and its revision - PDS-S (formerly called KJPS) guidelines	- Training for NGOs and District staff on the new, simplified SISCa monitoring tool - Training of *Suco* Councils members developing *Suco* Development Plans for Health - Various PSF trainings and refresher trainings – using a standardized approach with BCC and environmental health
HP and BCC	- National HP Strategy, 2011-2015 and its work plan - HP chapter of the Draft National Health Strategic Plan 2011-2030 - Detailed implementation plan for HP 2010 - Church health messages booklet dissemination and monitoring proposal - Various short videos and radio programs on child health and nutrition - Draft HP supervision checklist for DPHO	- New job description for DPHO-HP - Participation in the SISCa and PSF WG – though irregular
HMIS	- HMIS strengthening framework proposal document: "Decentralized Action for Strengthening the Health Information Management: a report from district level training workshops: - HMIS technical guidelines - HMIS SS checklist - HMIS database for CHC level - Wall charts for CHC to do suco level data analysis	- Multiple district-level trainings for HMIS data collection and use improvement - Follow-up assessments and workshops on RSF and HMIS implementation and process re-design - 'Improving Data Quality' documents - Participation in the "Data Think Tank" – specifically looking at a web site development and re-working the RSF process - Development and design of MOH website
General strategic support	- Contributed to the analysis and write-up of the TL DHS 2009-2010 report - Developed reporting format for national priorities taskforce to give feedback to national level form	- Oriented MOH staff to monitor National Priorities and support DHS teams to achieve them - Participated in the orientation / training of newly returned Cuban trained Timorese doctors and the

Intervention area	Development of Strategies, Guidelines and tools	Training, Monitoring, and Supervision Assistance
	districts - Contributed to the reproductive health conference, organized through the woman's caucus in the Parliament (and UNFPA) and its report. - Contributed to the design and facilitation of the national PSF conference	manual development for future orientations -

Annex 3:
SISCa Monitoring and Stratification Format

Visit date : .....
Name of personnel doing monitoring : .....
Name of SISCa post : .....
Aldeia : .....
Suco : .....
Sub-district / district : .....

General information	Instructions	SCORE
1. Is there any SISCa activity? (Y/N)	- Yes: score 10 - No: score 0 (→ finish, SISCa D)	
2. In the past 3 months, did the SISCa take place routinely every month?	- Every month (3 times): score 4 - Only 2 times: score 2 - Only 1 time (only today): score 0	
3. How many PSFs were active? …… / ……	- Minimum 5 active: score 4 - Between 1-4 active: score 2 - None active: score 0	
4. Did any of the Suco Coucil members participate? 1) Suco Head; 2) Aldeia Heads; and 3) other members	- Suco Head: score 3 - Aldeia Head: score 3 - Other members: score 2 - All: score 8	
5. In the past 3 months, was the Family Health Register updated every month?? - If updated: total population in the suco this month? ……	- Every month (3 times): score 4 - Only 1 or 2 times: score 2 - Never: score 0	
Sub-total general information		

Information per TABLE	Instructions	Tables					
		1	2	3	4	5	6
6. Is there an appropriate place (*) for each activity? (Y/N)	- Yes: score 2 - No: score 0						
7. Is there assistance (from health personnel or PSF) at each table? (Y/N)	- Health: score 3 - PSF: score 2 - Nobody: score 0						
8. Is there essential equipment (*) at each table? (Y/N)	- Follow instruction on p.2 - Score: 0, 1, 2, 3 or 4						
Total per TABLE							
Sub-total per TABLE							

TOTAL SCORE (sub-total general information + sub-total per TABLE)	
Stratification SISCa (**)	

(*) See explanation on page 2

(**) SISCa A = Score 64-84 ; SISCa B = Score 43-63 ; SISCa C = Score 22-42 ; and SISCa D = Score 0-21

EXPLANATION for question 6 – appropriate place

Appropriate place = prepared place in order to implement the table services (can be a table, a chair, mat …)

EXPLANATION for question 8 – essential equipment

From the following list, check if the 4 materials/equipment are in place. For each material/equipment:

- Write "1" or tick if it is in place
- Sum up the total (minimum 0 – maximum 4) and fill question 9 page 1.

