USAID's Reinforce Basic Health Services Project

Final Report

December 2015–December 2020

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Cover photo: Community health presentation to young mothers and children.
(Credit: USAID's Reinforce Staff)

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ACRONYM LIST

ANC	antenatal care
ARH	adolescent reproductive health
BEmONC	basic emergency obstetric and newborn care
BPCR	birth preparedness and complication readiness
CEmONC	comprehensive emergency obstetric and newborn care
CHC	community health center
CHO	community health officer
CITL	CARE International Timor-Leste
COVID-19	commonly used acronym for coronavirus 2019
CPS	clinical practice site
CQI	continuous quality improvement
EmONC	emergency obstetric and newborn care
ENBC	essential newborn care
FGD	focus group discussion
FP	family planning
FUAT	follow-up after training
GBV	gender-based violence
HAI	Health Alliance International
HIV	human immunodeficiency virus
HP	health post
HMIS	health management information system
HNGV	*Hospital Nacional Guido Valadares* (National Hospital Guido Valadares)
IMCI	integrated management of childhood illnesses
INS	*Instituto Nacional de Saúde* (National Institute of Health)
IP	infection prevention
IUD	intrauterine device
JDN	*Juventude ba Dezenvolvimentu Nasional* (Youth for National Development)
JSI	JSI Research & Training Institute, Inc. and John Snow, Inc.
KAP	knowledge, attitudes. and practices
LARC	long-acting reversible contraception
LISIO	*livriñu saúde inan no oan* (maternal and child health booklet)
LMIS	logistic management information system
M&E	monitoring and evaluation
MCH	maternal and child health
MHS	Municipality Health Services
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
NGO	nongovernmental organization
PHC	primary health care
PNC	postnatal care
PNDS	*Programa Nasional Dezenvolvimentu Suco* (National Program for *Suco* Development)
PPFP	postpartum family planning
PRADET	Psychosocial Recovery and Development in East Timor
PSA	public service announcement

PY	project year
SARA	service availability and readiness assessment
SBC	social and behavior change
SCD	safe and clean delivery
SISCa	*Servisu Integradu Saúde Comunitaria* (Integrated Community Health Services)
SOP	standard operating procedure
TA	technical assistance
TLDHS	Timor-Leste demographic and health survey
TNA	training needs assessment
TraKom	*Transporte Komunitáriu* (Community Transport)
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	woman of reproductive age

EXECUTIVE SUMMARY

In December 2015, USAID's Reinforce Basic Health Services Project (USAID's Reinforce) in Timor-Leste was awarded to JSI Research & Training Institute, Inc. (JSI). The five-year project was designed to improve the quality and use of maternal, newborn, and child health (MNCH) and family planning (FP) services in one model municipality, Covalima, by strengthening national and municipal health systems.

USAID's Reinforce conducted a comprehensive baseline assessment, including a health facility assessment (the SARA) and a community knowledge, attitudes, and practices (KAP) survey. Results indicated low levels of primary health care (PHC) facility readiness in Covalima and access challenges for communities. The baseline also revealed that community members had low levels of awareness and knowledge about birth preparedness and complication readiness planning and child spacing, leading to unhealthy practices such as delivering without skilled birth attendants.

The project filled these gaps through two main strategies: 1) building capacity for health services and systems at the national and municipal levels; and 2) improving healthy behaviors and increasing appropriate care-seeking at the community level.

While Covalima health providers prepared to update their MNCH and FP clinical skills, the National Institute of Health (INS) in-service training system also required strengthening. By the end of the project, the INS had implemented more than 70 percent of its strategic plan and established new procedures to coordinate sustainable partnerships with governmental and nongovernmental stakeholders. In Dili, INS established competency-based clinical training with USAID's Reinforce support, resulting in more trainers, and better clinical practice due to newly equipped skills labs and improved clinical practice sites that then exceeded national standards. The INS replicated this model of competency-based training through improved clinical practice in Covalima, resulting in training now delivered by municipality-based trainers with minimal involvement from the national level. In total, the INS trained 123 health workers from Covalima to manage non-complicated vaginal deliveries, and provide basic obstetric and newborn care, integrated management of childhood illnesses, and/or FP services between 2016 and 2020.

USAID's Reinforce worked with the Ministry of Health (MOH) and the Municipal Health Services (MHS) to strengthen their supervisory role in the 28 PHC facilities, ensuring regular supportive supervision visits paired with technical assistance (TA). The TA, through mentoring, coaching, and training, filled gaps identified at baseline in all facilities. By the end of the project, all seven community health centers (CHCs) and 15 health posts (HPs[1]) met MOH's required readiness standards. These efforts contributed to significant increases in the availability of services: FP increased from 48 to 71 percent; antenatal care (ANC) from 42 to 74 percent; obstetric and newborn care from 68 to 89 percent; immunization from 71 to 80 percent; and child health from 48 to 76 percent.

USAID's Reinforce TA included strengthening the management skills of CHC heads through training and quarterly microplanning meetings. Microplanning brought CHC managers, health providers, and community leaders together to analyze coverage data and use it to increase health services coverage,

[1] Six more HPs were added during the project, bringing the total number of PHC facilities to 28, including 7 CHCs and 21 HPs.

especially in remote and underserved communities. On average, 64 outreach activities were implemented every quarter as a direct result of the microplanning, reaching hundreds of pregnant women, mothers, and children under five for preventive services.

The KAP baseline revealed gaps that needed to be filled to ensure communities adopted healthy household behaviors, as well as care-seeking practices for preventive services and life-threatening conditions. Covalima MHS and USAID's Reinforce significantly expanded health promotion activities at the health facility level through films and health provider talks in waiting rooms and during counseling sessions, and at the community and household levels. Community discussion groups used health promotion videos and materials developed with USAID's Reinforce support, reaching an average of 1,618 women and 387 men every quarter. USAID's Reinforce also focused on establishing an enabling environment by involving community leaders as role models, facilitators, and influencers. Some community leaders led efforts to identify local transport vehicles for health emergencies. The project counted at least 54 community members benefiting from that initiative, which is called TraKom.

The project endline survey revealed significant increases in access to and use of facility services. Ninety-eight percent of Covalima pregnant women attended ANC and 61 percent attended their first ANC during the first trimester of pregnancy. Seventy-one percent of women delivered at the health facility (against 47 percent at baseline). Among FP users, an increased proportion used long-acting reversible methods (from 5 to 31 percent). Significantly more women and men were aware that complications could occur during pregnancy, childbirth, and the postpartum period. A higher proportion of pregnant women made a birth plan and FP knowledge also improved significantly, as 93 percent of women and 75 percent of men could cite at least one FP method by the end of the project, against 82 and 60 percent, respectively, at the beginning.

USAID's Reinforce partnered with a youth-led organization, *Juventude ba Dezenvolvimentu Nasionál* (JDN), and the MOH to develop a reproductive health education guide. JDN and MOH piloted the guide in Covalima high schools, reaching 146 boys and girls with life skills, reproductive health, gender, and nutrition education. The MOH introduced the guide in four more municipalities, approved it formally in 2020, and recommended other development partners to use it.

In March 2020, the project supported the government response to the COVID-19 pandemic by increasing knowledge and safety practices among health workers and communities and increasing the availability and use of handwashing materials in key locations of Covalima Municipality. The project distributed posters, stickers, and leaflets to nearly 300 households; distributed hygiene kits to 28 health facilities; trained community leaders as health educators; supported infection prevention and control training for about 230 health staff; and partnered again with JDN to reach youth 15–24 across Covalima with COVID-19 prevention and safety messages through workshops, group discussions, and social media.

USAID's Reinforce modeled a highly successful health systems intervention in Covalima Municipality that significantly improved the quality and availability of and access to MNCH/FP services while improving national-level INS and MOH practices and protocols. The project received national attention and accolades from the Ministry of Health, and the presentation of results at municipal and national levels provided key learning about practices and standards for future health system strengthening in Timor-Leste.

INTRODUCTION

Since it gained independence in 2002, Timor-Leste has made remarkable progress in maternal, newborn and child health (MNCH). Between 2009 and 2016, years of the last two Timor-Leste demographic and health surveys (TLDHS),[2,3] the percentage of pregnant women attending at least four antenatal care (ANC) consultations increased from 55 to 77 percent; institutional delivery increased from 22 to 49 percent; and deliveries with a skilled birth attendant increased from 30 to 57 percent. The maternal mortality ratio decreased from 557 deaths per 100,000 live births in 2009–10 to 195 in 2016, a tremendous achievement for a new nation with a nascent health system.

Despite these positive trends, there were many challenges. In 2016, more than half of women still delivered at home. The maternal mortality rate remained very high—second highest in South-East Asia—and the newborn mortality rate, at 19 deaths per 1,000 live births, had been rather stagnant for the past 15 years. The percentage of women attending the first postnatal care (PNC) checkup within two days after delivery only increased by 3 percent between the two TLDHS, reaching just 35 percent coverage in 2016. While the contraceptive prevalence rate progressed substantially during the first five years of the family planning (FP) program implementation (2004–2009), progress slowed during the following years and reached 24 percent in 2019, with an unmet need of 25 percent.

For more than 15 years, the Ministry of Health (MOH) has prioritized MNCH and FP programs, as outlined in numerous policies, strategies, and plans.[4] While this focus led to encouraging results, more efforts needed to be made to improve the quality of care, reach the women, newborn, and children who were not accessing services, and strengthen the system to sustain the gains acquired.

In December 2015, JSI Research & Training Institute, Inc. (JSI) signed the cooperative agreement for USAID's Reinforce Basic Health Services Project (USAID's Reinforce) in Timor-Leste. The project was implemented over five years with a budget of $8.5 million.

USAID's Reinforce built on 10 years of USAID support to the MOH and the *Instituto Nacional de Saúde* (INS – National Institute of Health) in basic health services strengthening.[5] Between 2016 and 2020, the project provided technical assistance (TA) to the MOH to improve and sustain MNCH and FP service quality and raise demand for these services in one focus, or 'model,' municipality (formerly called districts): Covalima. The project thereby contributed to a key development objective of USAID's Country Development Cooperation Strategy: Institutional and human capacity for development

[2] National Statistics Directorate, Ministry of Finance, Democratic Republic of Timor-Leste. (2010). *Timor-Leste Demographic and Health Survey 2009-2010 (TLDHS 2009–10).*

[3] General Directorate of Statistics, Ministry of Planning and Finance, Ministry of Health, Democratic Republic of Timor-Leste. (2018). *Timor-Leste Demographic and Health Survey 2016 (TLDHS 2016).*

[4] Including the following documents: 1) Democratic Republic of Timor-Leste (RDTL). (2011). *Timor-Leste Strategic Development Plan 2011–2030*; 2) Ministry of Health, RDTL. (2010). *National Health Sector Strategic Plan 2011–2030*; 3) Ministry of Health, RDTL. (2004). *National Reproductive Health Strategy*; 4) Ministry of Health, RDTL. (2005). *National Family Planning Policy*; 5) Ministry of Health, RDTL. (2015). *National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy 2015–2019*; and 6) Ministry of Health, RDTL. (2015). *Comprehensive Services Package for Primary Health Care*.

[5] From 2004 to 2015, John Snow, Inc. (JSI) has implemented the Timor-Leste *Asisténsia Integradu Saúde* (TAIS – Timor-Leste Integrated Health Assistance) Project and the Health Improvement Project (HIP).

strengthened to improve the lives of Timor-Leste's citizens,[6] as well as to Timor-Leste's national MNCH and FP strategies.

In March 2020, Timor-Leste announced its first coronavirus (COVID-19) case and soon moved to implement strategies to prevent spread of the disease and prepare to respond to additional cases. The government, and the MOH in particular, shifted its attention to this priority issue and the subsequent rulings and requests for assistance significantly influenced the focus of activities during the last months of the project. As a health systems strengthening project, USAID's Reinforce was well positioned to respond quickly to requests aligning with the infection prevention (IP), training, supportive supervision, and facility assessment activities already in the workplan. USAID's Reinforce budget was increased by $100,000 to support the government response to the pandemic. Key activities included increasing knowledge and practices among health workers and within communities; training youth peer educators to work on COVID-19 prevention; increasing the availability and use of handwashing materials in key locations of Covalima Municipality; and procuring a bio-safety cabinet for the National Health Laboratory.

A MODEL MUNICIPALITY

In June 2016, the U.S. ambassador and the vice-minister of health officially launched USAID's Reinforce, outlining the aim of developing a 'model municipality' in Covalima. The event was attended by the municipality administrator, the municipality health services (MHS) director and officers, MOH department heads and officers, health providers, community leaders, and local and international partners.

U.S. Ambassador Karen Stanton (right) and Vice-Minister of Health Dr. Ana Isabel F.S. Soares launch USAID's Reinforce Project, Covalima 2016

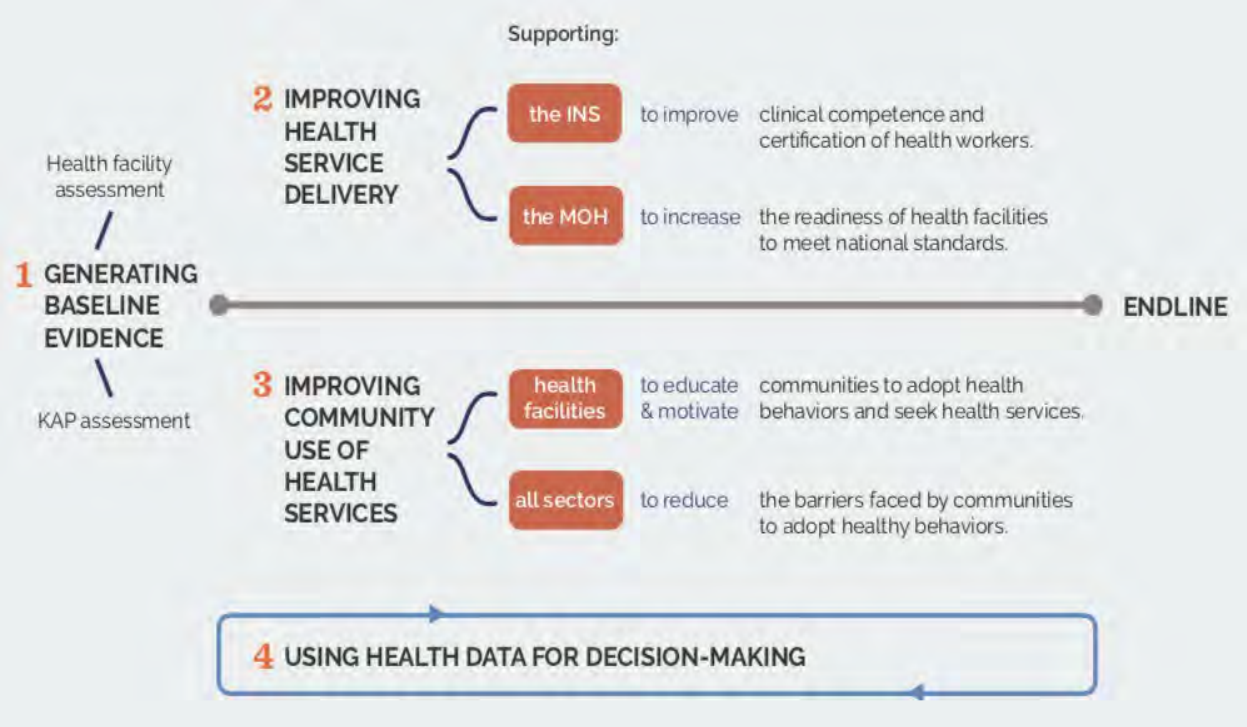
Credit: USAID's Reinforce Staff

As described by USAID's Reinforce and the MOH, in a 'model municipality,' well-trained and competent health providers deliver high-quality FP and MNCH services in fully equipped and people-friendly facilities in which providers receive consistent, high-quality supervision from MOH and INS experts.

[6] USAID Timor-Leste. (2013). *Country Cooperation Development Strategy 2013–2018*.

Health facilities are easily accessed by community members, who have the knowledge and skills to demand high-quality, client-centered services. Health providers and the facilities in which they work are supported by a municipal health system that uses data to make informed financial and programmatic decisions. In a model municipality, communities are empowered to work with government and civil society structures to generate innovative solutions to their health challenges. USAID's Reinforce was therefore implemented through a four-pronged approach, including: 1) generating baseline evidence; 2) improving health services delivery; 3) improving community use of health services; and 4) using health data for decision-making (Figure 1). Annex 1 provides explanations on how Covalima became a model municipality.[7]

Figure 1. Four Elements of USAID's Reinforce Approach to Develop a Model Municipality in Covalima



The main part of this report is structured around these elements, with particular emphasis on improving health services delivery by increasing the quality of services by certifying providers and improving the readiness of health facilities; and improving community use of health services through social and behavior change (SBC) interventions. These, as the project's main 'strategic approaches' were guided by the Continuum of Care and High Impact Practices in Family Planning.[8] The first element (generating baseline evidence) is described below, while the fourth (using data for decision-making) is highlighted throughout the sections of the report and summarized in Cross-Cutting Issues.

[7] USAID's Reinforce Project implemented by JSI. (2018). *Technical Brief: Covalima, Becoming a Model Municipality.*
[8] High Impact Practices in Family Planning: https://www.fphighimpactpractices.org/high-impact-practices-in-family-planning-list/.

This report also includes activities implemented to help MOH respond to COVID-19 as part of the two strategic approaches: to improve MOH's ability to respond appropriately to the pandemic, and to prevent the transmission of the virus in the community.[9] COVID-19 activities are described in the Cross-Cutting Issues section, and the summary report on COVID-19 work is in Annex 18.

GENERATING BASELINE EVIDENCE

USAID's Reinforce conducted a baseline assessment in Covalima to design interventions specific to the municipality's health sector challenges, and to measure the impact of these interventions at endline (see Findings and Results). The first component, a service availability and readiness assessment (SARA)[10] provided a snapshot of the status of services in Covalima's health facilities and indicated how they should be prioritized for receiving TA. The second component of the assessment, a community knowledge, attitudes, and practices (KAP) survey,[11] provided insight into MNCH and FP interventions and messages that would resonate with the community in Covalima. Table 1 below provides an overview of Covalima's health facilities and population targeted by the project at the time of the baseline assessment, per administrative post (formerly called 'sub-districts').

Table 1. Covalima Municipality's Health Facilities and Population

Administrative Posts	Population (1)	Health Facilities (Public)		
		Referral Hospital	CHCs	HPs
Fatululik	2,027	-	1	0
Fatumea	3,330	-	1	1
Fohorem	4,086	-	1	3
Maucatar	8.895	-	1	2
Suai Vila	25,815	1	1	5
Tilomar	7,885	-	1	2
Zumalai	13,263	-	1	2
Total	**65,301**	**1**	**7**	**21**

(1) Source: Ministry of Health. (2015). *2015 Census*

SARA Results

USAID's Reinforce and the MOH collected data in the 26 health facilities of Covalima operational in 2016, including Suai Referral Hospital; 7 CHCs; 15 HPs; and 3 private clinics. The World Health Organization's SARA tool was adapted to the Timor-Leste context.

In terms of **service readiness**, the referral hospital was much better staffed and equipped than other public facilities. HPs often had greater deficiencies in infrastructure and equipment functionality compared to the other facility types due to their remote location, poor roads, infrequent electricity, periods of drought and flooding, and insufficient budgets. Overall, Covalima Municipality had a number of gaps as well as disproportionate distribution of both staffing and equipment at the facility level that impeded service readiness. Key findings from the endline assessment included:

[10] The MOH, with technical assistance from USAID's Reinforce Project implemented by JSI. (2016). *Service Availability and Readiness Assessment in Covalima Municipality.*
[11] The Ministry of Health, with technical assistance from USAID's Reinforce Project implemented by JSI. (2016). *Knowledge, Attitudes and Practices Assessment in Covalima Municipality.*

- The core workforce density—approximately 23.8 health workers per 10,000 persons—met WHO minimum standards (23 per 10,000 population).
- About 31 percent of all facilities had an ambulance or multifunction vehicle based at their facility and accessible at all times.
- Approximately 58 percent of facilities had electricity available; 84 percent had an improved water source; and about 19 percent had no sanitation facilities or non-improved sanitation facilities.
- The hospital was well equipped with infection prevention (IP) equipment; HPs were largely lacking these, and in a number of CHCs and HPs that had equipment, it was not functional. The majority of facilities reported not having any IP guidelines.
- The hospital and CHCs were largely well equipped with basic equipment, although fewer basic equipment pieces were functional at the CHCs.

The SARA also assessed **service availability** of a range of services. Key service availability findings for FP, ANC services, and basic and comprehensive obstetric and newborn care are provided below.

FP Services

- All public health facilities provided FP services, but not all methods were provided at CHCs and HPs, as required by MOH guidelines.
- The national FP guidelines were available at 14 percent of CHCs and 13 percent of HPs; FP checklists and job aids were found at the hospital, 86 percent of CHCs, and 27 percent of HPs.
- Sixty-one percent of the facilities providing FP services had a service provider who had received FP training within the past two years.
- The availability of modern FP commodities in the service area was generally low in HPs, although almost all CHCs and the hospital had pills and male condom stock available. Availability of intrauterine devices (IUDs) and implants was much lower for CHCs.

ANC Services

- The hospital, 7 CHCs, 12 HPs, and 2 of the private facilities reported providing ANC services.
- National ANC guidelines were largely lacking across all facilities.
- Only half of the facilities providing ANC services had a service provider who received ANC training in the previous two years.

Obstetric and Newborn Care Services

- Twenty-four of the facilities reported they provide delivery services, which may include normal delivery and/or basic/comprehensive emergency obstetric care at baseline. This included the hospital, 7 CHCs, 15 HPs, and 1 private facility.
- Immediate/exclusive breastfeeding and hygienic cord care were offered at 23 of the 24 facilities.
- Other services (oxytocin, partograph, thermal protection) were available at varying levels among the 24 facilities offering delivery services.
- There were significant deficiencies in equipment, although almost entirely at the CHCs and HPs.
- CHCs and HPs reported higher levels of stockouts for most commodities.
- Among facilities offering delivery services, eight (the hospital and all seven CHCs) reported providing basic emergency obstetric and newborn care services.
- Among facilities providing BEmONC, only four indicated they had the guidelines for essential childbirth care.

- Three facilities providing BEmONC services reported someone on staff had received training in newborn resuscitation in the past two years.

KAP Results

The KAP study covered maternal and newborn health, birth preparedness and complication readiness (BPCR) planning, reproductive health, FP, and gender. Below are some of the main findings from baseline:

- More than 96 percent of women reported attending ANC during their last pregnancy and 83 percent went four or more times. However, almost half the women indicated that they did not attend ANC visits until at least the fourth month of the pregnancy.
- Forty-seven percent of the deliveries took place at a health facility. Of the 53 percent who delivered at home, only 10 percent were assisted by a skilled provider.
- Only 41 percent of women and 38 percent of men agreed that unforeseen complications could occur for the newborn within the first two days after birth.
- Umbilical cord care practices were largely hygienic (94 percent using a new razor blade). Eight-four percent placed the baby with the mother immediately after delivery; 96 percent breastfed their child after the delivery; 71 percent of women who breastfed their newborn did so within the first hour after delivery.
- Few women or men had comprehensive knowledge of the key danger signs during pregnancy, labor, or postpartum.
- Approximately 28 percent of women and 45 percent of men reported they made birth plans for their last pregnancy, but only 24 percent of women and 7 percent of men prepared a written birth plan.
- On average, women had three pregnancies with most resulting in live births. The average age of the woman at her first birth was approximately 21 years old. Only 7 percent of women and 3 percent of men knew that women are most fertile halfway between their periods.
- Fifty-six percent of women interviewed indicated they were currently using an FP method, with the vast majority (85 percent) indicating they currently used injectables.
- Almost half of women indicated that the decision about the currently used FP method was a joint decision with their partners; 39 percent indicated making the decision alone.
- Among women who had ever used a FP method, a significant proportion were not informed about side effects, what to do if experiencing side effects, or other method options that were available when they obtained their last method.
- A low proportion of women and men had heard, seen, or read an FP message in the past six months.
- Seventy-one percent indicated they could reach the closest health facility in 30 minutes or less, and 13 percent required more than an hour using the means of transportation they normally use.

IMPROVING HEALTH SERVICE DELIVERY

As mentioned above, the baseline outlined the need to improve the readiness of services provided in Covalima. While intensive TA was provided to MHS at the municipal level to ensure sustainability when USAID's Reinforce closes, in a still-centralized government, both strategies also required TA at the national level (INS and MOH) so that improvements in Covalima can be replicated in other municipalities. Dissemination of results and sustainability are discussed later in this report.

Strategy 1. Strengthen In-Service Provider Training

Box 1. Key Achievements for Strategy 1

1. With intensive and constant organizational development assistance, the INS implemented 72 percent of its Five Years Strategic Plan's expected outputs, as measured at mid-term (end-2017).
2. The three clinical practice sites (CPSs) improved quality scores from 68 to 85 percent at Comoro CHC; from 65 to 86 percent at Vera Cruz CHC; and from 71 to 87 percent at Suai Referral Hospital.
3. With USAID's Reinforce TA, the INS was strengthened with 22 new trainers based at national and municipal levels.
4. The project reached all its annual and end-of-project training targets: 339 health providers trained to assist non-complicated vaginal deliveries, manage obstetric complications, provide FP counseling, and/or insert long-acting reversible contraception (LARC); 314 competency checks conducted during training; 417 received follow-up after training (FUAT) visits; and by project end, 68 percent reached the required levels of competency.
5. Responded to the COVID-19 pandemic by training 187 health workers and health staff from Covalima and Dili CPSs.

A key factor of high-quality health services is the quality of human resources. The SARA outlined that most health providers delivering MNCH and FP services had not received any training during the previous two years. This is the role of the INS, which was created in 2011 as the national agency in charge of providing competency-based in-service training to health providers.[12]

Just before the project began, a situation analysis assessed the capacity of the INS and found that it lacked important elements—including curricula and training modules in various areas, unstandardized training rooms, and the absence of practicum sessions—to perform as a competency-based training institution. The report provided a series of recommendations for the INS related to its governance and core function of developing and delivering training programs.[13] The INS used these recommendations to

[12] República Democrática de Timor-Leste (RDTL). (16 de Março de 2011). Decreto-Lei Nº. 9/2011: Estatuto do Instituto Nacional de Saúde. *Jornal da República*, pp. 4654-4660.
[13] Martins, N. (2014). *Situation Analysis Study: The National Health Institute.*

develop a Five Years Strategic Plan 2015–2019,[14] with the aim of completing the conditions required for the INS to become a Center of Excellence for Training, Research and Institutional Management by 2019.

In June 2016, the project signed a memorandum of cooperation with the INS, marking the beginning of five years of on-going support focusing on: 1) providing organizational development assistance; and 2) institutionalizing competency-based training. A technical brief about USAID's Reinforce TA at the INS is available in Annex 2.[15]

Organizational Development Assistance to the INS

In the past few years, the INS has been facing an unpreceded increase in the demand for in-service training because of an increased number of health providers across the country and insufficient clinical practice time spent by students during pre-service.[16] Despite this, the INS' budget decreased over the past years and its number of human resources remained unchanged. Given these constraints, it became essential to strengthen management, leadership, and governance for more effective in-service training and use of resources. To provide that level of institutional capacity assistance, the project hired Dr. Nelson D. Martins, former Minister of Health (see Annex 3a).

The project helped the INS coordinate partners around its guiding document—the strategic plan—using a continuous planning and improvement cycle approach. From 2016 to 2020, joint annual planning workshops were held in the beginning of each year to encourage development partners allocate their support across the strategic plan's priorities. Each workshop resulted in a consolidated annual plan among INS, MOH, and partners.

Raymund Johansen of the Office of General Development USAID speaks during the INS partners meeting
Photo Credit: USAID's Reinforce Staff

USAID's Reinforce not only focused support on strengthening INS' services delivery (i.e., training), but also on strengthening the institution. For instance, the project committed to and provided a range of TA to enhance the management of the INS, such as:

- Developing standard operating procedures (SOPs) and regulations guiding the work of the INS.

[14] Ministry of Health, RDTL. (2015). *Instituto Nacional de Saúde Five Years Strategic Plan 2015–2019.*
[15] USAID's Reinforce Project implemented by JSI. (2020). *Technical Brief: Telling the story of assisting the INS transform itself into Timor-Leste's premier health training institution.*
[16] Timor-Leste Ministry of Health. (2019). *National Strategic Plan for Health Sector Human Resources (NHSWSP) 2019–2023.*

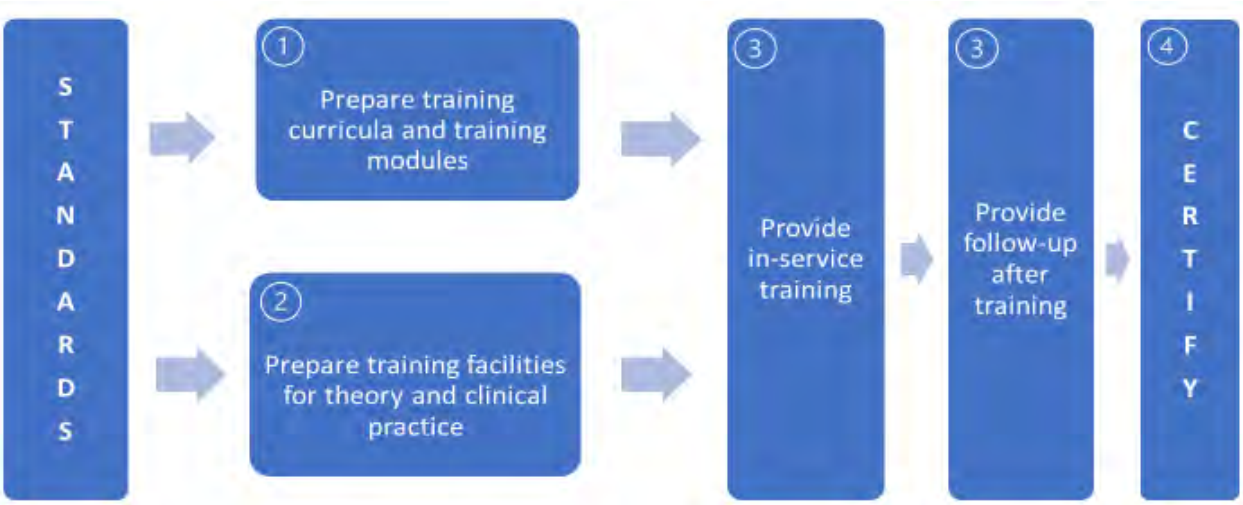
- Holding quarterly institutional governance meetings, such as the training working group meetings.
- Improving communication and information-sharing between the INS and stakeholders.
- Conducting regular quality monitoring and evaluation (M&E) of INS activities.
- Assisting in the recording of training with a database providing information on each trainee's history.

In 2017, the project recruited independent consultants to conduct a mid-term assessment of the strategic plan. Seventy-two percent of the plan's expected outputs were achieved. Of the 26 outputs expected for management, leadership, and governance, 24 were achieved, while 16 of the 21 expected outputs for quality of training were achieved.[17] This assessment formed the basis for the project to develop the next Five Years Strategic Plan for 2020–2024.[18]

Establishment of the INS as a Competency-Based Clinical Training Center

USAID's Reinforce worked with the Training Department to strengthen the required elements to establish competency-based training, the core function of the INS. Key priorities of the strategic plan received intensive TA to ensure that training participants get certified based on objectively assessed and acquired competencies. As displayed in Figure 2, the project assisted the INS to: 1) prepare training curricula and modules; 2) prepare training facilities and competent trainers; 3) provide in-service training and follow-up after training (FUAT); and 4) certify health providers. These steps are shown in Figure 2. Points 3 and 4 are described under Delivery of Clinical In-Service Training.

Figure 2. Approach to Competency-Based Training



Preparation of Training Packages (point 1 in Figure 2)

USAID's Reinforce mapped existing standards and training packages for MNCH and FP, following the Continuum of Care, to identify where TA was needed (Table 2).

[17] Guterres, J. C., with support from USAID's Reinforce Project implemented by JSI. (2018). *A Midterm Review of the INS Five Years Strategic Plan 2015–2019.*
[18] National Institute of Health. (2019). *Draft National Institute of Health (INS) Five-Year Strategic Plan 2020–2024.*

Table 2. Summary of MNCH and FP Guidelines and Training Packages Available at MOH Timor-Leste

Health Programs	Standard Guidelines		Training Packages	
	2016 and before	**Following years**	**2016 and before**	**Following years**
Maternal health (non-complicated vaginal deliveries)	National Midwifery Standards (2011) – outdated	Clean and safe delivery Standard Book (2016)	Clean and safe delivery training guides (before 2010) – outdated	Clean and safe delivery training guides (2016)[19]
Maternal health (obstetric complications)	-	National Standards and Protocols for Intrapartum Care and Immediate Postpartum Care for CHCs and Hospitals (2017)	-	BEmONC Training Package (2018)
Newborn health	Essential newborn care standards and protocols (2015) – up-to-date	-	Essential newborn care course (2015)[20] – up-to-date[21]	Essential newborn care course in Tetum (2016)
Child health	Integrated management of childhood illnesses standards (before 2005) – outdated	Integrated management of childhood illnesses standards (2017)	Integrated management of childhood illnesses training package (before 2005) – outdated	Integrated management of childhood illnesses training package (2017)[22]
Family planning	Standards book for FP (2015) – up-to-date		FP training package (before 2010) – outdated	FP training package (2016)[23]

Through the implementation of the safe and clean delivery (SCD), essential newborn care (ENBC), and FP training packages, USAID's Reinforce helped the INS test and conduct competency-based training, following the steps illustrated in Figure 2. The three packages were based on competencies and their expected acquisition for certification. For example, to be certified for SCD and ENBC, training participants were expected to acquire competencies such as filling the partograph, assessing the condition of and resuscitating a newborn, and conducting active management of the third stage of labor. For certification on FP, participants had to demonstrate effective communication and counseling skills, insert and remove implants and IUDs, etc.

Preparation of Training Facilities (point 2 in Figure 2)

The 2014 situation analysis outlined the absence of practicum sessions in skills lab and clinical setting at the INS. While a clinical training center would normally be located in a health facility, the INS operates

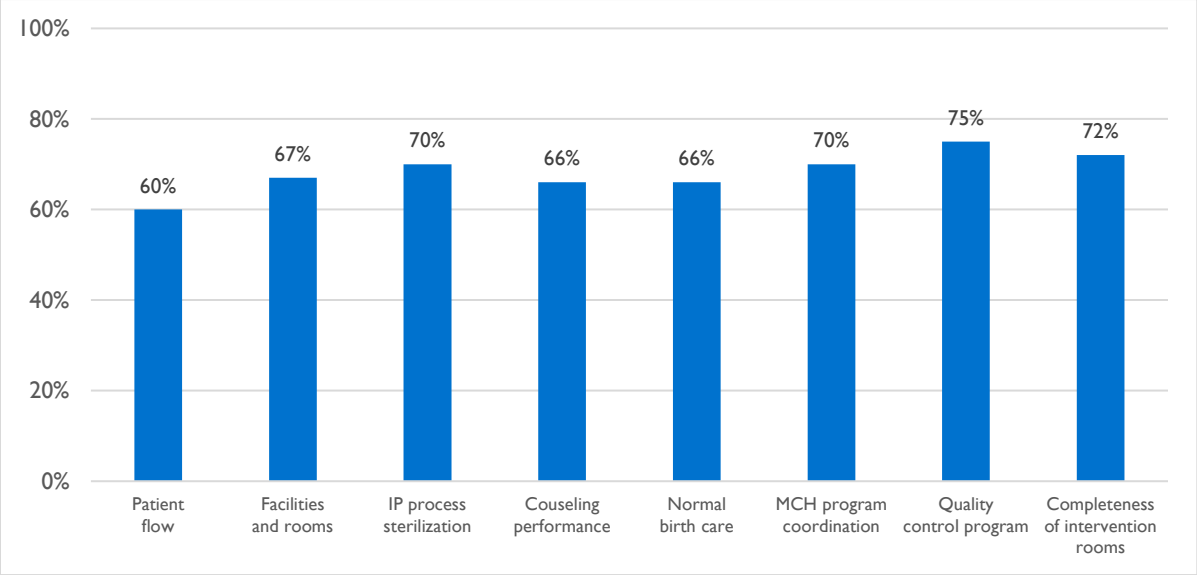
[19] National Institute of Health, with technical assistance from USAID's Reinforce Project implemented by JSI. (2016). *Revised clean and safe delivery training package.*
[20] National Institute of Health, with technical assistance from UNICEF. (2015). *Essential newborn care course.*
[21] JSI has proven the efficacy of chlorhexidine with partners in Nepal and introduced it in multiple other countries. Given the high number of deliveries occurring in homes and the high newborn mortality rate, JSI explored the possibility of introducing it to Timor-Leste. Despite signs of interests among some partners and a few MOH officers, JSI could not pursue the interventions due to: 1) the lack of leadership at MOH and changes in key positions including the minister and director of pharmacy; 2) high levels of hygienic cord cutting at home and facility; and 3) a lack of project funding.
[22] National Institute of Health, with technical assistance from WHO. (2017). *Integrated management of childhood illnesses training package.*
[23] National Institute of Health. (2016). *Revised family planning training package.*

differently by providing theoretical sessions in its classrooms and de-locating clinical practice to nearby health facilities. In the beginning of the project, these facilities (Vera Cruz and Comoro CHCs—also referred to as CPS), and an additional CPS in Covalima (Suai Referral Hospital) did not meet the SCD, ENBC, or FP standards. From 2016 onward, the project worked closely with the INS and the MOH to upgrade these sites and the training facilities at the INS, using a continuous quality improvement (CQI) approach. This included: 1) a preliminary assessment of the CPS;[24] 2) annual planning workshops; 3) implementation of the plans; and 4) a final assessment of the CPS (see points 1 to 4 below).

1) Preliminary assessment of the three CPSs and INS as a competency-based clinical training center

In 2016, the readiness of the three CPSs was assessed. Comoro CHC reached 68 percent; Vera Cruz CHC 65 percent; and Suai Referral Hospital 71 percent. Figure 3 shows an example of Comoro CHC and the components that required improvements in 2016.

Figure 3. Preliminary Assessment of Comoro CHC as a CPS, by Component



Source: Establishment of Skills Laboratories and a Clinical Training Center for Competency-Based Training in Timor-Leste.

2) Annual improvement planning workshops

To improve readiness, each CPS developed annual improvement plans with the involvement of the INS, MOH, and health providers and managers. The plans focused on infrastructure, basic equipment, availability of instruments, clinical procedures, and essential drugs for MNCH and FP, IP, and room set-up. In general, the three sites developed similar plans, identifying what they could implement on their own and the needs requiring outside support, such as those related to infrastructure, equipment, drugs, and training.

[24] USAID's Reinforce Project implemented by JSI. (2016). *Establishment of Skills Laboratories and a Clinical Training Center for Competency-Based Training in Timor-Leste.*

3) Implementation of the plans

Examples of TA to help the three CPS implement their annual plans and improve readiness include:

Training
USAID's Reinforce trained a core team of eight advanced trainers from the national level, who in turn trained an additional 14 trainers—doctors and midwives—based at the CPS in Dili and Covalima Municipality. To ensure the CPS delivered SCD, ENBC, and FP services at expected standards, the trainers trained most maternity health providers working in Comoro and Vera Cruz CHCs, Suai Referral Hospital, as well as in the *Hospital Nacional Guido Valadares* (HNGV), where services were being provided. Total numbers of trained providers are reported in Table 4.

Box 2. Investing in Timor-Leste's Health Workforce Improves Skills and Health Outcomes

Sra Carmen de Jesus Gusmao, midwife, head of the maternity ward at Suai Referral Hospital, was certified as a trainer in January 2017. As a senior midwife, she was a good candidate for becoming a trainer based in Suai Referral Hospital. She provides training, coaching, and mentoring to most midwives and doctors working at the maternity ward, and several others from Covalima's CHCs and HPs (see Annex 3b).

Carmen de Jesus Gusmao observes a trainee demonstrating the proper use of equipment.

Photo Credit: USAID's Reinforce Staff

For the INS, having trainers based at the CPS resulted in more efficient implementation of training activities, as practice could be conducted whenever a trainer and trainee were near a patient, without needing to call a trainer from the INS, who are often busy with other groups of trainees. Throughout the five years, the project and the INS provided TA to these trainers, ensuring they took on the full responsibility of teaching, coaching, assessing, and certifying health workers.

Every quarter, the INS organized a trainers' discussion forum, a platform allowing trainers to meet and discuss various topics of common interest, such as the advancement of various training standards, results, and the 13 municipalities' needs.

Supportive supervision

The INS and MOH used the preliminary assessment checklist to conduct supportive supervision, including assessing progress at the CPSs and provision of TA where required. Every six months, the supportive supervision triggered or confirmed small changes, such as re-arranging client status; adding chairs, tables, and cabinets in every room and benches in the waiting rooms; fixing broken taps and sinks; replacing bulbs; re-organizing delivery rooms; and ensuring cleanliness. These visits also helped the CPSs remind their supervisors about procurement, renovations, and training needs.

MHS officer explains correct care and storage of equipment during supportive supervision visit, Zumala.

Photo Credit: USAID's Reinforce Staff

Skills labs

Skills laboratories offer a space and opportunity for training participants to practice their skills, be assessed, and gain confidence to perform the required techniques and responsibilities in a controlled environment before providing clinical services to real patients. USAID's Reinforce provided assistance for the set-up of skills labs at the INS (next to the classrooms) and the three CPSs. The project procured models and equipment, and provided TA for the design of the skills lab and the development of SOPs to guide the work of the trainers.[25]

The effectiveness of practicing at the skills lab depends on the trainer's capacity to ensure that the participants focus on the 'patient.' It is also important that the trainers recreate effective communication to enhance teamwork. To support this, the project provided training on the skills lab SOPs to all trainers affiliated with the INS. The training focused on the trainers' duty of keeping up-to-date with clinical standards, maintaining the skills lab, and their role as facilitators. For the SCD and FP training, the SOPs proposed eight sessions of one-to-two hours each, as described in Table 3 below.

Table 3. SCD and FP Sessions at the Skills Lab

Theme	Models
Chapter 1: Clinical Decision-making Process, Definition of Infection Prevention Procedures, Principles, and Efforts in Infection Prevention	n/a (infection prevention simulation room)
Chapter 2: Early Recognition of Problems and Risks of First Stage of Labor	Advanced Childbirth Simulator S500
Chapter 3: Birth Preparedness and Complication Readiness	Advanced Childbirth Simulator S500
Chapter 4: Third and Fourth Stages of Labor	Advanced Childbirth Simulator S500
Chapter 5: Newborn Care and Three Main Components in Infection Prevention of the Newborn	NeoNatali

[25] National Institute of Health, with support from USAID's Reinforce Project implemented by JSI. (2019). *Standard Operating Procedures: Skills Lab at the INS.*

Chapter 6: Newborn Asphyxia Management, Indication for Resuscitation. Post-resuscitation Care, and Prediction of Respiratory Problems	NeoNatali
Chapter 7: Practicing IUD Insertion and Removal	Zoe Gynecological Simulator S504.100 & Female Pelvic Organs S506
Chapter 8: Practicing Implants Insertion and Removal	Rita S519 Reproductive Implant Training Arm

The project also developed four simulation scenarios—prenatal, labor and delivery I, labor and delivery II, and postpartum—designed to demonstrate participants' knowledge, techniques, and interpersonal communication skills.

Anatomical models in the skills lab help trainee midwives to become competent in management of newborn care and delivery before providing services to women.

Photo Credit: USAID's Reinforce Staff

The skills lab model designed by USAID's Reinforce was replicated by the MOH in Oecusse Regional Hospital with support from Health Alliance International (HAI), funded by the Department of Foreign Affairs and Trade. USAID's Reinforce provided technical support to introduce the INS SOPs and include the new trainers into the trainer's discussion forums.

Equipment

The preliminary assessment of the CPSs outlined serious gaps in clinical and IP equipment availability. The CPSs regularly raised the issues with the ministry, which was unable to procure the required equipment (see "challenges" under Learning and Dissemination of Results on page 57). In 2018, USAID approved JSI's request to procure equipment for the three CPSs. This intervention is described in detail under Strategy 2.

Infrastructure

The infrastructure problems at the three CPSs were largely due to the small size of their rooms (except the referral hospital), and the unreliability or lack of water and electricity supplies. In coordination with USAID, the project facilitated numerous visits from the U.S. Navy Seabees and other entities able to improve infrastructure (e.g., the Infrastructure Department of MOH and Dili and Covalima MHS).

The Seabees renovated the maternity ward in Vera Cruz CHC, as part of the Pacific Partnership 2019 exercise. In Covalima, the Pacific Angels renovated the municipal heath training room located in front of

the referral hospital, including the dormitories, sanitation, and electricity, and helped to equip the skills lab. At the INS, the Seabees constructed a new building including a large training room and a second skills lab. These new facilities—added to the increased number of trainers described above—will help the INS meet the high demand for training.

Management training at Suai Referral Hospital
USAID's Reinforce collaborated with St. John of God, an international NGO working at the HNGV to improve nursing and midwifery care, to deliver the health manager program to six directors from Suai Referral Hospital (three in 2018 and three in 2019). The course, which had shown success at HNGV, was organized in modules, between which participants worked on small individual projects focused on:

- Improving the quality of patient/treatment documentation in the outpatient department.
- Implementing a new filing system in the medical records department.
- Implementing handover of patients using appropriate tools.
- Improving patient assessment in the emergency department.
- Waste management.

Following the course, the participants reported that the program had helped them to be better leaders. USAID's Reinforce expanded the collaboration to train CHC managers (described under Strategy 2).

4) Final assessment

At the request of the INS, USAID's Reinforce commissioned an external assessment of the three CPSs.[26] The assessment used the same tools as in 2016, focusing on:

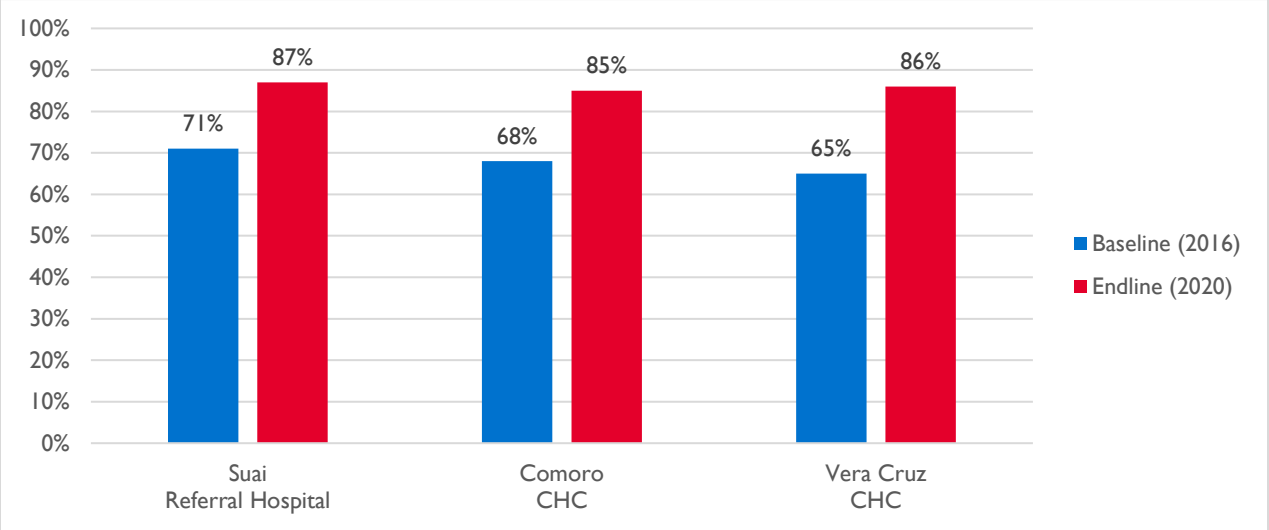
- Appropriateness of the space/rooms and patient flow.
- Process of IP (decontamination and sterilization).
- Waste management.
- Quality of counseling.
- Quality of normal delivery services.

5) Quality management

For most sections, the three CPSs improved to reach more than 80 or 90 percent compliance with the established standards in areas such as patient flow, counseling and clinical services, disinfection procedures, and availability of guidelines. Consequently, the overall scores, as shown displayed in Figure 4 at the start of the next page, show upward trends in all three sites. Nevertheless, the external assessment also identified areas of improvements for sterilization procedures, waste management, and quality management. The evaluation team recommended a list of concrete actions for the CPSs to implement to meet expected standards. Annex 4 provides details about the assessment and the list of recommendations.

[26] USAID's Reinforce Project implemented by JSI. (2020). *External Assessment of Obstetric Services and their Related Counseling Services at Three Clinical Practice Sites.*

Figure 4. Improvements at the Three CPSs



Source: External Assessment of Obstetric Services and their Related Counseling Services at Three Clinical Practice Sites.

Delivery of Training and FUAT

Delivery of Competency-Based Clinical In-Service Training (point 3 in Figure 2)

As the INS was developing or updating training packages and setting up its premises and CPSs according to national standards, it also initiated the delivery of SCD, ENBC, and FP training to primary health care (PHC) facilities in Covalima Municipality, with support from USAID's Reinforce.

In 2016, the INS conducted a training needs assessment (TNA) in Covalima to prioritize training in the municipality.[27] While the SARA already informed the project about the general gaps in training, the TNA revealed specific health worker's needs and the level of competency they reported reaching in key MNCH and FP services. The TNA was followed by three years of continuous in-service clinical training on SCD, BEmONC, ENBC, integrated management of childhood illnesses (IMCI), and FP for a total of 339 health providers (see Table 4). Among them, 314 completed the required competency checks during training.

Table 4. Number of Health Providers Benefiting from Clinical Training in the CPS, and in Covalima

Health facility	Number of personnel trained					
	As trainer	In SCD	In BEmONC	In ENBC	In IMCI	In FP
Clinical practice sites:						
Comoro CHC	3	14	- (5)	8	-	8
Vera Cruz CHC	2	5	- (5)	4	-	2
HNGV	4	11	-	-	-	-
Suai RH	4 (2)	25 (2)	-	9 (2)	3 (7)	17 (9)
INS and partners	7 (3)	11 (4)	-	2	4 (8)	1 (9)
Administrative post (total number of PHC facilities):						
Fatululik (2)	1	4	-	3	4	4

[27] Instituto Nacional de Saúde (INS) with support from USAID's Reinforce Project implemented by JSI. (2016). *Training Needs Assessment for Maternal, Newborn and Child Health in Covalima Municipality and two Health Centers in Dili, Timor-Leste.*

Fatumea (3)	-	3	-	4	7	4
Fohorem (4)	-	5	2 (6)	3	6	8
Maucatar (4)	-	8	-	8	9	12
Suai Vila (6) (1)	-	11	-	12	12	13
Tilomar (3)	-	7	2 (6)	6	9	9
Zumalai (4)	1	10	3 (6)	6	9	12
Total	**22**	**114**	**7**	**65**	**63**	**90**

(1) Suai Referral Hospital, located in Suai Vila Administrative Post, is included under CPS above.
(2) Includes 1 MHS staff.
(3) Includes 4 JSI staff.
(4) Includes 2 midwives working with Maluk Timor based at Vera Cruz CHC, and 4 JSI staff.
(5) Midwives from the CPS of Comoro and Vera Cruz were trained in BEmONCwith UNFPA funding.
(6) Fohorem, Tilomar and Zumalai CHCs are the three BEmONC facilities in Covalima, as per MOH Improvement Plan of Action for EmONC.
(7) Three MHS staff.
(8) Three JSI staff and one MOH staff (IMCI officer).
(9) Includes two MHS staff.
(10) JSI staff.

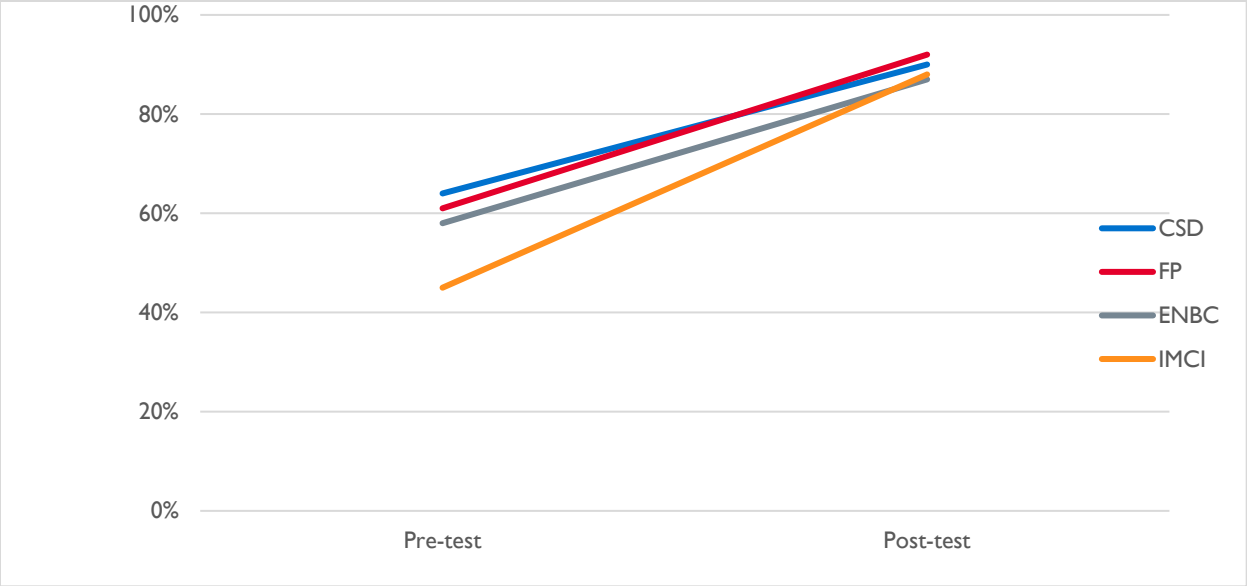
Figure 5 below illustrates the large proportion of time spent on clinical practice in all competency-based training delivered by the INS. The newly developed courses allocated more time at the skills lab and at the CPS; allowed time for repetitive competency assessments; and triggered more communication between trainers and trainees. Despite this, partly due to a lack of patients for practice, most participants required one or more FUAT session at the CPS or at the trainees' workplace after the training to become certified. Thanks to the increased number of available trainers, INS could implement a systematized cycle of FUAT until health workers reached competency.