No.	Table 1	Tick
1	Family Health Register (RSF) book	
2	LISIO (new ones as stock/reserve)	
3	General register	
4	Health map per aldeia / suco	

No.	Table 2	Tick
1	Scale	
2	MUAC	
3	Flipchart nutrition	
4	Home visit records (with the filled format as proof)	

No.	Table 3	Tick
1	Private space for consultation	
2	ANC equipment/material following BSP standards – monoscope, stethoscope, tens meter, fitameter, iron tablets and folic acid	
3	equipment/material Family Planning – natural and modern methods (injections, pills and condoms)	
4	equipment/material for immunization – vaccine carrier, vaccines (BCG, DPT/ Hepatitis B, polio, measles, and Tetanus Toxoid), ice pack, syringes, and flipchart immunization	

No.	Table 4	Tick
1	KUBASA KUBASA	
2	Hygiene equipment – nail cutter, brush, soap, towel and bucket	
3	Demonstration equipment/material, at least 1 – how to recognize mosquitoes' larvae, how to sanitize mosquitoes breeding places, how to use the insecticide "Abate,"…	
4	Health map for environmental health per aldeia	

No.	Table 5	Tick
1	Private space for consultation	
2	Basic essential medicines – antibiotics; anti-malaria; pneumonia; diarrhea; Scabies; anemia; Hypertension; gastritis; dengue fever; and UTI	
3	Basic equipment to diagnose diseases – stethoscope, tens meter, thermometer, tongue spatula and ENT equipment (for ears)	
4	Basic equipment for laboratorium – rapid test for malaria, pregnancy test and sputum carrier	

No.	Table 6	Tick
1	Community mobilization equipment – such as bell, megaphone …	
2	IEC material – posters, brochures…	
3	Promotion activities – like night events or community mobilization (from PSFs, suco/aldeia chiefs …)	
4	Other activities – cooking demonstrations, games, films…	

Background to SISCA tool improvements

TAIS II compiled feedback from districts on the use of the SISCa format at in January 2010. Feedback came from TAIS staff, district advisor and DPHOs HP. They were generally negative, such as: 1) CHC staff too busy during SISCa activities to properly use the format; 2) format requires skills in calculating percentages and calculation of percentages requires updated data on the Family Health Register; 3) format confusing on where and how to write scores; 4) CHC staff question the usefulness of format; 5) there are problems in the way scores were attributed: too many SISCa's get A or B…

TAIS also participated in three HP department-led important internal meetings to discuss the Monitoring format: 1) with HMIS department, Dr. Avelino and Dr. Sergio (district advisors), Natalia Araujo (Quality Control) and TAIS, where all agreed to simplify the monitoring format and finalize the supervision format developed by Quality Control; 2) with 4 DPHOs HP, who welcomed the new format and agreed to field-test it; and 3) with Natalia Araujo, who handed over her supervision format to HP department.

In February the HP department received some SISCa reports from QIV 2009. Overall, the reports were poor in quality and quantity and very late: 1) mistakes in calculations; 2) while most districts sent the number of SISCa visitors, only 6 sent the monitoring part; and 3) most reports were sent very late after a few reminders.

a. Simplified format

Therefore the HP department asked that TAIS develop a simplified monitoring format, which kept the same logic as the first one (a kind of checklist and scoring), but removed time-consuming and confusing parts. The recapitulative was also slightly modified. The simplified format was discussed internally at MoH with the Head of HP department's approval the new format was disseminated to districts in March.

b. Socialization of the tools

The TAIS TA and SISCa Officer sent a proposal to WHO ($7,000) to socialize the SISCa format in 13 districts and provide on-going supervision and capacity-building. Ermera district doesn't require special external budget and socialization will be done 3rd week of March.

c. Checklist for CHC

TAIS TA developed a checklist for CHC staff to use before every SISCa, in order not to forget any item (registers, medicines, IEC/BCC materials…). TAIS and HAI field staff revised it and checked with each program for approval.

A second revision was done in June to add a talley sheet as a way to better collect and summarize the visitor statistics for SISCa. The data collection and monitoring is very slowly improving but the seeming unpredictableness of ability to ensure the SISCa service , be it lack of staff or rains washing out the road or lack of funds to purchase fuel for the vehicles, continues to frustrate the use of a standardized process / tools to make the SISCa a routine, quality dependable service.

Annex 3: Excerpted from the "Developing District Collaboratives – decentralized action for strengthening the health information management system – the report from the district level training workshops" technical report.

3. Recommendations and next steps

Based on the level of performance of SIS assessed by the workshop participant, the following recommendations are being proposed for different level of the health system to strengthen management of the SIS.

A. Immediate recommendations

3.1 Reduce burden of data reporting to improve quality

The Health Metrics Network (supported by WHO) has proposed that a **'minimum dataset'** simplifies collection and improves the quality of data. SIS, TL should focus on essential indicators to monitor program trend and revision of HMIS formats and data items. There is a need to revise the current system and formats by identifying essential indicators of health service delivery and designing of the formats accordingly. With a minimum dataset, the load of preparing reports can be reduced and more focus can be given on improving quality and use of data.

3.2 Maximizing data use at all levels

To promote data use at health facility level, the level data is generated, regular monthly meetings should be organized at CHC level to conduct analysis, review and take joint actions. Analysis should be conducted by suco level to identify low coverage, by different services to identify "missed clients".