All training included theoretical sessions that participants had to pass by taking written tests. Figure 6 at the start of the next page shows that, on average, participants' knowledge significantly increased as measured from pre- to post-test.

Figure 5. Steps in Conducting Competency-Based Clinical Training Knowledge

Source: USAID's Reinforce Training Database

Figure 5. Average Improvements from Pre- to Post-Test for USAID's Reinforce-Supported Training



Source: USAID's Reinforce Training Database

Competency

Trainers measured competency with the checklists used during practice on models at the skills lab and with real patients/clients at the CPSs. In total, the project facilitated 417 sessions of FUAT for health workers to either reach or maintain competency levels. Among the 114 health workers trained in SCD, 114 acquired competency on models and 99 on real patients/clients; and among the 65 trained in ENBC, 46 acquired competency on models and 38 on real patients/clients. Among the 90 trained in FP, one dropped out after the theory portion of the training and:

- 89 were assessed as competent in counseling.
- 67 were assessed as competent in inserting implants and 64 in inserting IUDs on models at the skills lab.
- 57 were certified to insert implants, the most popular LARC. Of those, 10 were also certified to insert IUDs. Despite high-quality counseling and intensive information dissemination, health workers have been unable to obtain much interest from women about IUDs. Due to this, it is difficult for clinicians to gain enough practice to be certified and to keep their skills once at their facilities.

A midwife trainee inserts an implant contraceptive under supervision at CHC Fatululik

Photo Credit: USAID's Reinforce Staff

Box 3. Long-acting Contraception Changes a Woman's Life

The INS certified Vitorina de Jesus Cardoso to provide FP services at Fatumea CAC, including LARCs in February 2017. Vitorina is now able to counsel mothers on the full range of FP methods. (See Annex 5).

"Every woman has different needs and lives in a different situation depending on her age, the number of children she has, where she lives, and her health condition." Vitorina de Jesus Cardoso

Vitorina de Jesus Cardoso providing counseling and care to a client.

Photo Credit: USAID's Reinforce Staff

Certification and Maintenance of Certification (point 4 in Figure 2)

INS issued attendance certificates to all training participants who completed the courses as measured by pre- and post-tests and acquisition of competencies in the skills lab. Competency certificates will be given to the participants who passed all competency checks at the CPS, once the INS is accredited.[28] Once acquired, certification must be maintained through regular supportive supervision. According to INS regulations, health care providers should get refresher trainings every two years.

[28] During 2018, the project assisted the INS to get accreditation from the National Institute for the Instituto Nacional de Desenvolvimento de Mão-de-Obra (INDMO – Manpower Development), the institution in charge of accrediting in-service training institutions, However, due to a political impasse, the work could not be continued.

Box 4. Basic Emergency Obstetric and Newborn Care

USAID's Reinforce was an important player in national efforts to re-activate the emergency obstetric and newborn care (EmONC) program, led by the MOH with main support from the United Nations Population Fund (UNFPA) and other UN agencies. One of the project's midwives was involved at every step of the process, which included:

- Developing the clinical protocols for intrapartum and immediate PPC in CHCs.
- Attending the training-of-trainers with 14 national-level personnel working in the country's main health facilities.
- Preparing the first batch of BEmONC training, composed of 11 participants working in in-patient CHCs, plus one midwife from Zumalai CHC, Ana Maria Bianco Lopes,[29] supported by the project.
- Facilitating some modules of the BEmONC training.

Ana Maria Bianco Lopes increased her knowledge from 68 to 96 percent (measured with pre- and post-test respectively), both higher than her group average. She managed cases of clinical complication during training, and as described in Annex 6, used her new skills in Zumalai CHC upon her return. Following this first group, seven other health providers from Covalima attended the BEmONC training; this is essential to the ability of the municipality to save maternal and newborn lives.

Strategy 2. Improve Quality of Service Delivery

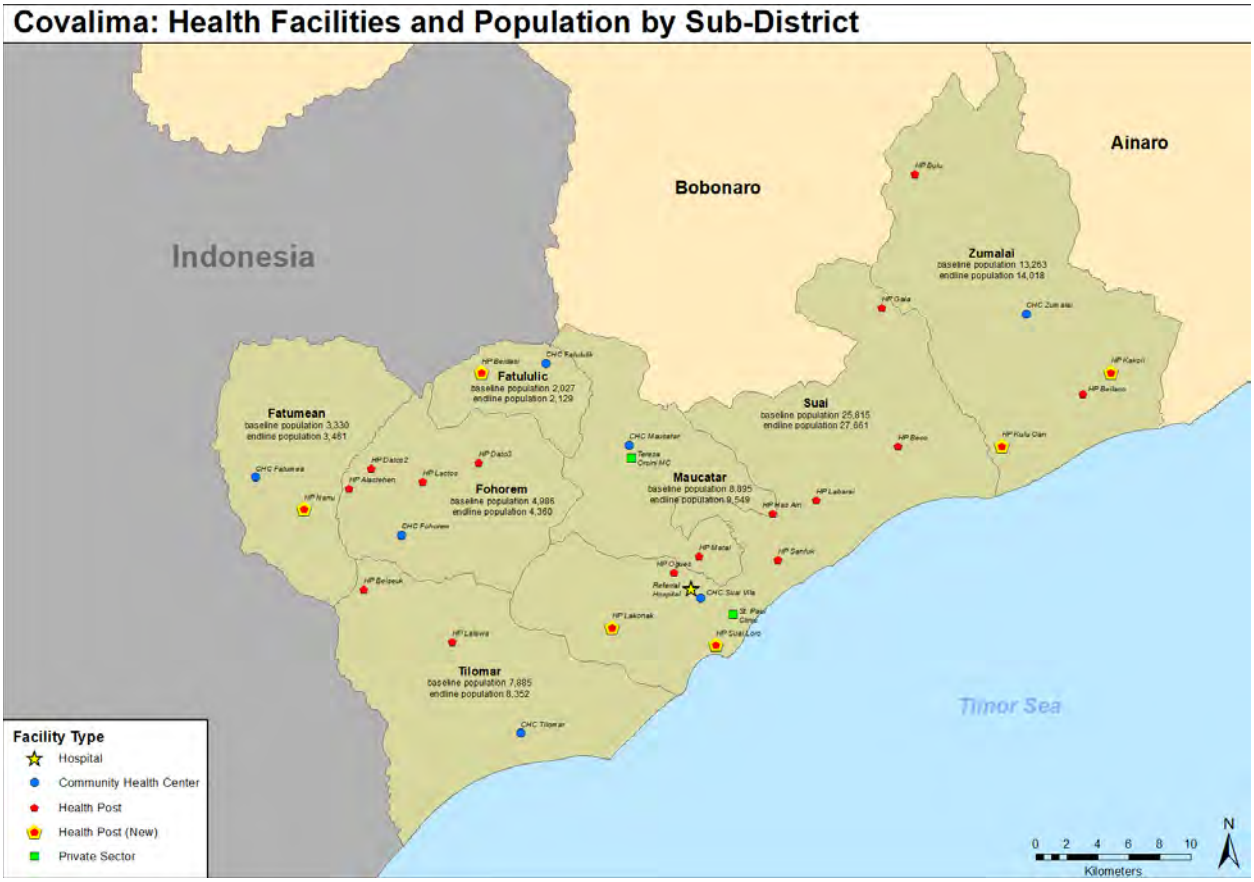
Box 5. Key Achievements for Strategy 2

1. Decrease in FP commodity stockouts from 36 to less than 20 percent, reaching the project's targets.
2. By the end of the project, 79 percent (22) of the health facilities in Covalima complied with MOH readiness standards, exceeding the project's target by 11 percent.
3. Increase in the availability of ANC, obstetric and newborn care tracer medicines, equipment, and materials.
4. All health facility providers were trained on domestic violence and linking victims to medical/forensic, psycho-social, and legal services.

Another key factor of high-quality health services is the readiness of health facilities. While USAID's Reinforce was working with the INS to increase the capacity of the health workforce in Covalima (see Strategy 1), it was simultaneously working with the MOH—mainly the Maternal and Child Health (MCH) Department, the M&E Department, and the Health Quality Control Cabinet—and Covalima MHS to

[29] Ana Maria is a senior midwife from Zumalai CHC. During the past two years she has received intensive training with support from the project, including on clean and safe delivery (November 2016), the logistic management information system, use of the *livriñu saúde inan no oan* (LISIO – maternal and child health booklet), and the response to cases of domestic violence. In addition, Ana Maria was trained as a trainer during the first year of the project and has been providing training other health workers in Covalima since then.

improve readiness of the municipality's 28 health facilities to provide high-quality MNCH and FP services to the population, with particular attention to communities in the most remote places.

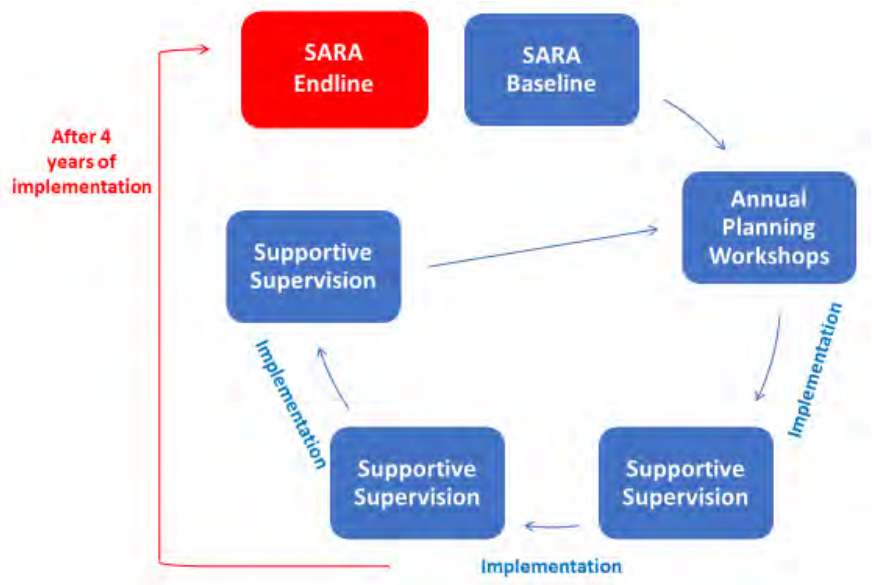


Source: JSI Research & Training Institute, Inc.

Model of Quality Integrated Health Service Delivery

These SARA data provided a solid base for USAID's Reinforce to prioritize its TA in Covalima's health facilities. The project encouraged the MHS to implement a cycle of quality improvement, using data for planning corrective actions and monitoring implementation through supportive supervision (Figure 7).

Figure 7. Improvement Cycle for Facility Readiness



Development of Annual Plans

The baseline data were first used for conducting inter-sectoral improvement planning workshops, organized under the leadership of the MOH and the Covalima MHS. The workshops were conducted three years in a row (2017, 2018, and 2019) and included participants from:

- State administration: municipality administrator, post administrators, and *suco* (village) chiefs.
- Health: HP personnel, CHC managers and personnel, MHS director, deputy director, and program officers, and national directorates and departments.
- Other sectors at the municipality level: electricity and water and sanitation departments and the *Programa Nasionál ba Dezenvolvimentu Suku* (PNDS – National Program for *Suco* Development).

The workshops resulted in the development of improvement plans (one per health facility). The plans included actions that facilities could implement themselves, such as re-arranging consultation and labor rooms, cleaning, filing, and printing job aids, and actions requiring other levels of decision-making, such as human resources, procurements, and infrastructure work. MHS and USAID's Reinforce developed the following lists to trigger actions outside of their scope:

- Needed personnel (for the MOH Human Resources Department).
- Infrastructure needing repair (for the municipality administrator and MOH Infrastructure Department).
- Protocols and job aids (for the National Directorate of Public Health).
- Lacking or broken equipment (for the MOH Equipment Department).
- Stock-outs of essential medicines (for the National Directorate of Pharmacy).

Implementation of Facility Improvement Plans

USAID's Reinforce helped Covalima health facilities at various levels with a range of actions to improve their readiness to provide high-quality services, illustrated in Figure 8.

Figure 8. Elements Strengthened by USAID's Reinforce for Improving Facility Readiness

1) Infrastructure

Issues

The SARA results from baseline highlighted challenges with infrastructure, especially at the HPs. For example, only four HPs had electricity available and only nine could ensure visual and auditory privacy. Twelve HPs in the municipality had water piped into their building, and 12 had adequate sanitation. The SARA did not provide information on building conditions, but the MOH facility readiness format did: two CHCs had issues with their roofs and one with its walls, and three HPs had problems with their roofs. Some facilities also required new rooms. Finally, at the beginning of the project, only two CHCs had a functioning car and five had a broken down car (two of which could not be repaired).

Technical assistance

Table 5 shows the required infrastructure repairs, as planned by the health facilities themselves in 2017. USAID's Reinforce encouraged health facilities to explore available government funding mechanisms for infrastructure, mainly managed by the Ministry of State Administration (through the municipal administrator and post administrators); conducted advocacy meetings with donors and decision-makers; and facilitated visits from the U.S. Navy Seabees to draw attention to Covalima's infrastructure needs.

Table 5. Compilation of 2017 Health Facility Improvement Plans

Components needing repairs	**Actions planned**	**Responsible**
Extension	Build treatment and examination room in Biseuk, Matai, and Sanfuk HPs	*Suco* chiefs, PNDS, administrators (post and municipal), and MHS
Toilets	Repair existing toilets or build new toilet in Biseuk and Sanfuk HPs	*Suco* chiefs and PNDS
Waste pit	Dig a pit to dispose medical waste in Kuluoan, Biseuk, Gala, and Sanfuk HPs	*Suco* chiefs and health providers
Visual and auditory privacy	Build new consultation and treatment room in Biseuk, Matai and Sanfuk HPs	*Suco* chiefs, PNDS, administrators (post and municipal), and MOH

Water	Pipe running water into the facility in Alas tehen, Lactos, and Has'ain HPs, and in Maucatar CHC	*Suco* chiefs, PNDS, and administrators (post and municipal)
Electricity	Install electricity in the facility in Has'ain, Dato rua, Dato tolu, Lactos, Beilaco, Alas tehen, Gala, and Sanfuk HPs	EDTL, administrators (post and municipal), MHS, and CHC
Ambulances	Repair broken down ambulances parked at the MHS; repair Suai Vila, Zumalai, and Tilomar CHCs ambulances; and buy new ambulance for Fohorem, Fatululik, and Maucatar CHCs	MHS and MOH
Communication	Buy and install landline or mobiles for all CHCs and HPs except Suai Vila CHC	MHS and MOH
Road (access to facility)	Repair the road leading to the facility in Biseuk and Bulo HPs	*Suco* chiefs, PNDS, and post administrators

During the project implementation, the following repairs and renovations were made:

- Renovation of the nutrition warehouse, installation of a new generator and 5,000-liter water tank, and re-paint of the walls of Has Ain HP.
- Renovation of ceiling, hand washing sinks, doors, and fans, re-painting of walls, repair of water pump and water pipe connections at Tilomar CHC.
- New electricity connections and water pumps at Suai Referral Hospital.

2) Drugs, equipment, and commodities

Issues

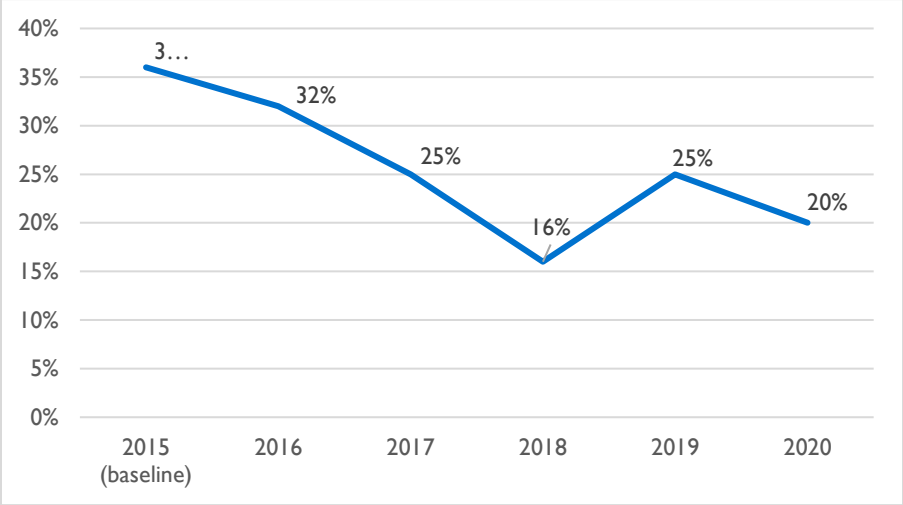
The baseline SARA showed a generally low level of modern FP commodity availability, especially at the HPs. Almost all CHCs and the hospital had pills and male condom stock available. However, the availability of injectables, IUDs, and implants was much lower for CHCs. While the service area at the hospital had a number of medicines available, several commodities were reported stocked out on the day of visit. CHCs and HPs reported stockouts for most commodities.

Technical assistance

USAID's Reinforce provided TA to MHS officers and health facility workers to keep their storage rooms clean and organized, monitor stock levels, check expiry dates (for medicines and commodities), and request new medicines, commodities, and equipment to the national level. At the same time, project staff based at the national level regularly met with MOH to ensure these requests were fulfilled. Throughout the five years of implementation, a decrease in FP commodities stockouts was observed (see Figure 9). As most FP commodity stockouts were due to inadequate stock management (contraceptives were still procured by UNFPA), the project collaborated with the MCH Department to provide training on the logistic management information system (LMIS) to midwives in charge of requesting contraceptives.[30] In total, 38 midwives were trained on the LMIS, covering all facilities providing FP services. MNCH medicines availability also increased (see Figure 10).

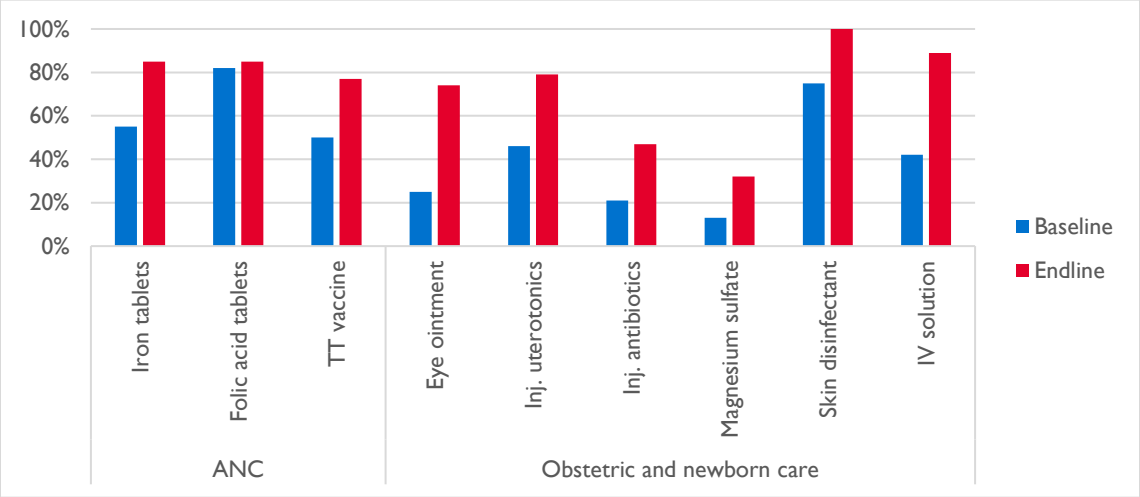
[30] The LMIS for FP commodities is managed by the MCH Department.

Figure 9. Trend in FP Commodity Stockouts in Covalima Health Facilities



Source: Health facility registers

Figure 10. ANC, Obstetric, and Newborn Care Tracer Medicines Availability



Source: SARA baseline and endline reports

Equipment procurement

For required equipment, despite advocacy at the highest level, planning and budgeting exercises, and various attempts to include equipment procurement in government annual budgets, the MOH was unable to fulfil its requirements. The project also approached several potential donors, without success. In 2018, USAID's Reinforce received USAID approval to procure the critically needed MNCH and FP equipment. This is an important contribution to completing the promise of the 'model municipality' and ensuring that the successes achieved through human resource development and TA are sustained.

In preparation for the procurement, USAID's Reinforce worked closely with the MOH Medical Equipment Department, Covalima MHS, and health facilities to develop a list of equipment required in each facility. The list was based on existing quantities assessed during baseline, multiple supportive

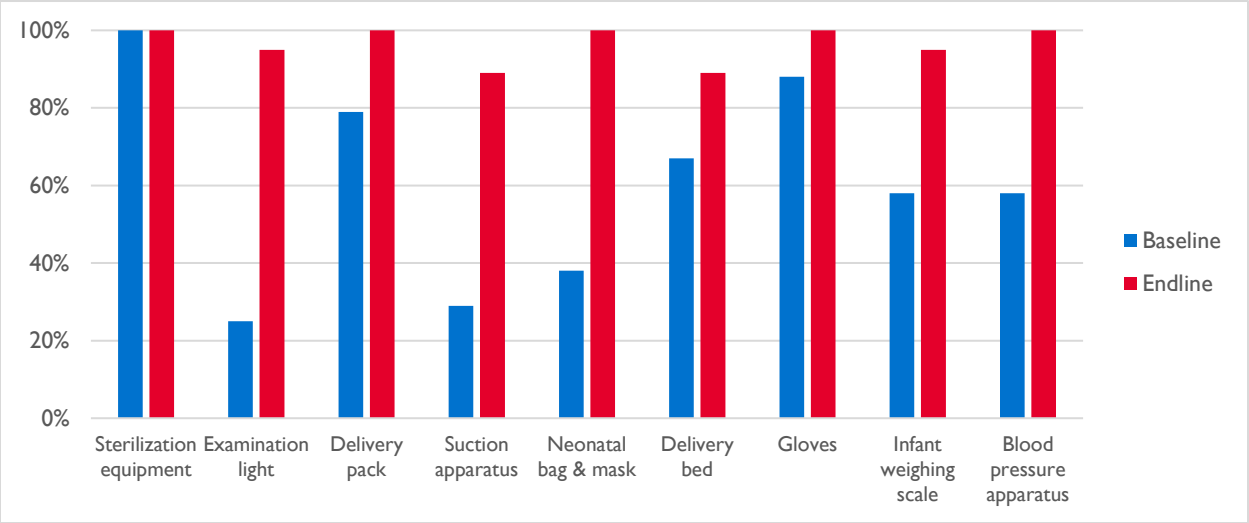
supervision visits, and MOH standards and approved specifications. In early 2020, a shipment arrived in Timor-Leste and distribution started. MOH biomedical technicians trained health workers at each facility on the use and maintenance of the new equipment, how to prepare and update inventory lists, and how to conduct self-assessments.

Gala community leaders receiving equipment donated by USAID. "When USAID mission director visited Gala Health Post a few months ago, he saw the reality, realized that the staff needed help, and responded to our needs with essential equipment. Now it is our turn to respond. We will monitor that it is used and well maintained in our health facility and we will guarantee that it remains in the facility for the health of the Gala community," said the Beco *suco* chief.

Photo Credit: USAID's Reinforce Staff

Consequently, the SARA endline confirmed significant increase in the availability of medical equipment across all facilities (Figure 11). Additional BEmONC equipment was available where midwives had been trained to assist deliveries with complications. CEmONC equipment, including an anesthesia machine, a resuscitation table with a heat source for newborn resuscitation, an incubator, oxygen, and a spinal needle, was available at the referral hospital.

Figure 11. Obstetric and Newborn Care Tracer Equipment and Material Availability

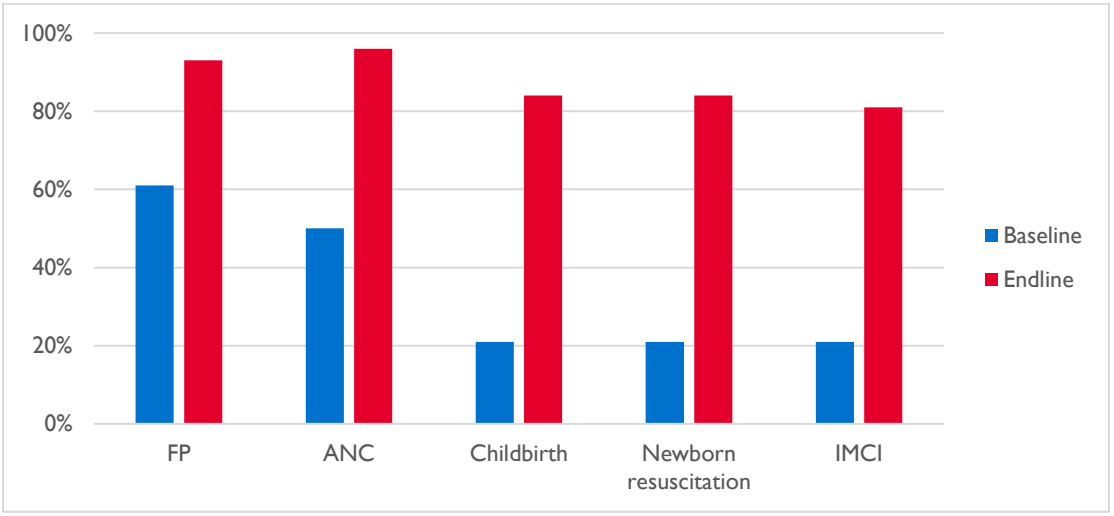


Source: SARA baseline and endline reports

3) Service delivery

USAID's Reinforce adopted multiple strategies to improve the quality of service delivery in Covalima Municipality. The first one—competency-based clinical training—is described under Strategy 1 and the SARA endline outlined significant progress (Figure 12). Aside from these structured training events managed by the INS, USAID's Reinforce worked with MOH and Covalima MHS in a range of other interventions, described below.

Figure 6. Health Providers Trained in MNCH and FP in the Past two Years

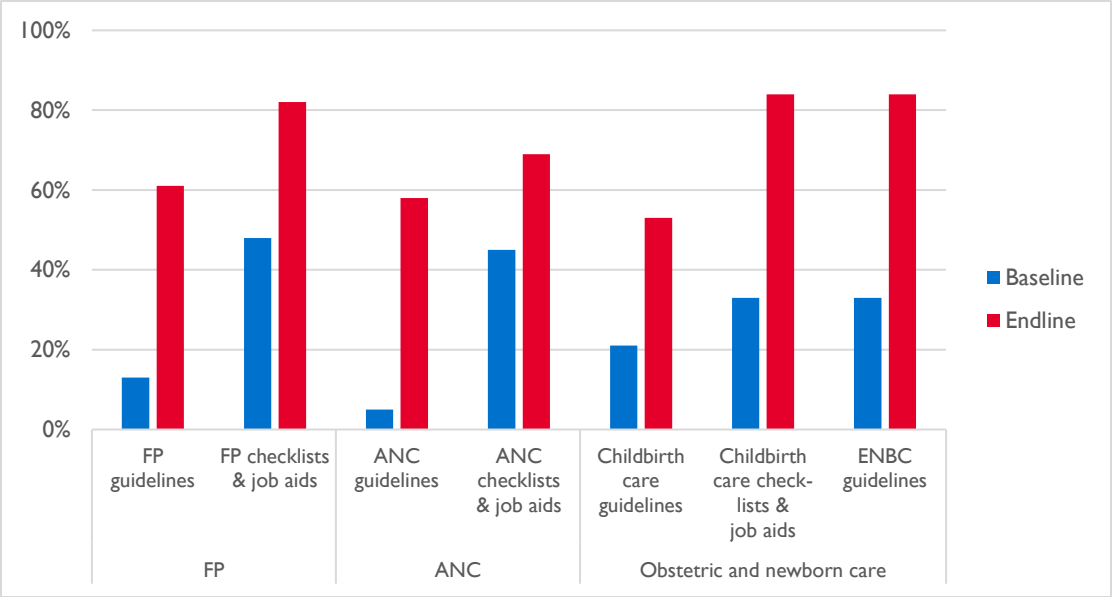


Source: SARA baseline and endline reports

Guidelines and job aids

The project ensured guidelines and job aids were present in the consultation rooms. Several job aids had to be developed or updated to conform to training standards (e.g., IP, partograph, IMCI wallchart, newborn resuscitation diagram). The SARA endline showed progress, particularly for job aids, which were carefully posted on the walls near patient care and consultation rooms (see Figure 13).

Figure 7. Obstetric and Newborn Care Guidelines and Job Aids Availability



Source: SARA baseline and endline reports

Routine technical assistance

MHS and USAID's Reinforce, through regular visits to the health facilities, also identified various training needs (not necessarily related to clinical competences nor included in INS' curriculum) and remediated identified gaps through coaching, informal discussions, working sessions, and more structured orientations when required. Through these activities, USAID's Reinforce not only improved service delivery, but also built the capacity of the MHS MNCH officer in her supervisory, advisory, and mentoring role for health providers. Remediation topics included:

- ANC training (for 43 midwives and medical doctors), especially about the MOH standard for ANC timing and recording.
- Working sessions on identifying postpartum women and newborns who were not receiving PNC; identifying women who delivered at home without the assistance of a health worker and ensuring they received adequate care (PNC and immunization for their newborn); ensuring all new and continuous FP users were receiving counseling every time they renew their contraceptive method; promoting FP services during immunization; and ANC consultations to avoid missed opportunities.
- Training on the *Livriñu Saúde Inan no Oan* (LISIO – Maternal and Child Health Booklet), including how to fill services records (ANC, PNC, immunization), promote birth planning and healthy behaviors, and complete the birth registration, for 28 midwives and medical doctors.
- Training on postpartum family planning (PPFP), particularly relevant for women living far from the health facility.

Autoclave and equipment well organized following TA visit to facility.

Photo Credit: USAID's Reinforce Staff

Continuous quality improvement
USAID's Reinforce and other partners collaborated with the MOH Health Quality Control Cabinet to set up continuous quality improvement (CQI) interventions across the country,[31] including a training-of-trainers in India attended by Covalima MHS MNCH officer, and a training for the municipal CQI team. As the COVID-19 pandemic started, the team focused its work on IP and reducing transmission of the virus.

4) Leadership and management

The CHC is responsible for providing high-quality PHC to the administrative post population and providing technical, administration, and logistics support to HPs in its catchment area.[32] Despite the critical role of CHCs, several reports and assessments identified weaknesses in the way they were managed. Building on the success of the health manager program implemented at Suai Referral Hospital, which increased the capacity of managers in various areas of quality improvement (see above, Establishment of the INS as a Competency-Based Clinical Training Center), the project collaborated again with partner St. John of God to provide similar training to three CHC managers (in Zumalai, Fatumea and Tilomar) and two MHS officers. The desired outcome of the course was to build the leadership capacity of health managers to improve patient care and safety outcomes through effective management practices.

5) Health management information system (HMIS)

Registers for MNCH and FP at the PHC facilities are used to record patients attending ANC, delivery, PNC, immunization, nutrition, child health, and FP. They allow health providers to follow patients' status and calculate the catchment area coverage. USAID's Reinforce worked with the Health Statistics and Information Department, in charge of the HMIS at the MOH, and provided TA to health workers on recording, compiling, and reporting accurate, complete, and reliable data to the level of quality required (see Box 6) and within the timeframe established by the MOH.

The project ensured the proper use and management of the Timor-Leste Health Information Software[33] in Covalima Municipality. USAID's Reinforce supported the MOH in a 5-day orientation for CHC, MHS,

[31] CQI for MNCH.
[32] Ministry of Health. (2015). *Comprehensive Services Package for Primary Health Care.*
[33] Local name for the District Health Information Software 2, an open-source software platform for reporting, analysis, and dissemination of data for all health programs.

and hospital officers in charge of data reporting, and provided routine TA to all health facilities using the software.

An important aspect of high-quality services is data use (see Figure 8). During the five years of implementation of USAID's Reinforce, HMIS data were used at multiple occasions, such as for:

- Assessing the quality of health services (timing of ANC consultations, identification of immunization and FP dropouts, and completeness of services provided during consultations, [e.g., provision of medicines, tests, or immunization during pregnancy]).
- Conducting quarterly microplanning and municipality meetings (see Strengthened Planning Processes through Improved Use of Data, below).
- Advocating support from the community where health care alone could not resolve problems (e.g., low coverage areas, organizing transport for community in needs).
- Developing annual planning and budgeting exercises.

Box 6. Improving Data Quality

In 2018, the MOH adapted the MEASURE Evaluation Multi-Indicator Routine Data Quality Audit tool to Timor-Leste with immunization indicators.[34] In 2019, it tested the tool with ANC1, ANC4, skilled birth attendance (SBA) and the second newborn visit in Covalima, including nine HPs, four CHCs and the MHS. The results were translated into recommendations that USAID's Reinforce and MHS implemented through routine TA:

- Increase the availability of guidelines and protocols for data management.
- Provide on-the-job training.
- Strengthen the capacity of health workers to manage good-quality data.
- Strengthen data archives at all levels of the system.
- Improve the quality and use of data for decision-making.
- Improve coordination and communication between the national and municipal levels.
- Strengthen supportive supervision.

A concrete example of data quality improvement concerned the recording of the fourth ANC visit. The MOH standard has been to count the ANC4 visit by the number of weeks of the pregnancy (weeks 35-–42). However, many midwives recorded pregnant women's fourth visits as 'ANC4,' regardless of the number of pregnancy weeks, which often overestimated the number of ANC4 visits. The project and MOH coached midwives on recording and adhering to data quality standards. From 2019 onward, HMIS data showed lower ANC4 coverage in Covalima, but this indicated a higher quality data that more accurately reflected actual ANC4 visits.

Supportive Supervision

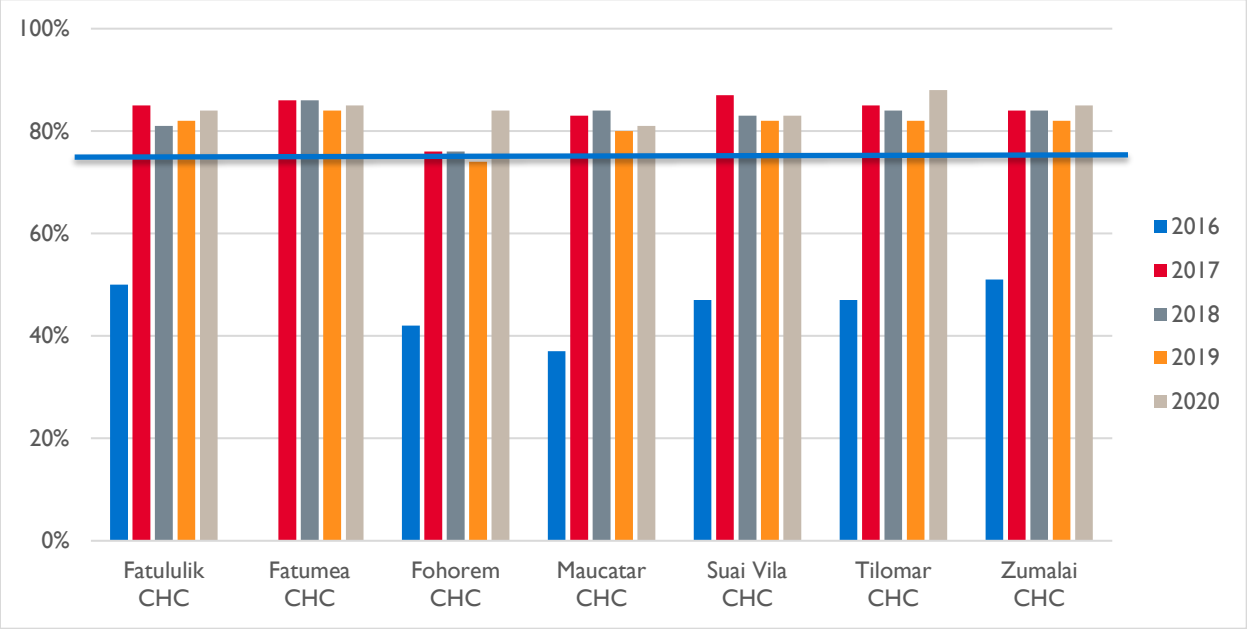
Supportive supervision is a facilitative approach to supervision that promotes mentorship, joint problem-solving, and communication between supervisors and supervisees. That supervisory method was adopted by the MOH more than 10 years ago, particularly for MNCH and FP programs through the

[34] UNICEF through GAVI funding, with technical assistance from John Snow, Inc. (JSI). (2018). Timor-Leste Routine Data Quality Assessment Report.

support of various USAID-funded projects. The MCH Department has used a series of checklists for supervising and coaching PHC providers—midwives and nurses—for safe motherhood, ENBC, immunization, and FP.[35] In 2013, the M&E Department developed a more general checklist to provide supportive supervision and assist health facilities reaching 'readiness' to provide quality services.[36]

These checklists were rarely used in Covalima when USAID's Reinforce started in 2016. Over the five years of implementation, the project helped the MHS conduct 436 visits in the municipality's 28 PHC facilities. USAID's Reinforce aim was that by the end of the project, 71 percent of these facilities would reach quality standards (or 75 percent score). As shown in Figure 14, the CHCs complied with readiness standards as early as project year (PY) 2, and managed to maintain that level of quality through the end of the project. All the TA described above—improvements in leadership and management, service delivery, HMIS, infrastructure and medicines, equipment and supplies—contributed to the increase.

Figure 84. Readiness of Covalima's CHCs From 2016 to 2020

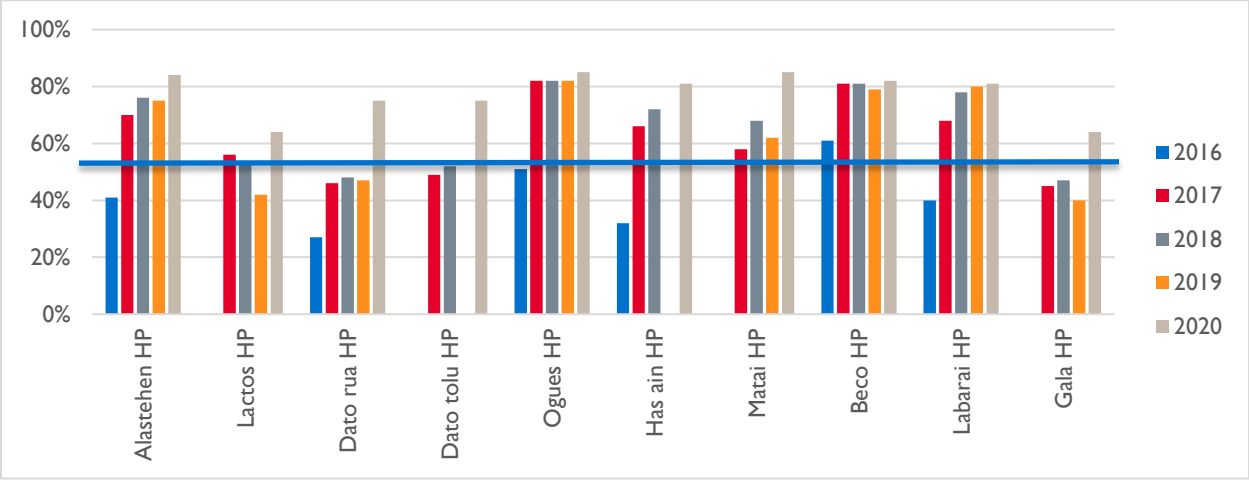


Source: USAID's Reinforce facility readiness database; also available at MOH M&E Department

Most HPs, however, faced more difficulty reaching adequate levels of quality. The impact of USAID's donation of essential equipment is reflected in the significant increase in some HP's scores during the last year of the project (see Figures 15 and 16).

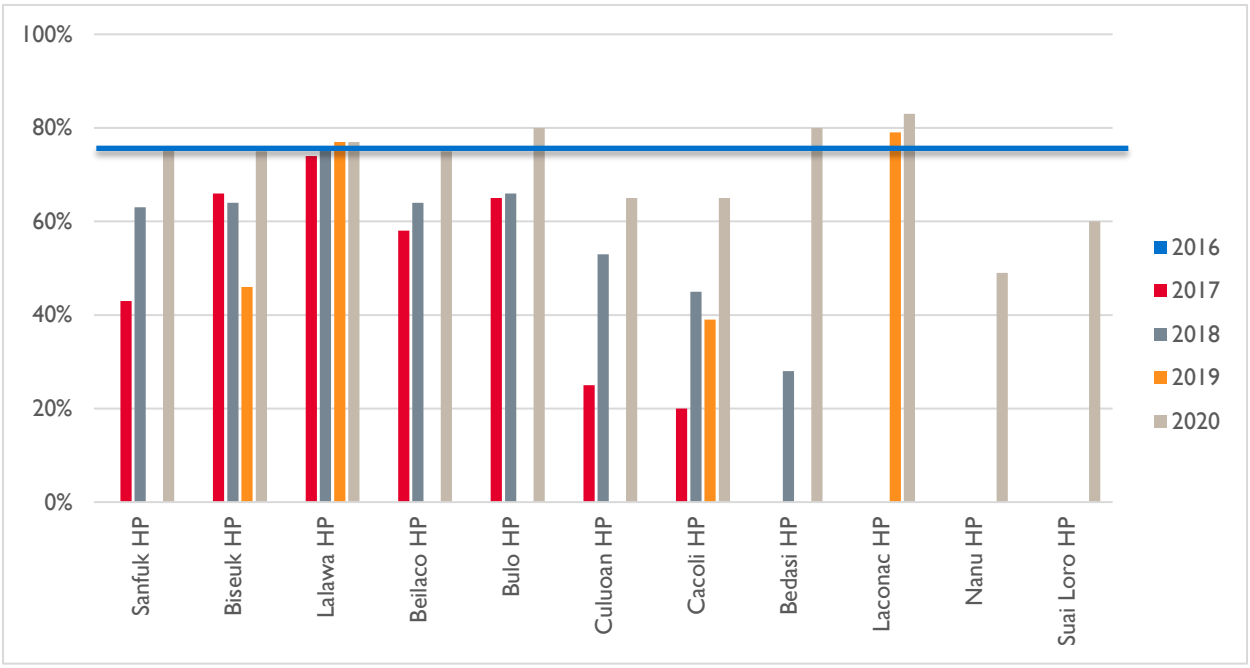
[35] Safe motherhood and newborn care supportive supervision checklist; Family planning supportive supervision checklist; expanded program on immunization supportive supervision checklists; and IMCI supportive supervision checklist.
[36] Facility readiness supportive supervision checklists.

Figure 15. Readiness of Covalima's HPs From 2016 to 2020 (1st part)



Source: USAID's Reinforce facility readiness database; also available at MOH M&E Department

Figure 9. Readiness of Covalima's HPs From 2016 to 2020 (2nd part)



Source: USAID's Reinforce facility readiness database; also available at MOH M&E Department

By PY5, the project exceeded its target and contributed to 79 percent of Covalima health facilities—all CHCs and 15 HPs—reaching the required 75 percent readiness score. For more information, please see the map on page 23.

Strengthened Planning Processes through Improved Use of Data

As mentioned above, USAID's Reinforce provided continuous support to the 28 public health facilities in Covalima to collect, compile, and report service data to the MOH. At the same time, the project worked with the different levels of the system—health facility, MHS and MOH—to encourage analysis and use of the coverage data collected and reported for planning and advocacy purposes.

Microplanning

At administrative post level (CHC), the project provided financial and technical support for the conduct of microplanning meetings. Microplanning is a tool and process that convenes health managers, health providers, and health users (represented by community leaders) on a quarterly basis to observe, discuss, and use local coverage data to plan actions to improve health services and the health status of the surrounding population.[37]

Although the tool had been used in several municipalities, the project made substantial modifications, which strengthened its effectiveness in terms of *suco* leaders' involvement and continuity from one quarter to the next. The following components were added: automatic dashboards; streamlined indicators; a revised action planning process that required referencing data and the previous work plan to determine each quarter's new activities; and a registry for children and women to better target follow-up activities for immunization and ANC at the *suco* level.

The project trained health providers and *suco* chiefs from all administrative posts on the use of the microplanning tool, which included a general orientation on understanding data, data-driven decision-making, interpreting data, and root cause analysis.

The training was an awakening for some community leaders in understanding data in a way that they had not known before. One participant stated, "Before, when I attended the microplanning activity, I just focused on action planning session. I did not pay much attention to the data the health worker was trying to show in the table or the graph. Now, it is clear for me. Before I make a plan to mobilize the community, I have to know the health information of my village and what needs to improve." [38]

The process was better understood after the training, as explained by Maria Fatima, Maudemo *suco* chief: "As community leaders, as village council members, after the microplanning meeting, we follow up and look for the children and pregnant women to remind them that they need to go to the health center."[39] See Annex 7 for more detail on microplanning.

During the quarterly microplanning meetings, the seven CHCs in Covalima developed 286 *suco* plans that were implemented by health staff and suco chiefs in the following quarter. On average, 64 *Servisu*

[37] The microplanning was originally developed by UNICEF and WHO to improve immunization coverage and was introduced in Timor-Leste in 2012 by the *Imunizasaun Proteje Labarik* (IPL – Immunization Protects Children) Project implemented by JSI to specifically increase immunization rates nationally.
[38] USAID's Reinforce Project implemented by JSI. (2018). *Incorporating Evidence into Decision Making Processes: Using Microplanning to Create a Data-Informed Culture in Covalima Municipality, Timor-Leste*.
[39] Close-out video of Maria Fatima.

Integradu Saúde Comunitaria (Integrated Community Health Services) (SISCa) or outreach activities were implemented every quarter as a direct result of the microplanning.[40] Each quarter, these outreach activities resulted on average in:

- 252 ANC services for pregnant women.
- 103 FP services, including the range of contraceptives approved by MOH policies.
- 372 immunizations for children under 1 year.
- 828 growth monitoring services for under-5 children.

Quarterly Municipal Review Meeting

Review meetings normally took place on a quarterly basis at the municipal level, organized by the MHS with the attendance of health facility managers, at least one MOH representative, partners, and relevant sector representatives (often represented by the municipality administrator, but in some instances staff from the electricity, water, and sanitation or education municipal departments attended). The objectives of the meeting were to present quarterly results and agree on improvements (either through plenary discussions or group planning). Quarterly coverage and quality results were alternatively presented by MHS officers (by technical area) and CHC managers (by administrative post).

SISCa Suai Loro

Photo Credit: USAID's Reinforce Staff

USAID's Reinforce assistance was instrumental in mentoring relevant MHS officers—for MNCH, M&E and HMIS—so that they used high-quality data for the presentations, and facilitated discussions to reach agreement on corrective actions. The project provided that support to more than 10 meetings. Several outcomes are direct results of these meetings:

- An opportunity for the municipal administrator to reinforce his support to the health sector, as well as assert his authority when it is not adequately managed.
- Avoiding duplication of partners' support (e.g., CARE International Timor-Leste [CITL] and USAID's Reinforce shared administrative posts for community support).
- Sensitizing other sectors on their role in health (e.g., electricity and water and sanitation for health infrastructure, education for child health).
- Increased accountability for the results and motivation to increase coverage and quality by the next meeting.

[40] Implemented with USAID's Reinforce assistance (vehicle and human resources) in five administrative posts (Fatululik, Maucatar, Tilomar, Suai Vila, and Zumalai) while Fatumea and Fohorem were supported by CITL.

- An opportunity for MHS and health facilities to request support to MOH national level and partners.
- A collaborative effort for improving the health of Covalima Municipality.

Strengthen the Role of the Health Sector in Responding to Domestic Violence

In Covalima Municipality, 51 percent of the women ages 15–49 have experienced physical, sexual, or emotional violence committed by their husband. This is 10 percent higher than the already very high national average of Timor-Leste.[41] Victims of domestic violence rarely report to the police, but they are likely to meet their PHC provider, either to treat the wound resulting from violence or through routine preventive services. To prepare these health workers address that challenge, USAID's Reinforce contracted PRADET[42] to deliver the '4R' training to 146 Covalima Municipality health workers, and teach them how to *recognize*, *respect*, *respond* to, and *refer* victims of domestic violence to appropriate psycho-social, medical, and legal services. Using examples from PRADET's experience, the facilitators taught participants about non-accidental injuries, attitudes health workers need to adopt during encounters with victims, and the role of PHC workers. Finally, guest speakers—including the police, and representatives from shelters and social and legal services—presented the mandate of their organizations forming the network of services to assist victims of domestic violence.

Following the training, health facilities referred more victims to PRADET. As an example, for the third quarter of 2019, PRADET recorded 2 cases of abandonment; 8 cases of domestic violence; 1 case of sexual violence; 2 cases of violence from someone outside the family; and 4 cases of sexual violence outside the family.

In 2020, USAID's Reinforce conducted interviews with 13 selected health workers trained on the 4R. The content of the training was well retained; most interviewees still knew the physical and emotional signs indicating that injuries might be non-accidental. All interviewees could still described how to show respect to patient survivors of domestic violence coming to their consultation, and most of them could explain the mandate of the organizations forming the referral network. The 13 providers stated they had been paying more attention to patients who are or might be victims of domestic violence since they followed the 4R training, and 11 felt safe and comfortable discussing this issue with patient (see report in Annex 8 and story in Annex 9).[43]

The few health workers who reported assisting victims of domestic violence followed the correct procedure, including recognizing domestic violence, providing appropriate health treatment, providing counseling in a private room to keep confidentiality, and providing information about the referral network for assistance. Thanks to Zumalai CHC doctor, two victims accessed support services they were not aware of before the encounter, while a doctor from Suai Vila maintained close follow-up with

[41] General Directorate of Statistics, Ministry of Planning and Finance and Ministry of Health, the DHS Program ICF. (2017). *Timor-Leste Demographic and Health Survey 2016.*
[42] PRADET (Psychosocial Recovery and Development in East Timor) provides psycho-social services at the country's five *Fatin Hakmatek* (quiet places) located in Dili and the five referral hospitals. The *Fatin Hakmateks*, including one in Covalima, are staffed with a midwife counselor who has been certified as a medical forensic examiner and who has established networks of stakeholders protecting victims of domestic violence, including the national police, the justice system, and civil society organizations.
[43] USAID's Reinforce Project implemented by JSI. (2020). *4R Training in Covalima Municipality Follow-up with Selected Health Workers.*

a mother and her baby suffering malnutrition as a consequence of domestic violence. See success story in Annex 9. Finally, Tilomar CHC health workers are better equipped to support the women and children living in Uma Mahon Salele who require their services.

IMPROVING COMMUNITY USE OF HEALTH SERVICES

As mentioned in the introduction, maternal and newborn mortality is still very high in Timor-Leste. Strategies 1 and 2 focus on preparing health providers and health facilities so that women and children receive high-quality health services. Strategies 3 and 4 ensure that women and children have access to these quality services by overcoming the first and second delays of: 1) making the decision to seek care; and 2) reaching a health facility. The KAP baseline highlighted crucial gaps that needed to be filled to increase uptake of healthy behaviors (Strategy 3), and create an environment that enables the practice of these behaviors (Strategy 4).

Figure 10. Social and Behavior Change Process

Strategy 3. Improve Home and Community Health-Seeking Behaviors

Box 7. Key Achievements for Approach 3

1. Key tools and interventions designed around BPCR planning and FP, such as videos and printed materials.
2. Facility-based and community group discussions conducted for an average of 1,618 women and 387 men every quarter on the topics of BPCR planning and FP.
3. 146 students trained on reproductive health, gender and life skills in four of Covalima's high schools; Adolescent Reproductive Health Education interventions endorsed by MOH for expansion to other municipalities.
4. Introduced TraKom, a community-based solution to provide transport for women in labor and others needing health care.

Social and Behavior Change Plan

USAID's Reinforce drew upon the KAP data to plan actions needed to produce behavior change impact. This was outlined in the project's SBC Plan,[44] which used the social ecological model, recognizing that a

[44] USAID's Reinforce Basic Health Support Project, implemented by JSI Research & Training Institute, Inc. (JSI). (2016). *Behavior Change Communication Plan for USAID's Reinforce Project.*

person's relationships and environment can influence his/her behavior as much as individual factors. The plan included behavioral objectives described in Table 6.

Table 6. USAID's Reinforce Behavioral Objectives, Baseline and Target Audiences

Behavioral objectives per stages of the continuum of care	Baseline (KAP or TLDHS2016)	Target Audience
Adolescent Health		
Increase reproductive health knowledge among unmarried adolescents	60% of the population is younger than 24 years old; 9.4% of adolescents in the 15–19 year age group have started childbearing in Covalima; 23% of women 15–19 have experienced violence since the age of 19 and 3% have experienced sexual violence	Girls and boys (age 16–18 years)
Maternal Health		
Pregnancy: Increase the percentage of women seeking at least four ANC consultations during pregnancy, at the timing recommended by the MOH *(Project Indicator #1.3)*	83% women attended ANC during their last pregnancy; 47% had their first ANC consultation during the first trimester; 17% of women felt that the best time for the first ANC visit was at month four of pregnancy	Primary: pregnant women Secondary: husbands and close family members Tertiary: health providers
Birth: Increase the percentage of deliveries at health facilities *(Project Indicators #1.4 and #1.5)*	47% of the births in Covalima took place at the health facility; 35% of households delivered at home because of distance or lack of transport to health facility; many couples could name 1 danger sign, most could not name 2 or more danger signs; 2% could recognize 3 of 4 of the key danger signs during labor	Primary: pregnant women Secondary: husbands and close family members Tertiary: community leaders
Postnatal: Increase the percentage of postnatal women who received PNC in the first 7 days after delivery *(Project Indicator #1.5)*	35% of the women received their first PNC within 2 days after delivery	Primary: pregnant and postpartum women Secondary: husbands and close family members
Family Planning		
Increase the number of couples seeking FP services *(Project Indicators #2.2 and #2.3)*	56% of the women (with a child younger than 2-years) were using a FP method,[45] 85% of these women were using injectables	Primary: married couples Secondary: health providers (counseling skills)
Child Health		
Postnatal: Increase the percentage of newborn babies receiving PNC *(Project Indicator #1.6)*	34% of newborn babies received postnatal checks within 7 days of birth	Mothers and caretakers
Child immunization: Increase the percentage of children receiving the third dose of DPT-HepB-Hib vaccine *(Project Indicator #1.7)*	48% of children ages 12–23 months had received the third dose of DPT-HepB-Hib vaccination	Mothers and caretakers

The SBC plan was implemented from PY2 until the project's close out through several interventions listed below and leading to concrete outcomes (highlighted in the KAP endline report):

[45] The Covalima contraceptive prevalence rate for modern methods per TLDHS2016 was 32 percent.