The health facility is the primary level of data collection and our focus should be on maximizing the use of data at this level. With reduction in the number of reporting forms and data items, health facilities can focus more on utilizing data to effectively monitor service delivery.

The districts are preparing a quarterly report, which is a good step. The quarterly report format should include analysis of causes of good progress as well as underperformance. It should also mention what are the next steps or action plan of the DHS to improve coverage of health services.

3.3 Defining standards and guideline

A guideline for recording and reporting SIS formats has been drafted; it should be finalized by SIS national level in coordination with national level program managers. Once the guidelines are finalized, health staff at every level should be training based on the guideline and how to effectively use the guideline.

3.4 Capacity building and Supportive supervision to improve data quality and use

Adequate training should be provided to all health staff in data collection, analysis and its use. Every program manager or health worker is involved in any or all of these activities and it is an important tool to assess individual and program performance. Comprehensive training should be provided to all health workers on these issues. It would also be worthwhile to include Health Information System & Monitoring as an additional subject for in-service training of health workers.

The national level should build capacity of district staff in conducting Supportive supervision at health facilities. Supportive supervision will help identify problems, develop local solutions and build on-the-job capacity.

All health workers should be trained in use of Tally sheet while making calculations or transferring data from register to reporting formats. It is easy to do calculations and check for mistakes.

3.5 Assign unique identifiers to health facilities

To enable smooth analysis of data over time and to make comparison between health facilities, unique identifies should be assigned to all health facilities.

3.6 Individual reporting by all health facilities

It has been observed that it is difficult to get reports by health facilities and find missing reports for health facilities. It would be ideal that all health facilities (including SISCa) should submit individual reports to the districts.

3.7 Organizing results sharing workshop on a quarterly basis

“Results-sharing” meetings should be organized at district level on a quarterly basis to present and discuss data and prepare quarterly action plans. A list of priority core health indicators should be defined by district and national level to measure performance and trend over time.

3.8 Developing collaborative - building teams, self-assessment and peer review

The SIS workshops conducted at the district level are a starting point for developing teams of DPHOs and CHC/HP staff at district level to promote learning and share best practices for strengthening SIS management. The district should focus on improving coordination among DPHOs at district level to conduct joint analysis, share and exchange data before submitting reports; develop capacity amongst the health staff at each of the facilities to ensure that they are able to manage all the functions of the HMIS (data registration, report generation, data quality checks, and transmission to the next levels); share experiences between health facilities within a district and between districts; promoting self-assessment by health workers on a regular basis and peer review of formats/reports to improve data quality.

3.9 Improve feedback mechanism

Feedback is important to confirm the results and provide comments on data quality and performance. SIS national and district level should provide quarterly feedback to CHCs, HP and Private Clinics on performance and quality of data. It can also include identifying "best health facility" based on good performance and data quality and providing recognition to facilities. This would set example for other health facilities to focus on improving quality and performance.

3.10 Providing adequate resources

Adequate registers, folders, cupboards, pen, markers and highlighters should be supplied to health facilities on a regular basis. The SIS national has taken the responsibility of providing SIS reporting formats to all district and health facilities. Provision of other supplies essential to carry SIS activities to CHCs and HPs, should be clearly worked-out between the district and national level.

B. Long-term recommendations

3.11 Integrating RSF within SIS

The ministry has initiated RSF to capture real-time denominators for births, deaths, pregnant women, new born and other priority diseases. This process needs to be carefully integrated within the current SIS mechanism and health workers should be properly trained in the collection, analysis and use of data from RSF.

3.12 Improving coordination between SIS and M&E

Data collection, processing, analysis and its use for monitoring implementation of health programs is a cyclical process where one step leads to another and functions overlap. In order to avoid confusion, reduce overlaps and synergize work between SIS and M&E these two departments should work in close coordination. It is a long-term recommendation to bring the two departments together under one umbrella in order to complete the cycle and synergize activities.

3.13 Developing an integrate framework for information system at the national level

The current SIS system disease focused with very less or no information on management. SIS should be a management tool for managers at various levels of health system to get the data on various management aspects. These aspects will help the manager make a better decision. The system should consider adding data on human resources, equipment and supplies, financial information and community involvement in delivery of health services. (Annex 2) Such information need not be collected on a monthly basis but can be collected once in 6 months but it will help mangers to identify weak areas of performance and take action.

3.14 LQAS household surveys

Another mechanism to check and maintain data quality on SIS is to introduce LQAS household survey. LQAS household surveys are conducted within supervisory areas of a health facility to identify coverage of health services. They are easy to implement and the methodology requires a smaller sample size. The

cost of implementing LQAS is low compared to other large scale household surveys and they provide robust information on coverage of health services.