- Compilation of existing printed and audio-visual SBC materials per stages of the Continuum of Care, and the production of additional ones.
- Training of PHC workers in interpersonal communication.
- On-going implementation of group and one-on-one discussions to promote key behaviors, complemented with mass media interventions.
- Development and implementation of an adolescent reproductive health (ARH) education intervention.
- Design of a *suco* engagement intervention on emergency transport.
- Training of *suco* councils on violence prevention, MNCH, and FP.

Educational and Communication Messages and Materials for FP and Birth Planning

The project mapped existing SBC materials likely to support the achievement of the behavioral objectives. Additional materials were developed during the course of the project to promote a more comprehensive approach to adolescent health, BPCR planning, FP choices and benefits, and engagement of the community in MNCH, emergency transport, and domestic violence (Table 7). The Adolescent RH Education Guide is described in the Adolescent Reproductive Health Education section.

Table 7. List of Existing and Additional SBC Materials

Continuum of Care Stage	Existing Materials (2016)	Additional Materials Developed by USAID's Reinforce (2016–2020)
Adolescent Health	Will Changes Happen to Young People during Puberty? Leaflet; What Are Your Dreams? Booklet; Teen Pregnancy Film	Adolescent Reproductive Health Education
Maternal Health (pregnancy, birth, and postnatal)	LISIO; Maternal Care Flipchart; Danger Signs During Pregnancy, During Delivery and After Delivery Posters	Welcome Angela Film; Home Reminder Poster for Birth Preparedness and Complication Readiness; Community Transport Guides; Orientation Guide for Community Leaders
Family Planning	(Outdated)	Do you Know the Family Planning Methods Used in Timor-Leste? Wallchart and Brochure; FP Benefits Public Service Announcements; Benefits of FP Booklet
Child Health (postnatal and child immunization)	LISIO; Newborn Care Flipchart; Danger Signs for the Newborn and Children Under-5 Posters; Caring for Babies and Young Children, Children's Immunization and Care for Sick Children Flipcharts	n/a

Maternal Health (Pregnancy, Birth, and Postnatal)

The materials described below include: 1) the fictional film "*Benvinda Angela"* to educate pregnant women, their families, and the community on BPCR planning, and to trigger individual and community actions; and 2) the BPCR poster to serve as a home reminder to plan for the birth and prepare for complications. Both materials are described in more detail in Annex 10. These two materials form part of a wider intervention that includes additional materials developed by other partners, training of midwives on BPCR (see Interpersonal Communication Training), and a community engagement activity advocating for and supporting community owned-transport (see Introduction of Innovative Health Transport Options).

BPCR Video "Benvinda Angela"

In 2017, more than 50 percent of women delivered at home in Covalima. Although BPCR planning can significantly help to reduce the first and second delays in reaching care during obstetric complications, it is not yet widely practiced. For example, knowledge of key danger signs during pregnancy, delivery, and the postpartum period were very low (2 percent of women and 3 percent of men could cite three of the four main danger signs during labor) and therefore likely to delay the family's decision to seek care in case of emergency.

Only 24 percent of women and 7 percent of men reported making a BPCR plan at baseline, and among them, just 35 percent included arranging transport as one of its elements. In response, USAID's Reinforce helped the MOH develop a 35-minute video, *Benvinda Angela* (Welcome Angela) to: 1) increase knowledge about obstetric complications; 2) encourage action in preparing BPCR plans; and 3) engage communities to organize local emergency transport options. The BPCR strategy, grounded in the social ecological model, recognized that pregnant women's relationships (husband, parents and parents-in-law, community) can positively or negatively influence decisions and can create supportive environments.

USAID's Reinforce and the MOH Health Promotion and Education Department Head attended the International SBCC Summit in Nursa Dua, Indonesia, in 2018 and presented the film *Benvinda Angela* at two separate multimedia showcase events.
Photo Credit: USAID's Reinforce Staff

Family Planning

Baseline data show that FP use was heavily skewed toward one method: about 85 percent of women cited using injectables. When knowledge of FP methods was examined, the same pattern was observed. In addition, less than 3 percent of women correctly knew when women were most fertile and 40 percent did not know about side effects. This data highlighted the need to improve FP counseling, so that women are knowledgeable about all available methods. While the FP training supported by the project ensured adequate counseling methods were taught to FP providers, it was also necessary to ensure SBC materials are available for FP providers, and current and potential users.

The FP wallchart

The FP wallchart had to be updated from the previous version of the "Do You Know Your Family Planning Choices?" This included increased clarity on the advantages and disadvantages of each method, a different order of the methods, and a new graphic design. The wallchart was then placed in all health facilities (waiting rooms and FP counseling rooms), providing women and clients information on the range of available methods. See Annex 11.

FP public service announcements (PSAs) for mass media use

The KAP showed that more than 80 percent of women and men were not aware of the wide range of benefits FP could provide to families, such as giving more time for work, reducing stress, and giving

more attention to children. The benefit most often cited was that it could improve women and children's health (cited 50 and 28 percent of the women, respectively). In addition, a low proportion of women and men had heard, seen, or read a FP message in the past six months. To remediate to this gap, USAID's Reinforce and MOH developed PSAs focusing on the benefits of FP and targeting specific populations (see Annex 12):

- PSA 1 focused on young couples.
- PSA 2 focused on the benefit of FP for the family's nutrition.
- PSA 3 featured a happy family in which parents are able to dedicate sufficient time to their children's development.
- PSA 4 featured a grandmother who fully supports her daughter and son-in-law in their decision to not have a second child too soon.
- PSA 5 featured the MOH director general and a member of parliament to show high-level commitments.

FP benefits booklet

The key information from the PSAs was summarized in a booklet, using photos of actors (Annex 13). This booklet did not detail contraceptive methods, as such a booklet was already available at the MOH.

Design and pre-tests of materials

All SBC materials developed by the project were designed using evidence to identify behaviors requiring improvements and determine the key messages. Drafts were pre-tested with target beneficiaries through focus group discussions (FGDs) to ensure clarity of messages, language used, and acceptance of visuals, and adjusted according to FGD feedback.

Health Providers' Interpersonal Communication Skills

A key finding from USAID's Reinforce baseline KAP study was that a significant proportion of women did not feel comfortable asking providers questions about information received. While this critical issue merits further exploration, it was generally acknowledged that health providers' interpersonal communication skills needed to be improved. The project provided TA to PHC providers through training and the recruitment of community health officers (CHOs).

Training in interpersonal communication and use of SBC materials

USAID's Reinforce supported the Health Promotion and Education Department of the MOH and the INS to conduct interpersonal communication skills training for 35 PHC workers in charge of SISCa from the referral hospital, all seven CHCs, and 15 HPs. The topics taught and practiced in role-plays included:

- Health workers as communicators, becoming change agents.
- Developing interpersonal communication skills.
- Information, education, and communication materials and how to use them with target audiences.
- Individual counseling.
- Planning, conducting, and monitoring SBC activities in communities.

Not surprisingly, participant knowledge on this new topic was very low at pre-test (28 percent average), but it increased significantly at post-test (78 percent average). As a result, during the endline KAP,

respondents indicated a much higher rate of satisfaction with the information they received on method side effects from providers.

When the SBC materials described above were developed, the project trained midwives and doctors on their use, particularly the BPCR package. For example, the project oriented midwives to their role in completing the form (writing down upcoming dates for ANC and telephone numbers of midwife, ambulance driver, and other relevant staff) with pregnant women during their first ANC visit, and health promotion focal points to their role in ensuring that posters were well-placed in households and understood by all family members.

USAID's Reinforce CHOs

Health promotion activities are an integral part of the Comprehensive Package for PHC[46] at HP and CHC levels. These activities need to be carried out by PHC doctors, midwives, and nurses during the various outreach activities (SISCa, mobile clinics) and domiciliary visits. To showcase good practices and demonstrate that health promotion can be conducted in a range of settings (at or away from the health facility), USAID's Reinforce expanded its team members by recruiting five CHOs based in the focus administrative posts of Fatululik, Maucatar, Suai Vila, Tilomar, and Zumalai.

Provision of Health Education to Community Members

The preparatory work described above provided the basis for conducting continuous health promotion activities in the community and health facilities targeting pregnant women, mothers and/or caretakers of newborn babies and children, couples of reproductive age, husbands, and extended family members (including in-laws). These audiences were defined in the guide Social and Behavior Change: Material Packages per Audience Groups,[47] which was developed to assist PHC providers and project staff conduct health promotion in the community. Adolescents and community leaders are addressed in the next sections.

Health promotion at the health facility

There are opportunities for health promotion at health facility waiting areas. First, the project installed televisions in all health facilities, where the MOH promotion films played continuously.[48] Second, the project's CHOs animated discussions with pregnant women, mothers and caretakers, and accompanying persons to reinforce the key messages and/or elaborate on the messages provided by health workers during consultations. For example:

- In the FP waiting area, these sessions were a good introduction to the various available methods that the midwife would explain in detail during the consultation.
- Birth planning was also introduced by the CHOs (showing the home reminder poster or key sequences of "*Benvinda Angela"*) and further explained during ANC consultation.
- FP counseling was offered to women seeking PNC.

[46] Ministry of Health. (2015). *Comprehensive Package for Primary Health Care.*
[47] USAID's Reinforce Project implemented by JSI. 2019. *Guide: Social and Behavior Change Material Packages per Audience Groups.*
[48] Early in the project, USAID's Reinforce compiled all existing films developed over the past 5 to 10 years and saved them into a USB. The compilation is now maintained by the Health Promotion and Education Department and was distributed to all partners.

Conducting health promotion also created links between services to reduce missed opportunities. The CHOs included information about FP choices in the immunization waiting area or on immunization days to inform mothers of young children about the options to space their pregnancies.

Community members watching educational health program in Maucatar

Photo Credit: USAID's Reinforce Staff

Health promotion in the community

Throughout the project, the CHOs encouraged PHC workers to conduct health promotion group discussions in the community to:

- Assist pregnant women and their families to seek at least four ANC during specific periods of the pregnancy; to know the danger signs during pregnancy, childbirth and the postpartum period; to develop BPCR plans; and deliver at the health facility.
- Teach pregnant women and their families to recognize the danger signs during pregnancy, childbirth, and the postpartum period.
- Encourage postpartum women to seek PNC at least four times after delivery.
- Assist mothers, fathers, and close family members to seek PNC for newborns; know the danger signs for newborns and children under 5; bring sick children to the health facility; and immunize children from birth to six years old.
- Assist mothers to give colostrum to the baby during the first hour after birth and breastfeed their babies exclusively during the first six months.
- Ensure mothers, fathers and couples of reproductive age know the contraceptive methods available in the health facilities; and explain the benefits of spacing pregnancies.

- Ensure parents-in-law/parents (grandparents) support daughter/daughter-in-law/son/son-in-law to space pregnancies by at least three years.

The CHOs and PHC workers visited a variety of settings, such as SISCa, mobile clinics, *suco* offices, markets, and community houses, to facilitate group discussions. The SBC materials described above were used at each session, followed by a discussion and questions and answers to ensure participants understood and reached the conclusion that adopting the behaviors would improve their well-being and possibly save their lives. In some instances, under the guidance of the *suco* (village) or *aldeia* (hamlet) chiefs (often following microplanning), CHOs, and PHC workers conducted home visits, following up on the BPCR plan or any beneficiary identified as dropout (for ANC, PNC, FP, or immunization).

Home visit in *suco* Debos Tabacolot

Photo Credit: USAID's Reinforce Staff

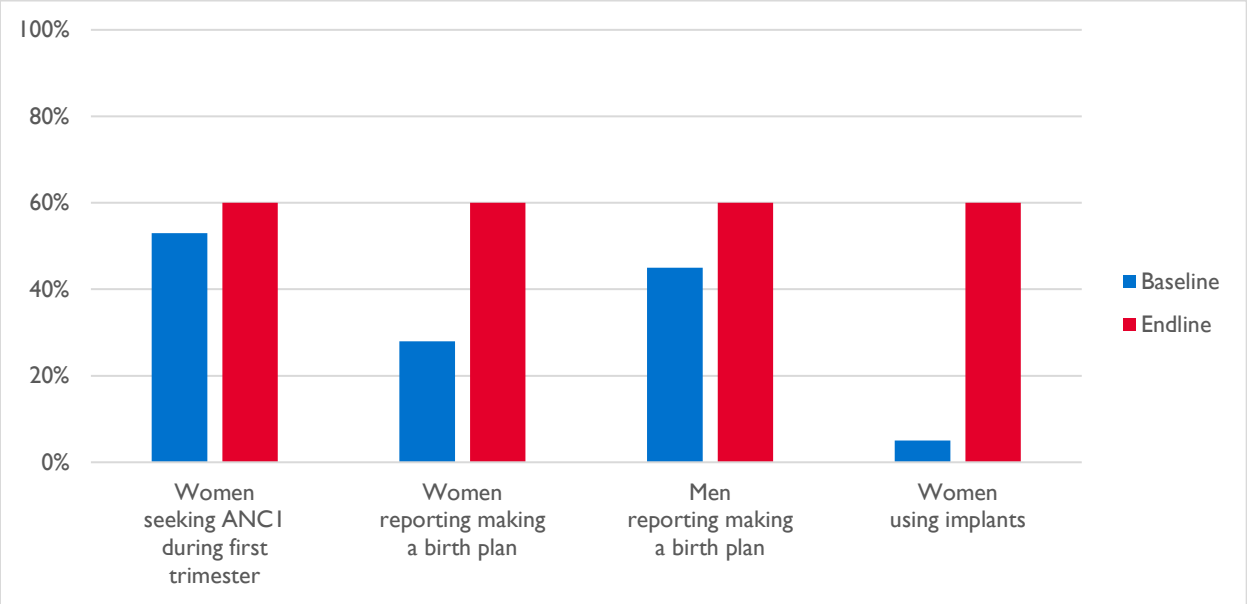
As shown in Table 8, through a continuous focus on educating the community and explaining to women of reproductive age (WRA), men, and older community members the benefits of healthy practices, the project conducted on average 120 group discussions, reaching around 1,618 WRAs (either pregnant, lactating, or in-between pregnancies) and 387 men every quarter from 2017 until mid-2020. The CHOs and PHC workers facilitated an average of 116 follow-up home visits per quarter. During the course of the project, the popular film events (212 in total) attracted 2,349 WRAs, 1,462 men, and 423 community members above 50 years old, more than likely grandparents who were helping their sons, daughters, sons-in-law, and daughters-in-law in parenthood.

Table 8. Number of Health Promotion Activities and Beneficiaries Reached

PY (No. of quarters)	Group discussions				Film events			
	No.	WRA	Men	Home follow-up	No.	WRA	Men	> 50
2017 (4)	136	1,401	129	-	1	29	17	9
2018 (4)	784	9,783	2,615	174	82	651	233	49
2019 (4)	507	6,932	1,386	740	84	758	466	163
2020 (2)	259	4,532	1,292	241	45	911	746	202
Total	**1,686**	**22,648**	**5,422**	**1,155**	**212**	**2,349**	**1,462**	**423**
Quarterly average	**120**	**1,618**	**387**	**116**	**15**	**168**	**104**	**30**

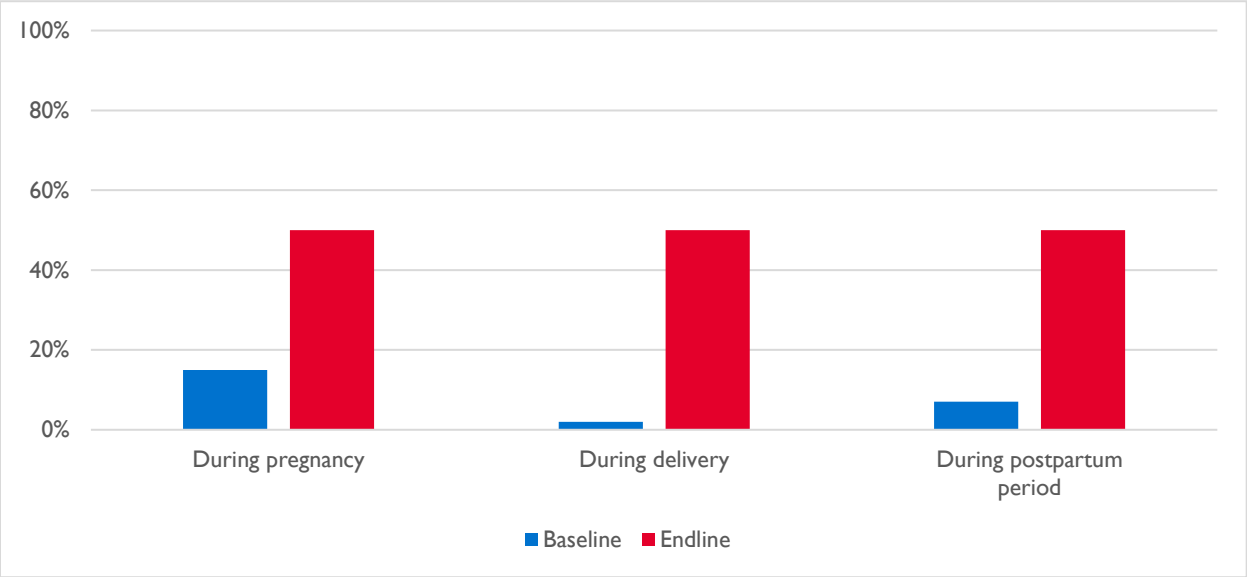
The endline result improvements can be attributed to the project's SBC efforts described above. As illustrated in Figure 18, the endline showed that 60 percent of pregnant women attended their first ANC during the first trimester (compared to 53 percent in 2016); 60 percent of women and men reported having made a BPCR (against 28 and 45 percent, respectively, at baseline); and among women using contraceptives, the proportion choosing LARC was significantly higher than at baseline, with an increase of 55%.

Figure 11. Key Behaviors Improvements from KAP Baseline to Endline



Endline results also highlighted significant improvements in the community's knowledge of danger signs. Figure 19, pictured on the next page, shows how among women interviewed, knowledge of the danger signs during pregnancy, delivery, and the postpartum period increased by 35, 48, and 43 percent, respectively.

Figure 129. Women's Knowledge of Danger Signs - Improvement from KAP Baseline to Endline



Adolescent Reproductive Health Education

Teenage pregnancy is a problem in Timor-Leste, with 7 percent of girls in the 15–19 year age group who started childbearing (more than 9 percent in Covalima).[49] For many of these girls and their families, early pregnancy has social consequences, such as the risk of not pursuing studies, limited economic opportunities, and facing additional responsibilities. For some of them, there are serious consequences for their physical and mental health, and teen pregnancy leads to higher risks of morbidity and mortality for them and for their children. In addition, the nutritional status of WRA is poor, which can have a significant negative effect on reproductive health outcomes (13 percent of deaths of women ages 15–19 are pregnancy-related), and 23 percent of women 15–19 have experienced violence since the age of 19, and 3 percent have experienced sexual violence.[50]

For these reasons, USAID's Reinforce collaborated with the MOH and developed an educational and interactive package of materials covering general information on ARH, including anatomy and physiology, and cross-cutting topics such as gender, nutrition, and core life skills.[51] The package was designed to be implemented over three 3-hour sessions, based on principles outlined in national and international guidelines and policies[52] and FGDs with 30 young people. The session outlines followed the key concepts, topics, and learning objectives established by the International Technical Guidance on Sexuality Education. The participatory activities and associated tools in each section were designed by

[49] TLDHS 2016.
[50] General Directorate of Statistics, Ministry of Planning and Finance, Ministry of Health, Democratic Republic of Timor-Leste. (2018). *Timor-Leste Demographic and Health Survey 2016.*
[51] Ministry of Health, with technical assistance from USAID's Reinforce Project implemented by JSI. (2020). *Adolescent Reproductive Health Education: Facilitation Guide.*
[52] Including: United Nations Education, Scientific and Cultural Organization (UNESCO). (2009). *International Technical Guidance on Sexuality Education*; RDTL. (2007). *Polítika Nasionál Foin-sa'e Timor-Leste nian (Timor-Leste National Adolescent Policy)*; Ministry of Health. (2011). *National Guidelines for the Provision of Youth-Friendly Services*; and the *Healthy Relations: Education for Young People Facilitator Manual.*

and with people ages 19–24 from JDN who had experience in health programs and were sensitized to reproductive health, gender, and nutrition. USAID's Reinforce improved existing MOH materials for presenting health topics.

MOH, USAID's Reinforce, and its partner JDN piloted the materials among 23 adolescents in one of Covalima's high schools, alternating health topics facilitated by MOH and interactive activities facilitated by JDN. The materials were improved and adjusted based on lessons learned during the pilot.

"I would like to suggest that these workshops are implemented in all the schools because school students should know about sexual harassment. We often experience this but we don't know that this is a crime. And, also, I suggest that these workshops should be done in the community because these problems are always happening there, as well as with my family and with my relatives. We can prevent this problem in the community if we can give this information to people with no access to education, including young men who are always sitting in the street with nothing to do."- Female ARH training participant.

Photo Credit: USAID's Reinforce Staff

Following that pilot, USAID's Reinforce pursued the decentralization of the intervention, and through JDN trained three young women and three young men from Covalima to facilitate workshop sessions in partnership with MHS officers. They delivered the workshops in four different high schools for 146 students (80 females and 66 males 14–19 years of age) in the administrative posts of Suai Vila, Zumalai, and Fohorem. Among them, 71 students completed all three workshops in the series; others attended at least one. These workshops were implemented using flexible models of timing and frequency as a way of testing delivery options for the MOH to consider in the future.

The MOH officially approved the Adolescent Reproductive Health Guide in 2020. The MOH has already implemented it in other municipalities and promoted it among other parts of government and development partners.

In addition to benefitting high school students in Covalima and across the country in the future, the ARH Education built the capacity of young adults as facilitators. Their reflections provide insight into how their involvement as facilitators is building their skills, knowledge, and competence as resources for the MOH at national and municipal levels. Further details of the experience of youth facilitators and the implementation are in Annexes 14 and 15.

Strategy 4. Community Engagement to Expand Use of Reproductive Health Services

Box 8. Key Achievements for Approach 4

1. Sixty-seven community leaders from four *sucos* (covering 25 percent of the population) trained in conflict resolution; anger management; prevention of gender-based violence (GBV), domestic violence, drug and alcohol abuse; and MNCH and FP.
2. Community-owned transport schemes established in five *sucos* and used by 54 emergency patients.

USAID's Reinforce involved community leaders in most of its interventions, including those to increase facility readiness and coverage, and mobilize their communities to visit the health facilities or to attend outreach activities. Community leaders are among the most trusted sources of information in the country,[53] and by law "carry health responsibilities, such as promoting the adoption of healthy lifestyles, the sensitization of the community for preventable disease (…) and the mobilization of the community to participate in vaccination campaigns."[54]

With such an important role, USAID's Reinforce provided training to ensure that *suco* councils take an active role in collaborating with health facilities in their *suco* or *aldeia*, and include health as a priority in their annual plans.

Community Training

USAID's Reinforce selected the *sucos* of Fatuleto, Maudemo, Debos, and Holpilat (covering 25 percent of the municipality's population; see map on page 23) and provided a one-week training. 67 of their community leaders (40 men and 27 women, including *suco* and *aldeia* chiefs, male and female delegates, women representatives, and male and female youth representatives) attended, gaining skills to positively influence their community's health-related practices. The training focused on MNCH, FP, and given the prevalence in Timor-Leste and strong link to reproductive health, GBV and domestic violence.

USAID's Reinforce contracted local NGO *Ba Futuru* to facilitate the first component of the training focusing on GBV and domestic violence. Specific topics included conflict resolution, anger management,

[53] United Nations Integrated Mission in Timor-Leste (UNMIT). 2011. *Timor-Leste Communication and Media Survey.*
[54] Suco Law No. 9/2016.

and the prevention of GBV, domestic violence, and drugs and alcohol abuse. In each *suco*, knowledge increased significantly from pre- to post-test, reaching almost the maximum in all *suco*.

Box 9. The Only Female *Suco* Chief from Covalima Trained by USAID's Reinforce

Maria de Fatima is the only female *suco* chief in Covalima Municipality. She leads in Maudemo, Tilomar administrative post. Along with other members of the *suco* council, she attended the training on conflict resolution, GBV and domestic violence prevention, and health promotion. In the post-training assessment, Maria Fatima explained that, as a community leader she needs to talk about domestic violence and explain that it is a crime. She said it is also important to start informing people when they are young by going to schools and providing age-specific information. Maria Fatima reported having shared this type of information before, and said she will continue to ensure that the community understands the seriousness of domestic violence.

Maria de Fatima (right) says "One of my roles as a *suco* chief is to remind the community to visit the health facility for preventive and curative services."

Photo Credit: USAID's Reinforce Staff

The second component of the training focused on health and was delivered by USAID's Reinforce and the MHS. The objectives were that by the end the training community leaders have necessary knowledge about MNCH and FP and share it with the community.[55] The training included theory and practice of health promotion and community leaders' role in it.

[55] USAID's Reinforce Project implemented by JSI. (2019). *Facilitation Guide: Strengthening the Role of Community Leaders in Health Programs.*

Three months after the training, *Ba Futuru* and USAID's Reinforce conducted post-training assessments to measure participants' training topics KAP.[56] See Annex 16 for the full report.

Introduction of Innovative Health Transport Options

As described in previous sections of this report, USAID's Reinforce provided TA to the MOH to reduce the burden of the first delay ('making the decision to seek care') through the production of BPCR materials and interventions, and the third delay ('receiving adequate care') through training and improvement of facilities readiness. However, when community members decide to seek care, they often face obstacles in reaching it due to a lack of emergency transportation. In Covalima, only 2 percent of households own a car or truck, there is no reliable public transport, and ambulances are often being repaired or in poor condition. To reduce the burden of the second delay ('reaching adequate health care'), the project encouraged selected *sucos* to set up community-owned transports to bring patients to health facilities when an ambulance is unavailable.

USAID's Reinforce developed two guides to assist health facility staff conduct advocacy and planning meetings with community leaders and transport owners on the need to arrange community transport for pregnant and postpartum women. The intervention was named 'TraKom' for *Transporte Komunitáriu* (community transport).[57,58] TraKom was initiated in five *sucos*; to date, Beco and Lepo have used TraKom for 54 patients, mainly pregnant women.

The role of community leaders in the dissemination of TraKom information was crucial, as 50 users mentioned having heard about TraKom from their *suco* chief. Truck owners were particularly helpful, as 37 of the patients requiring TraKom used a truck. Seventeen used a motorbike, a good alternative for lesser emergencies when a truck is unavailable.

Following enthusiasm from the MOH to expand TraKom to more *sucos* and municipalities, USAID's Reinforce proposed the recommendations found in the full report on TraKom implementation (Annex 17).

CROSS-CUTTING ISSUES

A few cross-cutting themes and issues are worth summarizing in this section, given their importance across the four strategies described above. They include: 1) using data for decision-making; 2) capacity-building for sustainability; 3) integrating FP and MNCH; 4) focusing on young adults and adolescents; 5) addressing inequities and gender bias; 6) responding to the COVID-19 pandemic; and 7) coordinating and collaborating with partners.

[56] USAID's Reinforce Project implemented by JSI. (2020). *Community Leaders Training.*
[57] Ministry of Health of Timor-Leste, with support from USAID's Reinforce Basic Health Services Project (2018). *Advocacy Guide for Community Transport Promoting Access to Health for Pregnant Women, Newborn Babies and Children.*
[58] Ministry of Health of Timor-Leste, with support from USAID's Reinforce (2018). *Implementation Guide for Community Transport Promoting Access to Health for Pregnant Women, Newborn Babies and Children.*

Using Data for Decision-Making

As first presented in Figure 1, using data for decision-making was the fourth element of USAID's Reinforce approach to showcase a 'Model Municipality' in Covalima. Across the report, the project promoted the use of evidence-based data to conduct planning and support decisions at all levels of the health system (national, municipal, health facility), at community level, and among project staff. Table 9 provides a non-exhaustive list of activities promoting data for decisions and the tools they used.

Table 9. Use of Data for Decision-Making across all Activities

Activity	Short description and tool(s) used
Provide organizational development assistance to the INS	Using INS and partners reports, assessed the implementation status of the INS Five Years Strategic Plan, and used results to develop annual plans
Establish INS as a competency-based clinical training center	Using CPS assessment data, planned improvements and monitored their implementation on quarterly basis
Deliver training and FUAT	Using TNA and supportive supervision data, planned training of health workers according to their work place; using training data, identified providers requiring FUAT for acquisition of maintenance of competencies
Showcase a model of quality integrated health services	Using baseline (SARA) and supportive supervision data, planned health facility improvements (including procurement of equipment) and monitored their implementation on a quarterly basis
Strengthen planning processes	Using service data from the HMIS, planned outreach activities to expand coverage and monitored increase on a quarterly basis through the microplanning
Develop SBC messages and interventions	Using baseline (KAP) and other survey data, identified key behaviors requiring improvement and planned interventions to overcome barriers toward adoption of these behaviors
Provide health education to communities	Using the project's health promotion database, ensured all sucos are covered with regular group discussions and film events
Advocate community engagement around critical health issues	Using coverage, survey and facility readiness data, developed advocacy materials to obtain community leaders' support for health program (TraKom, mobilizing communities, seeking funding for renovations of health facilities)
Hold monthly staff meetings	Using all project data, monitored project's indicators and planned improvement actions to remain on track

Capacity Building for Sustainability

Capacity building formed the core of every project activity, assisting MOH staff where they work and meeting their assessed needs. USAID's Reinforce approach to capacity building targeted multiple levels, including individual (beneficiaries), health providers, health managers, and the health system, so that by the end of the five years, activities would be sustained in Covalima Municipality and replicable in other municipalities.

Beneficiaries received continuous attention through community meetings and discussions. Women of reproductive age, their husbands, parents, and parents-in-law acquired knowledge on behaviors to adopt to remain healthy and care for their children. To ensure the next cohort of parents sustain these knowledge and practices, the project held RH health workshops with adolescents and ensured that PHC workers gradually took over the conduct of health promotion interventions.

During the five years of implementation, USAID's Reinforce built the capacity of health care providers in proven methods to improve clinical care quality, instituted systematic competency-based training and FUAT, and equipped health workers to deliver high-quality MNCH and FP services. Health managers

received management training and along with health providers, routine TA for the daily running of health services at PHC level.

Using Covalima as a model, the project worked closely with national officers and managers (at MOH and INS) to set up systems for institutional management, policy implementation, supportive supervision, and use of data for decision-making, so that these personnel would have the tools and capacity to replicate Covalima interventions in other municipalities.

Sustainability

There is significant evidence that many of the practices, standards, and innovations used during USAID's Reinforce project were embraced and, in some cases, taken further to scale by the MOH, INS, and the municipality of Covalima health services.

The MOH officially approved the ARH materials—the first of their kind—and refers other development partners to obtain orientation from USAID's Reinforce staff and health workers. World Vision has already received an orientation and the package of materials. USAID's Reinforce has handed off all electronic copies of the materials to HAI with an agreement that it will now serve as a resource to other development partners and the MOH. Recently, the MOH referred the NGO Childfund to USAID's Reinforce for support, and staff referred it to HAI for access to orientation and materials. The MOH had already led a preliminary scale-up of these materials and the activities to four additional municipalities, and the MOH consistently refers partners and municipal staff to this program.

The MOH decision to scale the concept of skills labs in Oecusse and continue planning for others is another indication of local ownership and efforts to sustain this important resource at INS.

Following the successful small project to introduce community transport solutions for health emergencies, the MOH and MHS attended a handover ceremony with community leaders and went on to advocate within the MOH system for this model to be introduced in other communities.

The Director General Service Delivery Dr. Odete Da Silva Viegas attended the project close-out meeting in Covalima and expressed commitment at the national level to support Covalima in sustaining many of the achievements and practices developed or strengthened with support from USAID's Reinforce. Dr. Da Silva Viegas shared plans for MOH to conduct monitoring and supportive supervisions in January 2021, specifically to continue this work. She then invited USAID's Reinforce to present the strategies and results of the project at the MOH National Strategic Plan Review Meeting 2011–2030 the following week to further advocate for replication of the project's work.[59] USAID's Reinforce

[59] MOH attendees included Vice Minister Bonifacio Maucoli Dos Reis; Director General Service Delivery Dr. Odete Da Silva Viegas; Director General Corporative Victor Soares Martins; Director of Cabinet Policy, Planning and Cooperation Narciso Fernandes; Former Vice Minister IV Constitutional Government Luis Lobato; Former Vice Minister VII Constitutional Government Ana Isabel F.S.S (attended project launch), National Director of Public Health Isabel Maria Gomes; INS Executive Director Domingas Pereira; National Ambulance Director Dr. Nilton Da Silva; Finance Director Marcelo Amaral; HMIS Department Head Ivo Cornelio Guteres; M&E Department Head Carlito Freitas; HP Department Head Misliza Vital; Director of Quality Control Cabinet Feliciano Pinto; National Laboratory Director Dr. Endang Da Silva; SAMES Executive Director Santana Martins;

presentation was well received by senior MOH leaders, including 13 MHS directors from all municipalities. Several commented on the importance of these results and the potential to replicate the project in other municipalities. A full report on this meeting can be found in Annex 22.

In Covalima, many of the management, implementation, and supervision roles have long been held and sustained by the MHS, the referral hospital, and the municipal administration. Community leaders have continued to build on their knowledge and skills following the training interventions, and respondents to the KAP indicate significant retention of health information and understanding of the importance of particular behaviors for ensuring healthy outcomes. INS trainers based in Covalima work independently to provide training in several areas and conduct FUAT and coaching with confidence and a strong understanding of the competency-based training system and knowledge and skills they are imparting.

Integrating FP and MNCH

Through new in-service training courses, ENBC and PPFP were integrated into the SCD. Concretely at service delivery point, pregnant women received counseling for FP during their ANC consultations, midwives provided counseling on PPFP in the maternity ward, and mothers bringing their children for immunization received FP counseling. These groups of beneficiaries—pregnant and postpartum women and mothers of young children—continued receiving such messages through community group discussions. This integration of services to reduce missed opportunities were reinforced by MOH and MHS officers during supportive supervision visits.

Focusing on Young Adults and Adolescents

Over the last two years of the project, training adolescents on reproductive health took a predominant place. As described above, USAID's Reinforce prompted a collaboration between youth organization JDN and the MOH to develop a modular package of interactive activities for high school students to learn about healthy relationships, concepts of gender and sex, the human body and developments during puberty, life skills, reproductive health, and other aspects for staying healthy. The innovative switching between games and activities led by youth facilitators and presentations on health and medical topics by MOH, all outlined in the Adolescent Reproductive Health Education Guide, was very effective, approved by high-level MOH decision-makers, and replicated in other municipalities.

Traditionally, MOH promoted FP services to mothers who already had three or four children. USAID's Reinforce managed to shift that practice and begin to focus as well on young couples, by promoting the benefits of child spacing to young adults to give them a chance to build a foundation for a healthy family.

Addressing Inequities and Gender Bias

USAID's Reinforce prioritized high-impact interventions for remote populations with less access to any or high-quality care, as identified during microplanning and meetings with community leaders. Many actions focused on raising facility readiness in remote health posts and maintaining it elsewhere.

Director of Pharmacy and Medications of MOH Dr. Alipio Gusmao. Other national directors, hospital directors, 13 MHS directors, CHC managers, and department heads attended.

The project also sensitized health providers and community leaders on GBV and domestic violence through training by collaborating with local NGOs PRADET and *Ba Futuru*. Finally, the Adolescent Reproductive Health Education Guide mentioned above included substantial time teaching adolescents about respectful relationships, speaking up about sexual harassment, and preventing violence.

Responding to the COVID-19 Pandemic

The emergence of the COVID-19 pandemic during the last year of the project created some challenges. However, because of its focus on health system strengthening, USAID's Reinforce was well-positioned to quickly provide critical support to the MOH. By partnering with government and local NGOs, USAID's Reinforce completed workplan implementation and responded to the emergency facing the government and the MOH. USAID's Reinforce contributed to COVID-19 orientation and training for health workers; overall coordination; community education; and community prevention including a focus on youth leadership as part of an effective communication strategy. A full report on these activities is found in Annex 18. USAID's Reinforce reached its targets while providing uninterrupted technical support to the MOH, INS, and Covalima MHS, thus ensuring continuation of critical MNCH/FP services.

Coordination and Collaboration with Partners

JSI is highly committed to avoiding duplication of effort by USAID's Reinforce and other partners, and through the MOH, JSI regularly assisted other projects in implementing interventions related to Covalima or USAID's Reinforce scope of work. For example, the project collaborated with the organizations below:

- UNICEF, to implement its package of MNCH SBC materials in Covalima; finalize the ENBC training package; revise the facility readiness supportive supervision format; implement CQI processes; and implement the first Routine Data Quality Audit conducted in the country.
- WHO, to adapt the SARA to Timor-Leste context; implement international guidelines on a variety of topics; and implement the Measles Rubella/Polio Immunization Campaign in Covalima.
- HAI, to implement the Liga Inan project (funded by Australia's Department of Foreign Affairs and Trade) and to complete key clinical COVID-19 activities (funded by USAID's Reinforce).
- UNFPA, for the BEmOC training, health facility audits, FP training, and ARH.
- St. John of God, for the health manager training program.
- CITL, for sharing focus administrative posts in Covalima and avoiding duplication of actions.
- Maluk Timor, for increasing trained human resources at Vera Cruz CPS.
- Partnered with local organizations PRADET, JDN, and *Jurídico Social Consultoria*, to deliver 4R training to Covalima municipality health workers in the 4Rs (how to recognize, respect, respond to, and refer victims of domestic violence to appropriate psycho-social, medical, and legal services; please see Annexes 8 and 9 for more information), train young people to become peer educators for both adolescent reproductive health and COVID-19 prevention (Annexes 14, 15, and 18), and to develop materials for health facility staff to conduct advocacy and planning in order to develop community transport (see Annex 17).

In response to the COVID-19 pandemic, USAID's Reinforce coordinated with many of the above partners and worked closely with several more. In addition, the project played a central role in bringing development partners together at the INS through the joint annual planning (described in Strategy 1)

and the trainer discussion forum group meetings, which allowed the INS to better coordinate partners and ensure their activities and commitments were met. Partners were then able to adjust their support according to the environment and available resources.

The project also participated in the quarterly health development partners meetings, chaired by WHO and the European Union, as well as in the bi-monthly international health NGOs meetings.

LEARNING AND DISSEMINATION OF RESULTS

Key Lessons Learned

(1) There is high demand among community leaders for more training on health messages and basic information about safe delivery, family planning, immunization, and the use of data for planning, among other topics.
(2) Health workers demonstrated a high level of retention of key information on recognizing and responding GBV when interviewed years after the initial training.
(3) Health systems strengthening approaches prepared the municipality to respond to the COVID-19 emergency. Responses included:
   - A regular pattern of municipal meetings among facility managers, MOH directors, and local partners was quickly adapted to include COVID-19 coordination meetings and action planning.
   - The regular meetings already ensured up-to-date knowledge of where trained staff, critical equipment, and transport options were available so was adapted to COVID-19.
   - The routine community engagement sessions during the project enabled new messages to be quickly added and encouraged the integration of these messages into familiar health discussions on topics such as hand washing and sanitation.
   - Regular supportive supervision by MOH meant that tracking and mitigating disruptions in ongoing provision of essential services during COVID-19 was quick and efficient, with all facilities continuing to provide these services successfully.
(4) There is a high level of interest in and respect for good-quality data among facility managers, health workers, and MOH directors. However, there is insufficient staffing and a lack of systems in place to meet this interest and need for credible data. USAID's Reinforce learned that the efforts at the municipal level will only succeed if the MOH human resource strategy includes dedicated positions for data management and consistent tools and practices at the facility level where the data are initially recorded.
(5) Planning and implementation of all health in-service training was immediately more efficient and better organized with the introduction of the annual planning and coordination meetings and the operationalizing of the five year strategic plan as part of USAID's Reinforce technical assistance to INS management.
(6) The National MOH department perceives development partners as potential budget support for municipalities and rationalizes not funding them with the explanation that "Partner X will pay for that." Municipalities understand their responsibility to take over all project activities; however, we observed that each year their budgets were not funded with this same explanation provided. Donors need to address this practice in high-level, bilateral, or other agreements. It is a long-standing practice that cannot be changed at the project and partnership level, at which government and partner staff have little leverage with national ministries.
(7) Adolescents and youth continue to be uninformed about their reproductive and other health needs. The continuing refusal of the health system to offer RH/FP services to young people increases health and well-being risks for all youth.

(8) It is possible to obtain government approval of sensitive material, such as the ARH materials developed with support from USAID's Reinforce. It is necessary to build strong relationships and establish trust while working with champions who can advocate within the government system. USAID's Reinforce learned that accepting compromise and focusing on opening the door to future achievements is an important first step. An activist position—or insistence that all elements of sexual health be incorporated, for example—may create too much risk for government partners, so a step-by-step process is more likely to succeed.

Challenges

Political Impasse

From mid-2017 throughout 2018, the government of Timor-Leste went through a political and institutional crisis. As a result, two subsequent constitutional governments were run with reduced budgets, not allowing funds for program implementation. This situation happened at a time when the project had already conducted advocacy to government to include interventions and funds for the gaps identified in the baseline study, but with these funding restrictions, this could not be completed. As a partial response to this situation, the project funded some of the interventions originally identified as the government's responsibility.

Initial Low-Level of Readiness in Covalima Health Facilities

USAID's Reinforce was designed to be implemented in one of the Health Improvement Project focus municipalities, where USAID investments had produced outcomes, especially in the readiness of health facilities. Covalima had received very little donor support before 2016, and the SARA results highlighted very low levels of readiness for high-quality service delivery across all visited facilities. Despite continued TA for improving facility readiness, further major investments from the government (or other sources) were needed to bring health facilities up to standards. Areas of particular need that could not be supported by the project included emergency transport and maintenance and repair of infrastructure. During PY3, as a response to this, JSI signed the Modification of Assistance No. 6, allowing the project to procure some basic medical equipment, which contributed greatly to improvements in facility standards.

Challenges at INS to Fulfill its Mandate

Despite the improvements in Covalima due to project efforts, there were still a number of challenges at INS to fulfill its mandate. While in-service management and clinical training needs across the country are huge, in 2019, only about 1.5 percent of the MOH's budget was allocated to INS. The same amount was allocated in 2020. There is also an insufficient number of trainers at INS to serve municipalities other than Covalima, creating significant bottlenecks in ensuring training and FUAT occur as needed. The project responded to this by prioritizing the training of more trainers in Covalima, supporting direct coaching and follow-up by Covalima trainers, and facilitating relationships between INS trainers and those at the new skills lab in Oecusse to strengthen this decentralization.

FP and ARH in Timor-Leste Context

Young people in Timor-Leste desperately need information about and access to RH services. In Covalima, more than nine percent of 15–19 year olds started childbearing (TLDHS 2016). In 2017, the MOH disseminated a revised draft National FP Policy, which included limiting access to FP to adults and married couples only, and promoting only the Standard Days Method. While the policy was not

approved, withholding adolescent access to sexual and RH information and services remained the norm for several years. In response, USAID's Reinforce worked closely with the MOH on an ARH education guide that was approved once agreement was reached on content and delivery.

Dissemination of Results

USAID's Reinforce has consistently disseminated learning and results throughout the project using a range of modalities. Its Reinforce Project Timor-Leste Facebook postings reached many people. Success stories and technical briefs along with photo essays and presentations were shared through formal gatherings and informal networks, including the regular meetings of international NGOs working in the health sector. Regular progress updates were held with MOH partners, and USAID's Reinforce approaches and results were amplified throughout the years internationally as well as in the U.S. using JSI's website, technical e-newsletters, and social media platforms.

USAID's Reinforce and the MOH participated in global conferences and presented on methods, approaches, and results. The MCH Health Promotion Department presented at the 2018 Social and Behavior Change Summit in Indonesia; USAID's Reinforce staff and MOH staff presented together at the International Conference on Family Planning in 2018; and USAID's Reinforce and partner JDN presented a poster session remotely at the 2020 APHA conference. Abstracts were accepted for presentation at two additional international conferences that have been postponed into 2021, beyond the life of the project.

As part of the closeout of USAID's Reinforce project, an end-of-project conference was held to present the highlights from the SARA, KAP, and project data. Short video interviews allowed the voices of a community leader, a trainer, and a youth leader to share experiences and learning.[60] Many participants attended via video conference and others attended in-person in Dili, including government partners. Speakers included U.S. Ambassador Kathleen Fitzpatrick; USAID Mission Director James Wright; Vice-Minister Mr. Bonifacio Maucoli Dos Reis; and Municipality Administrator Mr. Afonso Nogueira Nahak who attended in-person in a Dili conference room. Handouts of key documents were given directly to these participants and sent to all Zoom invitees by email.

Another closeout meeting was held in Covalima to share project results and the SARA and KAP survey results with the MHS, facility managers, and health workers, as well as several local development partners. The final presentation of results was shared at the national strategic plan 2011–2030 review meeting of all municipalities in Manufahi, under the direction of the DG of Health Services Delivery Dr. Odete da Silva Viegas.

[60] Videos accessible here: https://www.jsi.com/stories-from-the-reinforce-basic-health-services-project-in-timor-leste/

ANNEX 1:

Technical Brief: Covalima, Becoming a Model Municipality

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HUSI POVU AMERIKANU

JSI

USAID'S REINFORCE BASIC HEALTH SERVICES PROJECT

Covalima | Becoming a Model Municipality

Project Background

USAID's Reinforce Basic Health Services Project (USAID's Reinforce) was launched in June 2016 to support the Timorese government to improve the quality, availability, and use of maternal, neonatal and child health (MNCH) and family planning (FP) services. The Project focuses on institutional development and technical assistance to the Ministry of Health (MOH) and its National Institute of Health (INS), building their capacity to deliver stronger health services nationally and in one municipality, Covalima.

Covalima is situated in the remote southwest of Timor-Leste, and in some parts of the municipality, the mountainous terrain limits access to services, including health and education. The table below shows key data from Covalima compared with national data.

What Is a Model Municipality?

In a model municipality, well-trained and competent health providers deliver quality FP and MNCH services in fully-equipped and people-friendly health facilities where providers receive consistent, high-quality supervision from MOH and INS experts. Health facilities are easily accessed by community members, who have the knowledge and skills to demand quality, client-centered services. Health providers and the facilities in which they work are supported by a municipal health system that uses data to make informed financial and programmatic decisions. In a model municipality, communities are empowered to work with government and civil society structures to generate innovative solutions to their health challenges. This brief will describe USAID's Reinforce's approach to fostering a model municipality in Covalima.

Key MNCH and FP Indicators Compared between Two Timor-Leste Demographic and Health Surveys (TL-DHS)[1]

INDICATOR	National (TL-DHS)		Covalima (TL-DHS)	
	2009-10	2016	2009-10	2016
Pregnant women seeking at least four ANC	55%	77%	-	78%
Pregnant women delivering at a health facility	22%	49%	28%	47%
Women seeking postnatal care (delivery to 2 days)	25%	35%	36%	35%
Children receiving 3 doses of DPT-HepB-Hib vaccine	66%	62%	81%	48%
Total fertility rate	5.7	4.2	4.4	-
Contraception prevalence rate	22%	26%	44%	33%
Long acting reversible contraception methods use	2%	8.2%	2%	5.5%
Unmet needs for FP	31%	25%	17%	20%

- Covalima maternal health data are consistent with the national average, highlighting the need to increase institutional deliveries.
- Immunization coverage dropped significantly among children 12-23 months of age.
- Although higher than the national average, FP outcomes were better seven years ago.

Approach

To improve health outcomes, community members must demand high-quality services and health providers must have the knowledge, skills, and infrastructure to provide those high-quality services. In Covalima, USAID's Reinforce is building a bridge between health services and people by implementing a four-pronged approach (see figure below): 1) generating baseline evidence; 2) improving health service delivery; 3) improving communities' use of health services; and 4) using health data for decision-making.

USAID's Reinforce Approach

1. Generating Baseline Evidence

USAID's Reinforce conducted a baseline assessment in Covalima, which allowed the Project to design interventions specific to Covalima's health sector challenges. The first component of the assessment, a community knowledge, attitudes, and practices (KAP) survey,[2] provided insight into MNCH and FP interventions and messages that will resonate with the community in Covalima. The second component, a service availability and readiness assessment (SARA),[3] provided a snapshot of the status of health services in Covalima's health facilities. The SARA results highlighted gaps in service delivery – including infrastructure, human resources, equipment and supplies, and commodities – and indicated how health facilities should be prioritized for receiving technical assistance from the Project.

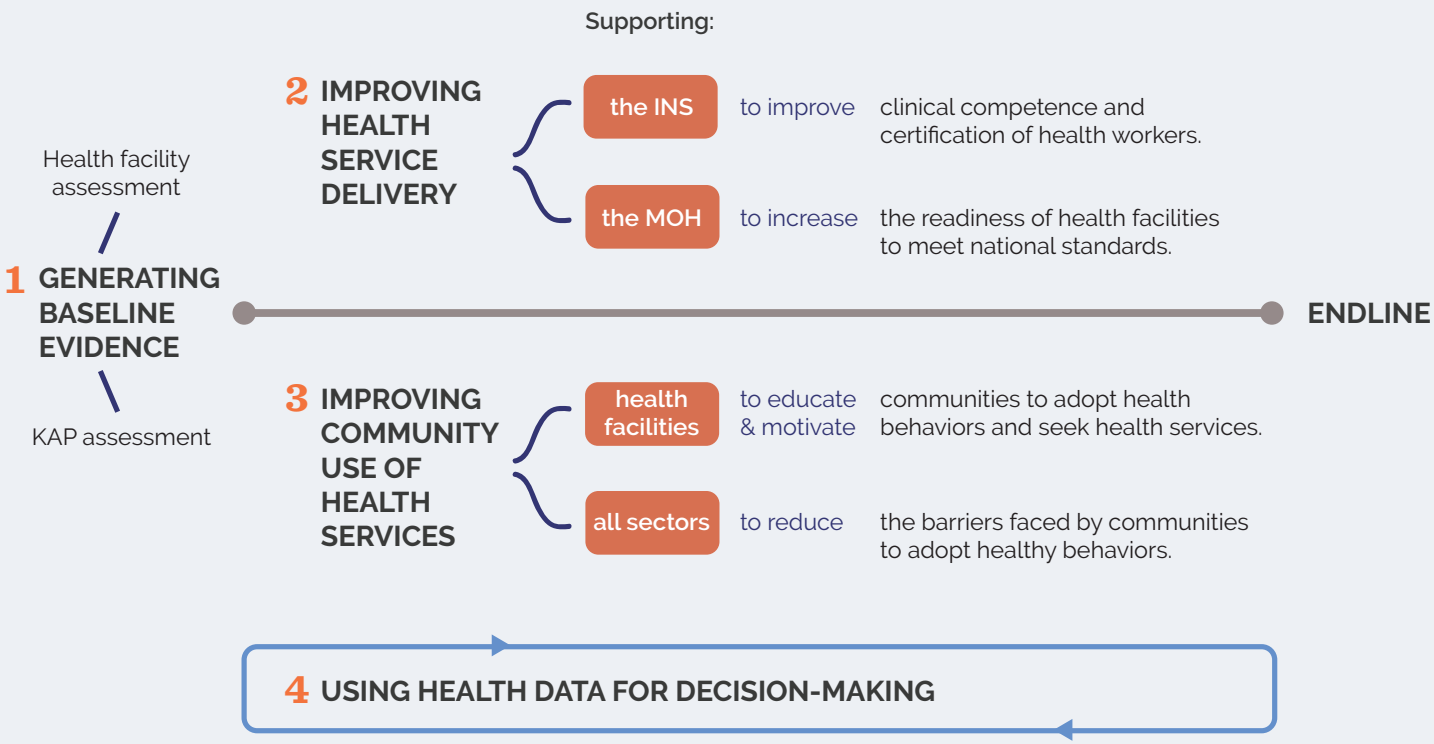
2. Improving Health Service Delivery

Clinical competency and readiness of health facilities are two essential components of a model municipality able to deliver high-quality health services. USAID's Reinforce focuses on improving health provider skills, strengthening supportive supervision for health providers, and equipping health facilities to provide high-quality services. To improve clinical competency, USAID's Reinforce is supporting the INS to become a competency-based training center through updating training materials, training master trainers, and setting up practicum sessions at the INS skills laboratory and clinical practice sites. The Project supports the INS in rolling out competency-based trainings and providing consistent follow-up for health providers working in Covalima.

The Project also works with the MOH and Covalima Municipality Health Services to help Covalima health facilities meet national standards. Supportive supervision is an excellent opportunity to promote quality services and provide on-the-job training and skills-building for health personnel. Supervision also helps to ensure availability of needed medicines and equipment, and enables joint problem-solving.

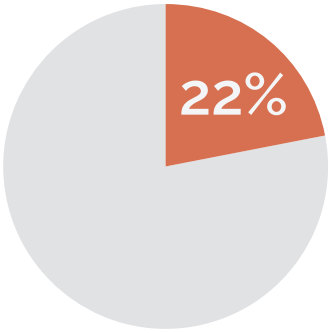
USAID's Reinforce encourages collaboration with partners and other sectors that can contribute to health facility improvements, in particular for infrastructure, water and electricity, emergency transport, equipment procurement, and other key MOH programs not directly supported by the Project.

Four Elements of the Approach



3. Improving Community Use of Health Services

Motivating communities to adopt healthy practices and increasing their use of MNCH and FP services, as well as working on reducing the barriers faced by these communities to access services are essential elements of building a model municipality. To improve the community's use of health services, USAID's Reinforce developed a behavior change communication (BCC) plan based on the KAP findings for each Project indicator,[4] and discussions with the MOH and national- and municipality-level partners. USAID's Reinforce is helping the MOH develop BCC materials, support health providers to counsel women of reproductive age and their husbands during consultations and during home visits, support health providers to hold group discussions in facilities and during outreach activities, and advocate with community leaders – all with the same message of promoting healthy practices and overcoming any obstacle preventing families to adopt these.