3.15 Provide adequate IT and database support

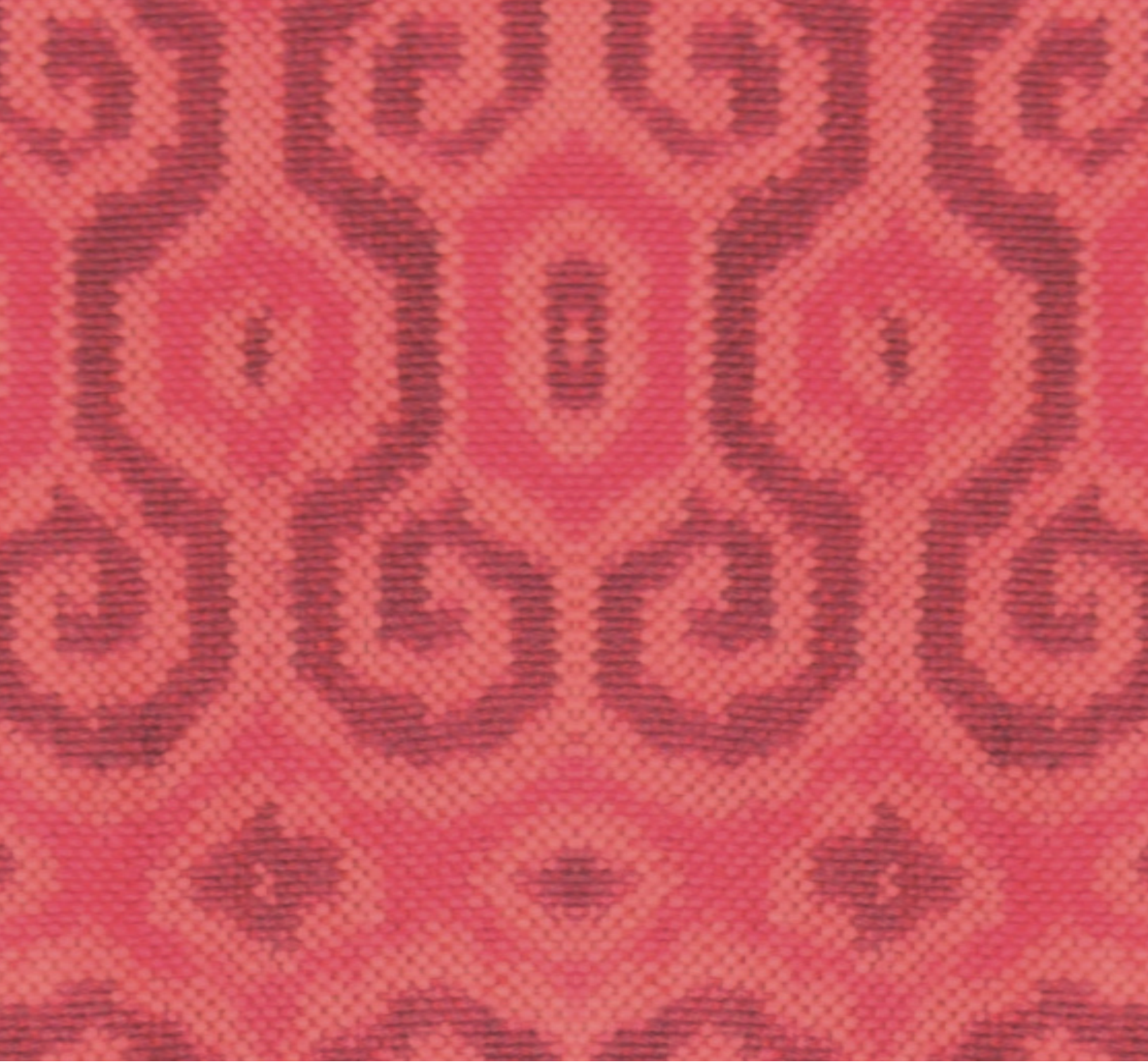
Once the forms are finalized by the ministry, a database should be developed to support and facilitate data entry, transmission and analysis. The database would facilitate data transfer from health facilities to districts and to the national level. It will be much faster and chance of data entry error will be very less. For sure, this needs availability of functional computers at health facility and district level. Availability of internet facility will facilitate faster transmission but even with lack of internet at health facility level a database will be very helpful in maintaining records and conducting analysis.

In the longer run, the SIS database can be linked to other information systems and data sources like population based surveys to maintain a "data warehouse" of all information and facilitate cross analysis between different sources.

3.16 Developing a long-term strategy for Health Information System Strengthening

The Health Metrics Network (supported by WHO) provides framework for formulating country Health Information System (HIS) strategy (Annex 3, HMN framework). The framework looks at current levels of various information systems useful for health and supports local team to identify challenges and map a strategy for the future.

An assessment was conducted some years back but it did not lead to development of any strategy. It will be very helpful for the SIS department to search for the assessment and with revisions it can be used to develop the strategy.



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