Nearly a quarter of the population is between the age of 15 to 24 years.

USAID's Reinforce reaches out to this population, setting the stage for a lifetime of positive health behaviors.

4. Using Health Data for Decision-making

Model municipalities use data to monitor results and plan improvements. The Project provides technical assistance to the Municipality Health Services to conduct its quarterly review meetings, where coverage rates for all programs and health facility readiness data are presented and discussed with health providers and managers, municipality and administrative post authorities, and partners. At the administrative post level, USAID's Reinforce encourages the use of suco coverage data during micro-planning to plan outreach to areas with low access. In its next phase, USAID's Reinforce will introduce a data infographic to inform health facility staff about achievements and assist health facility managers to interpret the data they collect and track progress.

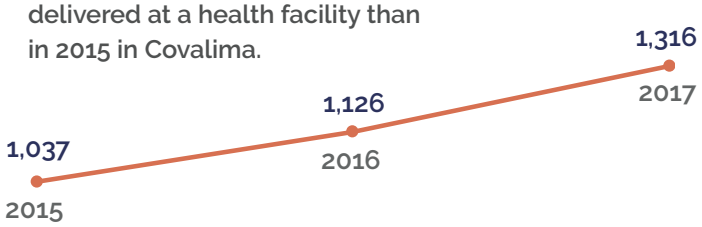
USAID's Reinforce also models data use for decision-making at the Project level. Using the baseline assessment and health management information system (HMIS) data as the basis of Project decisions, the Project team holds monthly meetings where data is discussed and used to develop work plans. The team also conducts "deep dives" into the data to better inform decision making around key issues, such as the correlation between FP results and commodity stock levels, and discrepancies between skilled birth attendance and postnatal checks for mothers and newborns.

Showcasing a model municipality is ambitious and must be done in concert with government and non-government partners. To improve the readiness of health facilities and increase their utilization, **USAID's Reinforce** uses data to work with the MOH and the Municipality Health Services to build partnerships with other sectors – such as State Administration for the renovation of health facilities and community mobilization – and other development partners including UN agencies, donors, and non-governmental organizations.

2017 Results

In less than two years of implementation, USAID's Reinforce has assisted the Covalima Municipality Health Services to move closer to being a model municipality. Since the beginning of the Project, key MNCH and FP indicators have improved in Covalima, including in antenatal care, skilled birth attendance, postnatal care, immunization, and contraceptive use.

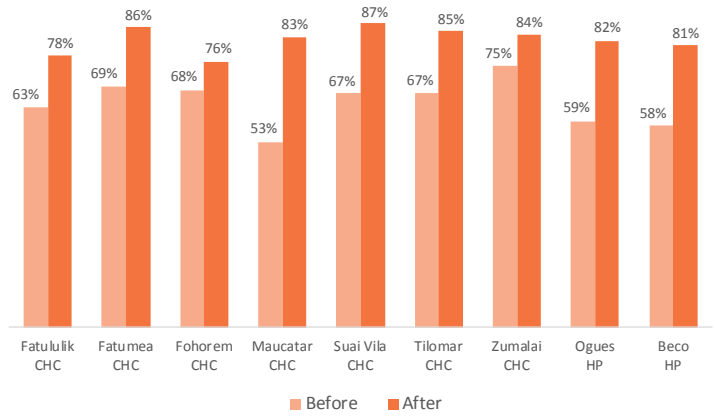
In 2017, almost 280 more women delivered at a health facility than in 2015 in Covalima.



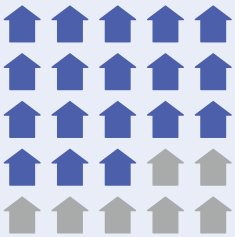
USAID's Reinforce has ensured that, out of the 25 public health facilities in Covalima, 18 are staffed with at least one health provider certified to provide safe and clean delivery, 24 are staffed with at least one health provider certified to provide FP counseling, six are staffed with at least one health provider certified to provide the full range of contraceptive methods, 17 are staffed with at least one FP provider certified to insert contraceptive implants, and 13 are staffed with at least one health provider certified in integrated management of neonatal and childhood illnesses (IMNCI).[5]

Following a year of regular supportive supervision from MOH and subsequent technical assistance, on-the-job training, and orientations to improve readiness and availability of services, all seven community health centers (CHCs) and one health post (HP) in Covalima meet national standards. Only one CHC met national standards at the beginning of the Project.

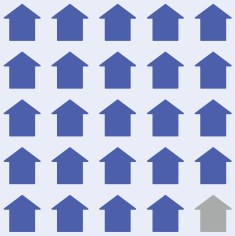
Following intensive technical assistance, 9 health facilities in Covalima reached the MOH readiness standards.



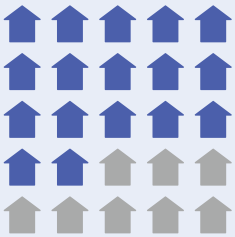
Out of the 25 facilities in Covalima, the number of facilities now staffed with at least one health provider certified to provide specific services:



18 provide safe and clean delivery



24 provide short-acting FP methods and fertility awareness based methods



17 provide long-acting FP methods

Expected Results

As a model municipality, 100 percent of Covalima's health facilities will have the facilities, equipment and certified staff they need to provide the basic package of health services and Covalima's community members will have the skills and knowledge to access those services appropriately. The Municipality Health Services leadership will have the skills to plan for and supervise all facilities, reacting to changing conditions and improving health.

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[2] Democratic Republic of Timor-Leste – Ministry of Health and National Institute of Health and JSI Research & Training Institute. 2017. Knowledge, Attitudes and Practices in Covalima Municipality: Baseline Assessment.

[3] Democratic Republic of Timor-Leste – Ministry of Health and JSI Research & Training Institute. 2017. Services Availability and Readiness Assessment (SARA) Report.

[4] USAID's indicators are selected indicators from the MOH M&E guidelines.

[5] USAID's Reinforce will be supporting additional training in Covalima in the coming months, including newborn care, child care, and emergency obstetric care (EmOC).

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ANNEX 2:

Strengthening the Timor-Leste National Institute of Health: A Partnership in Institutional Development

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USAID'S
REINFORCE BASIC HEALTH SERVICES
PROJECT

Strengthening the Timor-Leste National Institute of Health: A PARTNERSHIP IN INSTITUTIONAL DEVELOPMENT

OCTOBER 2020

What changed at the *Instituto Nacional de Saúde* (National Institute of Health, INS) in Timor-Leste after four years of institutional development support?

As a capacity-building institution, the INS plays a key role in improving the quality of health services. With a timeframe of less than five years, USAID's Reinforce Basic Health Services Project (USAID's Reinforce) worked closely with the INS to increase the quality of care delivered by the health workforce through strategic and sustainable changes at the INS. The ultimate goal of the project's work with the INS was to reduce mortality and morbidity by improving the quality of care provided in the public health system.

PHOTO ABOVE: *Before working with actual patients, an INS trainee practices her family planning counseling skills with her trainer.*

Capacity development requires attention to institutional culture and history. This is especially important for a young organization like the INS, which was created in 2011. To support sustainable change, USAID's Reinforce and the INS needed to agree on the starting context and challenges.

Leading with Analysis and Respect for Institutional Culture

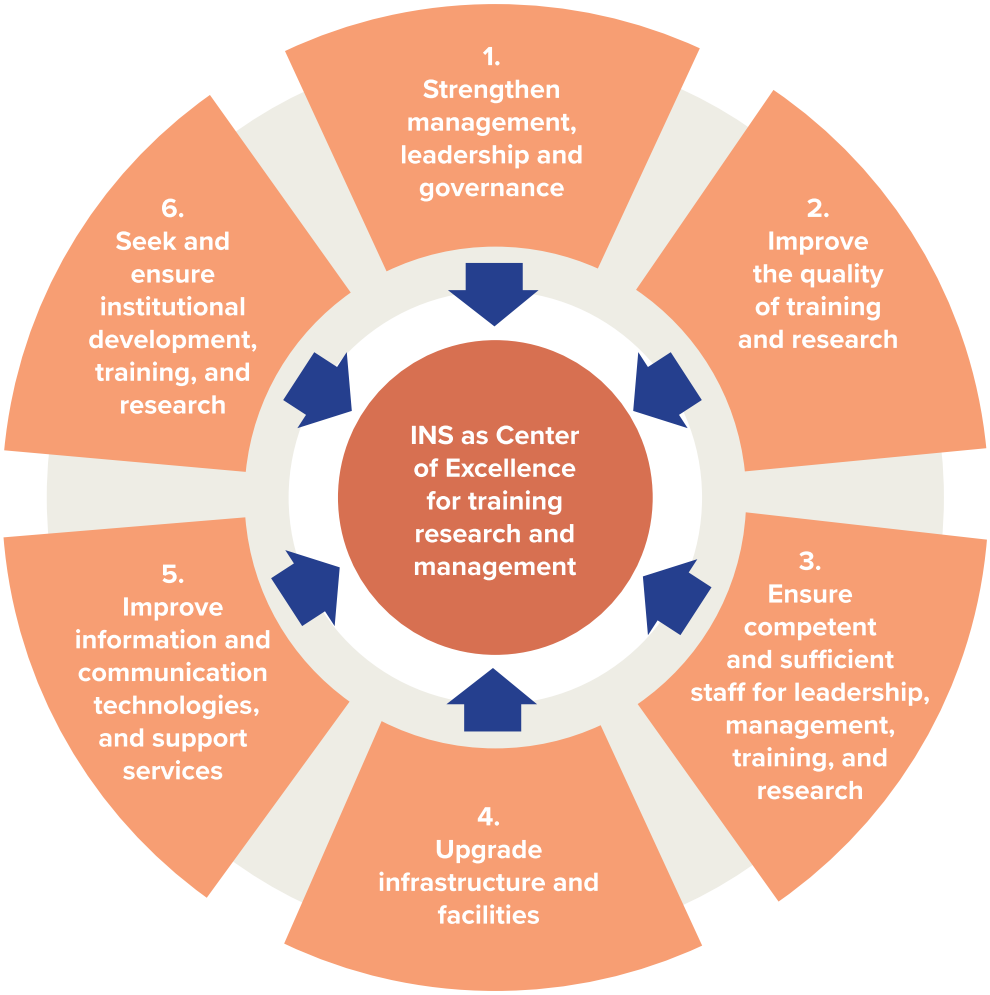
Fortunately, INS capacity was assessed in a 2014[1] situation analysis that found it lacked elements necessary to fulfil its role as a competency-based training institution. These included a lack of curricula and training modules in various clinical areas, unstandardized training rooms, and the absence of practicum sessions in skills laboratories and clinical settings. The situation analysis report included recommendations, summarized in Figure 1.

Defining the Core Opportunities

USAID's Reinforce inherited a strong working relationship with the INS from the prior USAID-funded project,[2] and used the 2014 situation analysis results to update the project work plan to focus on building capacity to develop and implement strategic plans, and institutionalizing competency-based training.

The INS director and core senior staff agreed on these priorities. Its collaborative institutional culture facilitated plans to build upon prior and current work and included a variety of partner inputs.

FIGURE 1. COMPONENTS TO BE STRENGTHENED AT THE INS



[1] Martins, N. (2014). Situation *Analysis Study: The National Health Institute*. Dili: Timor-Leste Ministry of Health.

[2] The Health Improvement Project, also implemented by JSI.

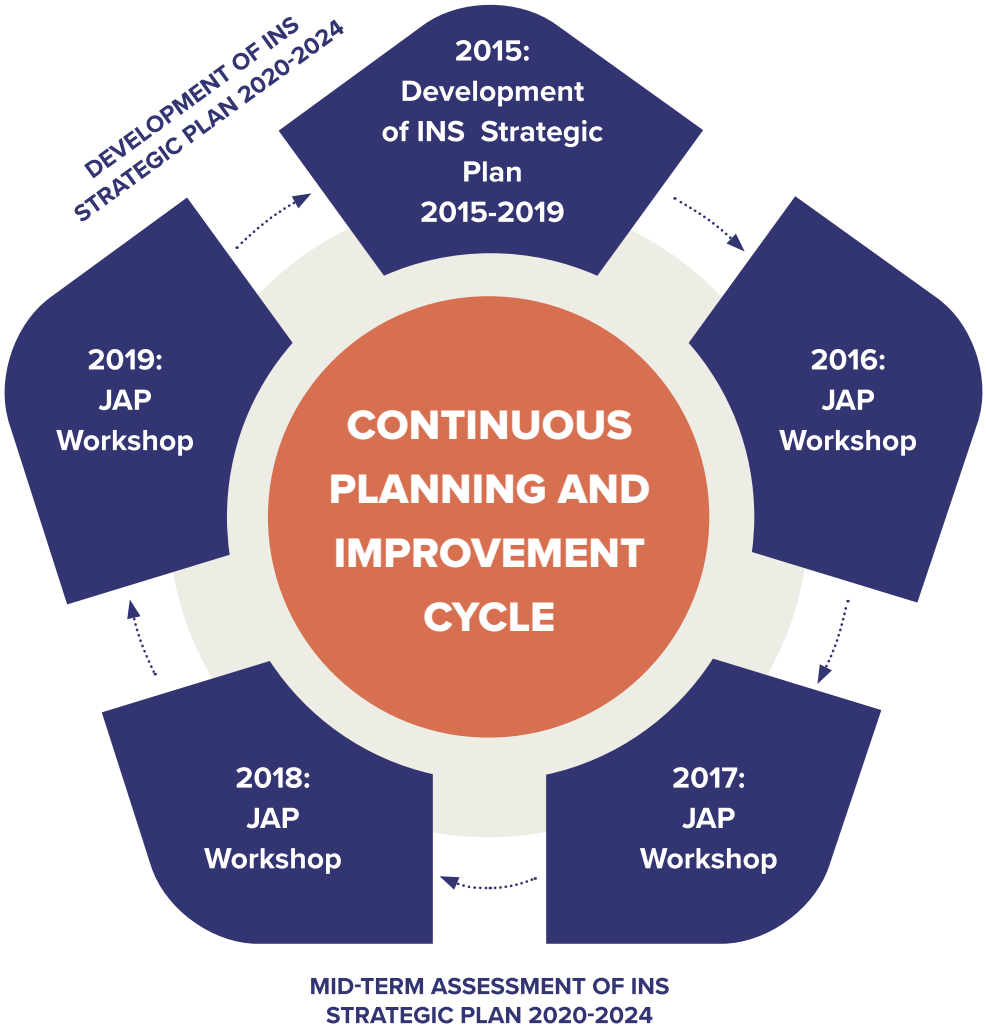
Strategic Planning: The Roadmap to the Future of the INS

Without a comprehensive plan, the INS would continue to operate in an environment of competing needs and limited resources. USAID's Reinforce helped develop a five-year strategic plan to resolve several long-term problems, described further below.

1. Multiple annual plans developed with individual development partners

Coordination among development partners was ineffective, leading INS staff to use multiple annual plans simultaneously and struggle to identify priorities. Using a continuous planning and improvement cycle approach (Figure 2), USAID's Reinforce helped the directorate of cooperation coordinate partners' support for a new guiding document, the Five-Year Strategic Plan (2014–2019).[3] From 2016 to 2020, joint annual planning (JAP) workshops were held at the beginning of each year to encourage development partners to allocate support for the plan's priorities. Each workshop resulted in a consolidated annual plan that INS, the Ministry of Health, and partner participants used for follow-up and prompt implementation.

FIGURE 2. CONTINUOUS PLANNING AND IMPROVEMENT CYCLE FOR INS STRATEGIC PLAN IMPLEMENTATION



[3] *Instituto Nacional de Saude Five-Year Strategic Plan 2014-2019*. Dili: Timor-Leste Ministry of Health.

2. Rising demand for INS services with stagnant or reduced annual budgets

Since its creation, the INS has faced increasing demand for in-service training, as the number of doctors, midwives, nurses, and paramedics working in Timor-Leste's health facilities almost doubled from 2011 to 2015 (and is expected to nearly triple by 2021). Also, the significant increase in the training of health professionals in Timorese universities after 2011 further reduced the already insufficient clinical practice time that students spent in pre-service. This was compounded by the return by 2015 of over 800 Cuban-trained Timorese physicians who received almost no clinical training during medical school. Because they lacked the practical clinical training needed in the workplace, INS' role in upgrading new clinicians' skills increased.[4] Despite this, the INS budget—including the general state budget, the human capital development fund, and development partners' support—decreased over the past few years.[5] Given these constraints, it was essential to strengthen management, leadership, and governance to increase the efficiency of in-service training.

The INS gathered partners together to work on strategic planning.

3. Inefficient, centralized training

In addition to a limited budget and small training staff, almost all in-service training before 2018 was held at the INS in Dili. USAID's Reinforce developed a plan to train trainers and hold in-service trainings in Covalima, the project's model municipality, to reduce the workload of the INS trainers who support all 13 of Timor-Leste's municipalities. This model of decentralized training is discussed in the next section.

The participatory development process for the strategic plan in 2015, led by the INS and project senior staff, included interested partners (e.g., United Nations agencies, nongovernmental partners). The process helped INS leadership improve coordination and identify opportunities to increase effectiveness and efficiency. In 2019, the INS began to develop its next strategic plan (2020–2024), which was completed and submitted for approval in 2020.

Competency-based Training: Building Methods and Tools that Expanded INS Impact

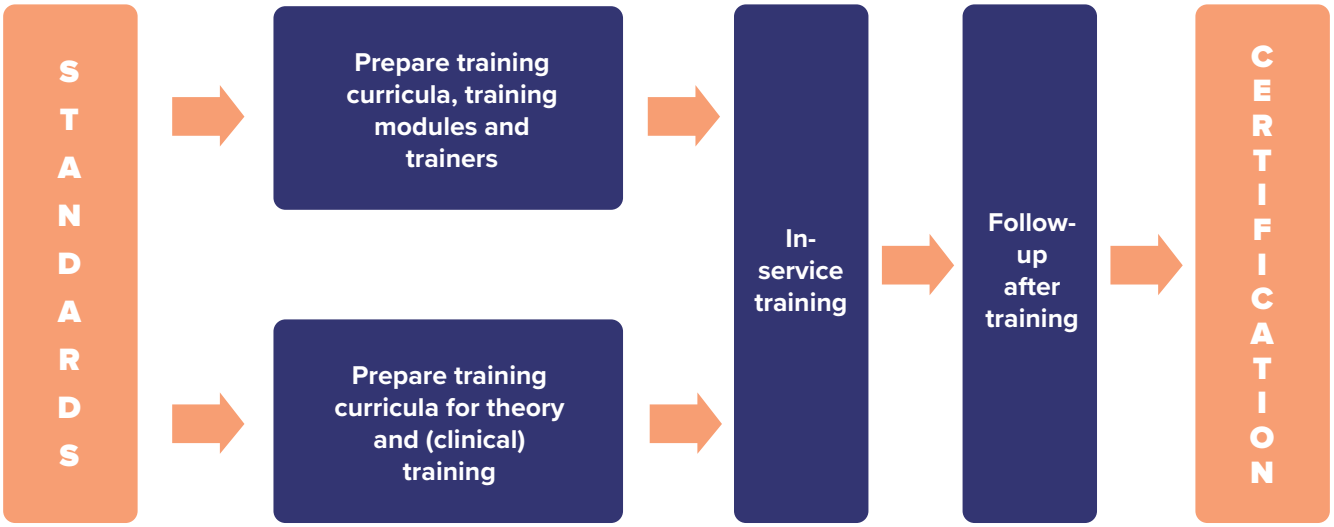
Commitment to competency-based training: human resources and facilities

In the 2015–2019 strategic plan, the INS committed to design and deliver in-service competency-based clinical training to health professionals based on clear, demonstrable standards. USAID's Reinforce provided technical assistance to ensure that all conditions for certification were in place, e.g., updated training curricula and modules, certified competent trainers, and prepared training facilities. (Figure 3).

[4] Timor-Leste Ministry of Health. (2019). *Draft National Strategic Plan for Health Sector Human Resources (NHSWSP) 2019–2023.* Dili: MOH. By strengthening competency-based training, USAID's Reinforce provided new graduates with basic competencies for clinical services at primary health care facilities.

[5] National Institute of Health. (2019). *Draft National Institute of Health (INS) Five-Year Strategic Plan 2020–2024.* Dili: Timor-Leste Ministry of Health.

FIGURE 3. APPROACH TO COMPETENCY-BASED TRAINING



Updating training curricula and modules

USAID's Reinforce mapped standards, training curricula, and modules for maternal, newborn, and child health (MNCH) and family planning (FP) to identify where technical assistance was needed. The project used the clean and safe delivery (CSD) and FP training packages to help the INS test and conduct competency-based training, following the steps illustrated in Figure 3.

Both updated training packages set clear expectations for skills acquisition before certification. Each includes a reference book based on national standards, trainers' and participants' guides, and checklists for assessing clinical competency.

Training advanced and junior trainers

USAID's Reinforce trained a core team of advanced trainers from the national level, who in turn trained health providers (doctors and midwives) from Covalima Municipality as junior trainers so that training did not depend on the availability of Dili-based trainers, who were often unavailable for months due to high demand. Over its course, USAID's Reinforce provided intensive technical assistance to Covalima-based trainers so they could take responsibility for teaching, coaching, assessing, and certifying health professionals.

Improvement of training facilities at the INS

To support competency-based training, the INS training center required improvements as outlined in the 2014 situation analysis, especially facilities for practicum sessions in a skills lab and clinical practice settings.

The INS provides theoretical sessions in its classrooms and clinical practice sessions in two nearby community health centers (CHCs). These CHCs (Vera Cruz and Comoro) were upgraded using a continuous quality improvement approach based on assessments/self-assessments, workshops, in-service training, and supportive supervision. The skills lab was assembled at the INS premises near classrooms, set up like a typical clinic, and equipped with clinical models and equipment to enable practice of clinical skills.

A health provider proudly shows her certification in safe and clean delivery.

After Covalima staff were certified as junior trainers and with support from USAID's Reinforce, clinical practice was decentralized to Suai Referral Hospital. The U.S. Air Force equipped the hospital with a skills lab and renovated a training room where trainers conduct quarterly quality improvement exercises. In 2020, USAID's Reinforce gave the skills lab additional clinical equipment to create a fully functional space.

In-service training, follow-up after training, and participant certification

Beginning in 2016, the INS significantly increased the amount of time students spent on clinical practice during all of their courses. The newly developed courses allocated more time to using the skills lab, practicing on actual patients, and performing competency assessments. This resulted in more communication between trainers and trainees. The INS acknowledged that because most participants would not acquire certification by the end of a 10-day course, partly due to the limited number of patients available at clinical practice sites, one or more follow-up visits after training at the trainees' workplace could be used to complete certification. These sessions are possible because of the increased number of available trainers and three new clinical practice sites.

In 2016, the INS conducted a training needs assessment in Covalima to prioritize training in the municipality.[6] This was followed by an intensive three-year period of in-service training on CSD, FP, essential newborn care (ENBC), integrated management of childhood illnesses (IMCI), and basic emergency obstetric and newborn care (BEmONC). Thanks to the newly trained junior trainers in Covalima and the preparation of training facilities in Suai Referral Hospital, the INS conducted several trainings and all follow-up after training sessions in Covalima Municipality. Given the seven-hour drive from Dili, this decentralization increased availability and lowered the cost of in-service training.

An INS trainer (left) uses a checklist to observe a trainee (middle) practicing her skills.

[6] Domingos Soares, I. d. (2016). *Training Needs Assessment for Maternal, Newborn and Child Health in Covalima Municipality and two Health Centers in Dili, Timor-Leste*. Dili: InstitutoNacional de Saúde (INS) with support from USAID's Reinforce.

INS trainees practice their skills using a mannequin in the newly equipped skills lab.

The INS established certification rules early in the process of re-activating the CSD and FP trainings, requiring successful completion of multiple assessments: knowledge (measured during pre- and post-tests); practice on models at the skills lab (measured with competency checklists); and practice on actual patients (measured with the same checklists during the 10-day training and/or follow-up after training sessions). Providers must maintain certification through regular supportive supervision.

Results: What changed at the National Institute of Health in Timor-Leste after four years of institutional development support?

While capacity development at the INS is supported by multiple partners, the legacy of USAID's Reinforce is **strengthened implementation of the strategic plan and institutionalized competency-based training at the INS**, both of which were agreed upon in the project's memorandum of cooperation with the INS.

While it may be too soon to measure the extent to which the process for strategic plan development and implementation has been institutionalized at the INS, the collaborative development cycle and JAP meetings as shown in Figure 2 have been implemented consistently since 2016. The second INS strategic plan (2020–2024) is being implemented, and the next JAP is planned for 2021. At mid-term, 72 percent of the INS strategic plan 2015–2019 outputs had been achieved. Of 26 outputs expected for management, leadership, and governance, 24 were achieved, as were 16 of 21 outputs for quality of training.[7] The systematic approach adopted by the INS for gathering its development partners around its strategic plan resulted in a more efficient management of limited resources.

[7]Guterres, J. C. (2018). *A Midterm Review of the INS Five Years Strategic Plan 2015–2019*. Dili.

Institutionalizing competency-based training at the INS includes tangible products such as the updated CSD, ENBC, FP, and BEmONC training packages and the three skills labs for CSD, FP, and BEmONC established at the INS, Vera Cruz CHC, and the Suai Referral Hospital. USAID's Reinforce provided skills laboratory equipment and worked with INS to finalize a guide and standard operating procedures.

The skills lab model designed by USAID's Reinforce was replicated in Oecusse Regional Hospital by another partner, and other labs are being considered. In Oecusse, USAID's Reinforce facilitated the technical exchange between municipalities and shared the guide and protocols. This initial scale-up of skills labs is an encouraging indication of sustainability.

Significantly, the number of available trainers increased to eight advanced trainers at the national level and six junior trainers in Covalima Municipality. An intangible outcome is their role as leaders and guardians of the competency-based training model that they promote at the Trainers' Discussion Forum held quarterly in Dili to discuss training methods and resolve problems.

Trainings increased in both quality and quantity, with 336 health professionals trained in CSD, FP, ENBC, IMCI, and BEmONC, and 253 follow-up after training sessions provided. The clinical practice site upgrades at Comoro and Vera Cruz CHCs and Suai Referral Hospital increased their readiness in areas such as infrastructure, equipment and supplies, administrative procedures and management systems, and trainers' qualifications.[8]

USAID's Reinforce showcased a **successful decentralized competency-based training program** in Covalima Municipality. Six qualified trainers are available for routine follow-up after training visits to help the municipality's health workers maintain the competencies they achieved during training.

USAID's Reinforce Project and the INS strengthened **management, leadership, and governance**, resulting in improvements to standard operating procedures, quality monitoring, information-sharing within the INS and with stakeholders, implementation of competency-based in-service training, and a commitment to continue strategic planning. In fewer than five years, this investment has positioned the INS to scale vast improvements to the quality of care provided by Timor-Leste's public health system.

[8]This approach is described in the technical brief *Covalima: Becoming a Model Municipality*. JSI Research & Training Institute, Inc. through USAID's Reinforce Project. (2017). Dili.

The USAID's Reinforce Basic Health Services Project was launched in 2016 to help the Timorese government improve the quality and use of maternal, newborn, and child health and family planning services through technical assistance to the Ministry of Health personnel working at national level and in the model municipality of Covalima.

ANNEX 3:

Web-Based Annexes:

a. Reflecting on the evolution of Timor-Leste's Health System since Independence
b. Photo-Essay: Saving Lives through Training

Annex 3a: Reflecting on the Evolution of Timor-Leste's Health System since Independence

Dr. Nelson Martins in the newly-equipped skills lab at Timor-Leste's health training institution, the National Institute of Health. JSI equipped the lab with funds from USAID through our Reinforce Basic Health Services Project.

In 2019, Timor-Leste marked twenty years since the referendum that gave the country independence from Indonesian rule. Dr. Nelson Martins, who until recently was JSI's senior capacity development advisor embedded at the National Institute of Health, served as one of the early Timorese doctors who provided critical medical services during the fight for independence and through the emergency and transitional phases of the Timor-Leste government. He played and continues to play an integral role in strengthening Timor-Leste's health system to this day. The Reinforce team sat down with Dr. Nelson Martins to discuss the evolution of Timor Leste's health system since the country's independence in 2002.

Annex 3b: Photo Essay: Saving Lives through Training

Carmen de Jesus Gusmao is a dedicated midwife and head of the maternity ward at the only referral hospital in Covalima, a remote and mountainous municipality in Timor-Leste. Every day, Carmen helps deliver babies, provides antenatal care for pregnant women, ensures newborns get the care they need, provides family planning counseling and services for women, and manages the maternity ward staff. Thanks to support from USAID's Reinforce Basic Health Services Project, Carmen was able to attend two competency-based trainings organized by the INS.

Carmen de Jesus Gusmao received her certification as a competent, safe, and clear delivery provider thanks to support provided by USAID's Reinforce project.

ANNEX 4:

External Assessment of Obstetric Services and their Related Counseling Services at Three Clinical Practice Sites, 2020

USAID's Reinforce Basic Health Services Project

External Assessment of Obstetric Services and their Related Counseling Services at Three Clinical Practice Sites

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USAID's Reinforce: External Assessment of Obstetric Services and their Related Counseling Services at Three Clinical Practice Sites

Cooperative Agreement No. AID-472-A-16-00001

Prepared by
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Cover Photo: Reinforce assessor with CHC staff. (Staff photo)

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External Assessment of Obstetric Services and their Related Counseling Services at Three Clinical Practice Sites

1. Background

This report relates the main findings of an external assessment of the maternity department (obstetric services and their related counseling services (ANC, normal delivery, PNC)) at CHC Comoro, CHC Vera Cruz, and Suai Referral Hospital, all three of which are Clinical Practice Sites. The assessment was done between 13 and 21 January 2020. For each facility, the report shows progress over time as evidenced by five assessments (both internal and external) that were done since the baseline assessment in 2016. While this report focuses on the bigger picture and highlights the most salient findings and most important recommendations, it does not mention every detail of the findings. Those details can be found in the individual site level reports.

The focus of this assessment was on the following areas:

1. Appropriateness of the space/rooms and patient flow
2. Process of infection prevention: decontamination and sterilization
3. Waste management
4. Quality of counseling
5. Quality of normal delivery services (based on 60 steps)
6. Quality management

The methodologies used for this assessment included:

- Direct observation using check lists
- Staff interviews
- Review of available guidelines and basic statistical data

2. Results

Overall results of the assessment and comparison with previous assessments

Tables 1-3 show a summary of the changes over time for each section at each Clinical Practice Site. The tables show the results of the checklist assessment and compare them with the results of the previous assessments. The tables are color coded in the following way:

- Bright red colors for the lowest results: 60% and lower
- Darker red morphing into dark green as results improve: 61%-85%
- Bright green colors indicating the best results: >85%

Brief discussion of results

For most sections, we can see a progressive change from red or dark green colors to brighter green colors, indicating progressive improvement over time. Not surprisingly, the overall scores show the same trend. Invariably, there will be some difference in judgement between different assessment teams. Since different assessments were performed by different teams, we would expect some fluctuation in the results. For example, it is possible that the first self-assessments that were done in May 2017 were somewhat optimistic. Nevertheless, we can see clear progress in the results of external assessments. And over the past year and a half we also see a closer alignment between external and internal assessments. For more detailed results including the sub-section scores, please refer to the individual facility reports.

These tables can be used to identify the remaining red (and dark green) sections where improvements can still be made. The main areas that show low scores are 'Quality Management' and 'Completeness of Intervention Rooms' (the latter mainly because of weak scores in the 'Waste Management' sub-section. While the sections on 'Infection prevention process – Sterilization' show good overall scores, there are important issues with the sterilization process that need to be resolved. The remainder of this report provides guidance as to why some scores are low. The recommendations section provides guidelines on how to improve the scores further. With a few targeted improvements, there is still potential for considerable improvement.

Table 1. Overall Results CHC Comoro

CHC Comoro						
Sections	Baseline 2016	Self assessment May 2017	External assessment Oct. 2017	Self assessment Nov. 2018	External assessment July 2019	External assessment Jan. 2020
Overall Score	**68%**	**76%**	**72%**	**84%**	**86%**	**85%**
Patient flow	60%	57%	65%	73%	73%	90%
Facilities and Rooms	67%	75%	68%	75%	77%	83%
Infection Prevention Process- Sterilization	70%	83%	74%	91%	96%	91%
Counseling Performance	66%	68%	71%	80%	80%	91%
Normal Birth Care	66%	78%	80%	99%	99%	96%
MCH Program Coordination	70%	78%	60%	83%	93%	100%
Quality Control Program	75%	79%	65%	71%	71%	40%
Completeness of Intervention Rooms	72%	74%	75%	75%	75%	71%

Table 2. Overall Results CHC Vera Cruz

CHC Vera Cruz						
Sections	Baseline 2016	Self assessment May 2017	External assessment Oct. 2017	Self assessment Nov. 2018	External assessment July 2019	External assessment Jan. 2020
Overall Score	**65%**	**90%**	**70%**	**82%**	**92%**	**86%**
Patient flow	64%	78%	68%	78%	89%	86%
Facilities and Rooms	70%	87%	68%	77%	86%	92%
Infection Prevention Process- Sterilization	65%	96%	71%	86%	98%	86%
Counseling Performance	60%	99%	68%	69%	100%	92%
Normal Birth Care	64%	94%	78%	94%	100%	97%
MCH Program Coordination	70%	88%	55%	68%	93%	100%
Quality Control Program	63%	81%	53%	74%	79%	40%
Completeness of Intervention Rooms	66%	85%	71%	71%	69%	66%

Table 3. Overall Results Suai RH

Suai RH						
Sections	Baseline 2016	Self assessment May 2017	External assessment Oct. 2017	Self assessment Dec. 2018	External assessment July 2019	External assessment Jan. 2020
Overall Score	**71%**	**83%**	**69%**	**83%**	**90%**	**87%**
Patient flow	80%	82%	66%	82%	82%	95%
Facilities and Rooms	73%	88%	66%	77%	87%	91%
Infection Prevention Process- Sterilization	70%	84%	70%	85%	94%	86%
Counseling Performance	66%	70%	63%	71%	81%	81%
Normal Birth Care	66%	82%	74%	96%	98%	97%
MCH Program Coordination	70%	83%	65%	73%	90%	90%
Quality Control Program	75%	88%	66%	76%	75%	51%
Completeness of Intervention Rooms	78%	86%	75%	75%	88%	85%

3. Accomplishments and Challenges

Appropriateness of the space/rooms and patient flow

Overall, patient flow is quite well organized. The maternity of CHC Comoro obviously is housed in an older building with more space constraints, especially given the relatively higher patient load. Nevertheless, the patient flow makes sense and limits unnecessary traffic in the corridor and other spaces. Patient flow is not an issue at Suai RH. Most outpatients are seen in a spacious consultation room located in the OPD department, while inpatients have the full use of the maternity. In addition, the patient load is relatively low. The level of cleanliness is generally good to very good. Suai RH stands out as very clean, maybe not surprising since they benefit from newer buildings and have a lower patient load.

Figure 1: Staff at CHC Comoro

At CHC Comoro, privacy is seriously compromised in the delivery room with two delivery beds. The foot end of the beds is directed toward the door that does not close properly. The situation is bad enough to recommend that most deliveries be done in the room with one delivery bed, that does not have this privacy issue. In the meantime, the least that should be done is repair the door so that it can be properly closed. To patients who are not familiar with the layout of CHC Comoro, it may come across as somewhat of a labyrinth. Patients may get lost when they are referred to another department. We observed a patient who was sent to the pharmacy ending up in the lab. Simply asking patients if they know where they are supposed to go could avoid most of this confusion. At CHC Comoro the foot end of two of the three delivery beds are broken and supported by a bucket or chairs. At CHC Vera Cruz, the recovery room is in the main building, about 30 meters from the maternity. When it rains, it is difficult to transfer patients because there is no covered corridor connecting the two.

Process of infection prevention: decontamination and sterilization

Disinfection procedures are well adhered to at all three sites. A common problem is forgetting to take the instruments out of the disinfection solution. A simple solution like using a kitchen timer could help prevent this. Instrument cleaning procedures are equally well adhered to. At CHC Vera Cruz and Suai RH, instrument cleaning is done in the delivery room. In Suai this does not pose any problems. At Vera Cruz, the sink is closer to one of the delivery beds and there is no countertop space close to the sink for drying the instruments.

Across the three facilities, preparation of chlorine 0.1% for high-level disinfection is not as well known as the preparation of chlorine 0.5%. There are probably two contributing factors: it is not used as often as chlorine 0.5%, and there is no job aid for the preparation of chlorine 0.1% (as opposed to chlorine 0.5%). The clamp for handling high-level disinfected instruments should be kept in a disinfected container and regularly sterilized or disinfected. It is not clear with which frequency clamp and container are sterilized or high level disinfected.

At each facility there are issues with the sterilization procedure. CHC Comoro and Suai RH use an autoclave while CHC Vera Cruz uses dry heat. At CHC Comoro, procedures are generally OK, but there is no autoclave tape to confirm proper sterilization. Except maintaining the water level, no routine maintenance of the autoclave is done. The manual of the autoclave is available and it outlines basic daily and weekly maintenance that could be easily performed by maternity staff. Making a job aid with these basic steps could be helpful.

At CHC Vera Cruz, sterilization is done in a dry heat oven that is located in the emergency department of the CHC. The latch of the oven door is lose and as a result the door does not close tight. This allows a lot of heat to escape and compromises the sterilization process. Staff commonly prod the door shut with a chair. Sterilization tape that is appropriate for dry heat as verification of effective sterilization is not available. At Suai RH, sterilization is done in an autoclave. Autoclave tape is used to ensure that sterilization has been effective. However, instruments are commonly autoclaved in a closed, non-perforated metal container that has been wrapped in cloth. This compromises sterilization. Instruments should be sterilized in metal drums that are perforated (and with the perforations open). Alternatively they can be put in non-perforated metal containers, but these containers should be kept open during the sterilization process. The autoclave process cannot guarantee sufficient pressure and humidity inside a closed, non-perforated container. For further reference, see also the 2016 WHO document 'Decontamination and reprocessing of medical devices for health-care facilities', p.60: 'Non-perforated metal containers are only suitable for dry heat sterilization.'

Storage of sterilized and high level disinfected instruments is generally good. They are kept in well organized cupboards. At all three facilities sterilized materials are marked with the date of sterilization, not the expiration date. Staff at all facilities claim that sterilized instruments that have not been used within seven days of the date of sterilization are re-sterilized. There are indications that this is not always strictly adhered to. Most staff at all three facilities appear to have received one dose of Hep.B vaccination about 2-3 years ago. While this may provide protection for some staff, the complete schedule of Hep.B vaccination involves three doses.

Waste management

Waste management poses considerable challenges at all three facilities. Inside the maternity building, staff practice separate collection of sharps, bio-waste and general waste. However, once it is taken outside, bio-waste is combined with general waste in bins. This mixed waste is picked up and ends up at waste dumps, leading to infection and contamination hazards. At the two CHCs, sharps are picked up separately for incineration. At Suai RH sharps used to be incinerated on-site, but since the incinerators have not been working for a number of years, sharps are now also mixed with the general waste.

Suai RH has two incinerators, neither of which are functioning (fig. 2). At the CHCs in Dili, mixed waste is picked up by public waste collectors with little or no protective gear. We have no information on the Hep.B vaccination status of those waste collectors. In Suai, the persons who pick up the mixed waste wear protective gear and, about two years ago, received one dose of Hep.B vaccination. Liquid waste

Figure 2: Incinerator at Suai RH and manufacturer details

drains from the sink in the delivery room into a closed system at CHC Comoro and Suai RH, and into an open gutter at CHC Vera Cruz.

Quality of counseling

Counseling tends to be quite general and not specific to the needs and situation of the patient/client. E.g. no difference between counseling at K1 and at K4. Midwives do not use physical examples of methods during FP counseling and some of them lack knowledge about certain methods. During observed counseling sessions, the client was offered limited opportunity for questions. Free, informed choice was compromised because the midwife promotes 'the best option'. Benefits and disadvantages of different options are not always clearly discussed. Limited space in CHC Comoro affects privacy during counseling sessions. Counseling sessions performed by trained midwives were markedly better compared to those performed by midwives who had not been trained.

Quality of normal delivery services (based on 60 steps)

Quality of normal delivery services is good with generally very high scores. A Lack of breastfeeding support, even for primiparous patients, is common. It was observed at all three facilities. Complications are not always recognized for what they are and/or responded to appropriately (e.g. delayed second stage was not acted upon for about two hours). Delayed vit. K administration was observed at CHC Comoro and at Suai RH.

Quality management

Standard guidelines are available at all three facilities. Quality management scores low at all three sites because there is no evidence of a functional structure that routinely identifies problems and tries to solve them. At all three facilities, the most commonly used quality tool appears to be the checklist for normal delivery (based on the 60 steps and promoted by 'Reinforce'). This checklist seems to be used on a quarterly basis at Suai RH and at more irregular intervals at the CHCs. At CHC Comoro, questions on client/patient satisfaction appear to be asked during an exit interview prior to each discharge, but there is no written documentation available. Exit interviews do not appear to be done routinely at CHC Vera Cruz or Suai RH. At Suai RH however, there is a suggestions/complaints box and a telephone number that patients or relatives can call with complaints is functional and widely advertised throughout the hospital. A set of checklists designed to be used for regular observation (see figure 3) is available at all facilities, but it is not used at any of them.

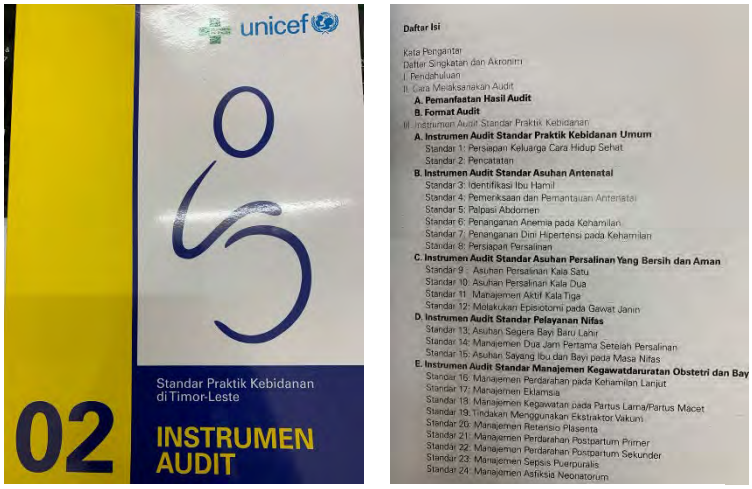

Figure 3. Set of tools that trainers can use to supervise midwives and trainees

4. Recommendations

Table 4 shows the main recommendations that generally apply to most if not all facilities. This report is limited to those recommendations that are likely to require considerable central level support. A more exhaustive list of recommendations for each section facility can be found in the individual facility reports.

Waste management and quality management are two areas in which all three facilities can make considerable improvements. In addition, some sterilization procedures need to be reviewed.

1. Sterilization Procedures

Staff tend to rely on the automated program of the autoclave or dry heat oven they are using for sterilizing instruments. They rely on the accuracy of the program and trust that temperature, humidity, and pressure reach sufficient levels for a sufficient amount of time to assure proper sterilization. While it is OK to rely on automated programs, staff should only do so if the autoclave or oven is routinely maintained according to the daily, weekly, and monthly maintenance instructions specified in the manual of the machine. And if they are using appropriate sterilization tape (which is different for autoclaves compared to dry heat sterilization). At the time of the assessment, only Suai RH was routinely using autoclave tape and routine maintenance was not practiced at any facility (with exception of maintaining the water level in the autoclaves). In addition, the dry heat oven at CHC Vera Cruz requires minor but vital repairs. Sterilization procedures at Suai RH need to be reviewed since sometimes instruments are autoclaved in closed, non-perforated metal containers, a practice that is OK in dry heat ovens but not in autoclaves.

Sterilization Procedures: Sterilization equipment requires:

1. *Regular routine maintenance*
2. *Confirmation of effectiveness by using appropriate sterilization tape.*

If either one of these cannot be performed, it is important to verify the time during which the equipment reached the appropriate sterilization temperature.

2. Waste Management

Figure 4: Mixed general and bio-waste on the sidewalk in front of CHC Vera Cruz

At all three facilities, staff carefully separate bio-waste and sharps from general waste. However, bio-waste is combined with general waste before it leaves the facility (fig. 4). In addition, it appears that sharps are also combined with general waste at Suai RH. There are no waste management protocols available to the staff. Bio-waste should be incinerated (alternatively buried in a deep and protected (properly fenced) pit). At the time of the assessment, waste management practices at all three facilities contribute to considerable contamination and infection risks for staff, waste collectors, and the general population. The assessment team feels that this is an important issue that requires urgent, and probably higher level (MHS, MOH, other ministries) attention.

3. Quality Management

Quality management requires a team that constantly assesses various aspects of quality of the services that are provided, and whenever possible quality breaches are identified, perform more formal measurements to identify the underlying root causes of the problem(s). Once causes have been identified, improvement interventions need to be designed, implemented, and their effectiveness assessed. Establishing a proper quality management system is not an easy task and maternity staff would need the concerted support of the Director of Quality (if this position exists), the Clinical Director, the INS, and Reinforce to achieve this.

The assessment team suggests starting with some basic **Quality Assurance (QA)** activities. As for now, the only quality assurance tool that appears to be used is the Normal Delivery checklist promoted by the Reinforce project. It is important for maternity staff to institutionalize the use of this checklist and expand it to the checklists found in the tool shown in Figure 2. The assessors feel that all trainers should regularly use these tools to assess the skills of not only trainees, but of all the maternity's clinical staff. This should provide proof that staff strictly adhere to the standard guidelines for normal deliveries, complications, and counseling sessions. The maternity in-charge should ensure that all trainers have sufficient time budgeted in their schedules to take part in such checklist observations, that the observations are actually done, and that the outcome is discussed with the midwives and the trainees. Given that these facilities are Clinical Practice Sites, it is important that staff strictly adhere to the standard guidelines. If these recommendations in quality management are implemented, they will have a direct effect on the quality of counseling services (section 4) and the quality of normal delivery services (section 5).

Quality Management: Start with simple activities but make sure to institutionalize and routinely perform them:

1. *Quality Assurance:* Check list observations with the necessary follow-up.
2. *Quality Improvement:* Routinely collect patient satisfaction information and systematically analyze and respond to it.

In the realm of **Quality Improvement (QI)**, the assessment team suggests starting with basic data collection on patient satisfaction. Facility staff will likely need the support of the INS and Reinforce to organize this in a way that is acceptable to the patients and that provides staff with the most accurate and useful information. They will also need support with the routine review and analysis of the collected information and to formulate meaningful responses to the findings in the form or improvement interventions.

Table 4. Recommendations and Responsible Authorities

Facility	Recommendations	Responsible
	1. Appropriateness of the space/rooms and patient flow	
CHC Comoro	• Fix the labor ward door so that it can be properly closed.	CHC management
CHC Comoro	• Either replace two broken delivery beds or arrange for them to be repaired in a structurally sound way.	CHC management and MHS Dili
CHC Vera Cruz	• Consider construction of a covered corridor to facilitate transport of patients from the delivery room to the observation room (which is located in the main building).	CHC management and MHS Dili
	2. Process of infection prevention: decontamination and sterilization	
Suai RH	• Instruments should not be autoclaved while in a closed, non-perforated container. Containers should either have perforations (that are in the open position during the autoclaving process) or should be kept open in the autoclave.	RH staff
All facilities	• Both sterilization date and expiration date should be clearly marked on boxes with sterile instruments. If only one date is marked, clearly indicate whether it is the sterilization or the expiration date.	Maternity staff
All facilities	• A job aid for the preparation of chlorine 0.1% would be helpful. (Consider a combined 0.5% and 0.1% job aid)	Maternity staff and 'Reinforce'
All facilities	• Assure regular (preferably daily) sterilization or HLD of the clamp that is used to move HLD instruments and its container	Maternity staff
CHC Comoro	• Assure the availability and use of autoclave tape	CHC management
Suai RH and CHC Comoro	• A job aid (in Tetum) with the schedule of daily, weekly, and monthly maintenance of the autoclave could be useful. o Autoclave manual is available at CHC Comoro o Autoclave manual could not be found at Suai RH. It is a *Tabletop Type N Class Autoclave REXMED RAU-326*	Maternity staff and 'Reinforce'
Suai RH and CHC Comoro	• Implement the maintenance schedule for the autoclave.	Maternity staff
CHC Vera Cruz	• The latch of the door of the dry heat oven used for sterilization of all instruments (and located in the emergency room) needs to be tightened so that the door closes properly. Most likely this can be fixed by a general mechanic.	CHC management and CHC staff
CHC Vera Cruz	• Sterilization tape suitable for dry heat sterilization (this is different from autoclave tape!) should be used if at all possible.	CHC management and 'Reinforce'

All facilities	• Ensure complete (3 doses) Hepatitis B immunization for all staff and waste collectors	Facility management and MHS
	3. Waste management	
All facilities	• Find safe and appropriate options for the disposal of bio-waste	Facility management
All facilities	• Assure that staff have access to existing waste management protocols (or develop them if not existent)	Facility management
Suai RH	• A solution needs to be found for at least one of the incinerators. Most likely the best option is the one manufactured in Australia (the larger one of the two). It has clear instructions on the outside and it has the tallest chimney. • One option would be to verify if there are incinerators of the same make in the country or in Dili that are functioning. If so, possibly the person who manages it could provide support to Suai RH. • Another option would be to get in touch with the company in Australia that manufactured the incinerator and attempt to find out what the most likely cause of the malfunctioning could be.	RH management and 'Reinforce'
CHC Vera Cruz	• Consider options for covering the open sewage canal on the CHC grounds.	CHC management, MHS Dili, and 'Reinforce'
	4. Quality of counseling	
All facilities	• Prepare for a counseling session, based on the type of client. Make sure to have all the educational tools and check lists that you may need. Education materials are not limited to paper materials but include items like physical examples of family planning methods so clients can see and feel them. Assure the counseling session is specific to the needs and the situation of the patient/client.	Facility staff
All facilities	• Since these facilities are Clinical Practice Sites, there is an added importance for staff to provide optimal counseling to clients and patients. Trainers should engage in continued training, not only of trainees, but also of maternity staff. See more on this in the section on Quality Management.	Facility Trainers, Maternity in-charge, INS, 'Reinforce'
	5. Quality of normal delivery services (based on 60 steps)	
All facilities	• Reinforce the importance of all steps, standards and good practices. While some of them may be more essential than others, none of them should be considered optional.	All trainers
All facilities	• Assure all mothers receive information on and help with breastfeeding	Facility staff
	6. Quality Management	
All facilities	• **Quality Assurance:** Institutionalize a system to routinely identify and correct gaps in the adherence to the guidelines and the steps in the delivery process. This can	Trainers, INS, 'Reinforce'

	be done through routine observation exercises by all trainers, with the use of existing checklists. There should be a quarterly calendar for this. For complications, ad hoc observations should be done as complications present themselves, and with the help of the checklists in the MOH/UNICEF tool shown in figure 2.	
All facilities	• The previous recommendation also applies to counseling sessions.	Trainers, INS, 'Reinforce'
All facilities	• During the above-mentioned observations, document the findings/observations and immediately provide feedback to the observed staff.	Trainers
All facilities	• Ensure that a functional checklist observation system is put in place and regularly assess its functionality.	Maternity in-charge
All facilities	• Routine review of all partographs can be a good Quality Assurance activity at maternities. It would serve a double purpose: 1. Assure that partographs are filled out completely and appropriately, and 2. Assure that midwives adhere to the current standards of obstetrics and midwifery.	Maternity in-charge and trainers
All facilities	• **Quality Improvement:** Routinely assess and document patient satisfaction interviews. Consider doing this with the help of anonymous questionnaires. Facilities may need help to institutionalize such a system, to organize the systematic review of findings, and to formulate and implement appropriate responses to the findings in the form of improvement interventions.	Maternity staff, INS, 'Reinforce'

ANNEX 5:

Long-Acting Contraception Changes a Woman's Life

Long-acting Contraception Changes a Woman's Life

Thirty-nine year-old Rosentina lives in a remote village in Timor-Leste's Covalima Municipality, where she spends her days caring for her seven young children, keeping her house in order, taking care of the family's animals, and working in their nearby fields.

Despite not having much time for rest, Rosentina is fit and happy, with a supportive husband and fulfilling time with her children. However, one year ago, Rosentina suffered a miscarriage during the third month of her eighth pregnancy. Although she lost a lot of blood, Rosentina was treated successfully at the Fatumea health center.

Vitorina de Jesus Cardoso, the midwife who took care of Rosentina, changed Rosentina's views about her health and wellbeing. Vitorina is used to seeing women like Rosentina, who work tirelessly day after day to ensure their children thrive, eat well, and attend school.

Recently, with support from USAID's Reinforce project, which, among other things, works to improve the quality of family planning services in Covalima, Vitorina attended a family planning training facilitated by the National Institute of Health. At the training, Vitorina learned about the benefits of spacing children: more rest for the mother who can fully recover from the pregnancy and delivery, more attention for the baby and siblings, and more time for sharing remunerative tasks with husbands. The training also taught Vitorina how to counsel women to space their children and choose the right contraception for spacing.

While Rosentina was recovering from her miscarriage, Vitorina counseled Rosentina and her husband about the benefits of birth spacing. Without hesitation, the couple decided they should not risk getting pregnant too soon after the miscarriage. "I was lucky to survive after the loss of my baby, but my children and my husband need me more than ever right now and I have to be healthy for them," said Rosentina.

After further family planning counseling from Vitorina, Rosentina decided the contraceptive injection was the method for her and soon went home to her family. From that day on, she fully enjoyed her life without worrying about being pregnant again.

Rosentina happily sitting in front of her house, with two of her healthy children and Midwife Vitorina.

But Rosentina's village is a long walk from the health center and after returning two times for subsequent injections, which need to be repeated every three months, Vitorina happily informed Rosentina that she was now certified to provide long-acting contraceptive methods. These methods, which include contraceptive implants and intrauterine devices (IUDs), would free Rosentina from having to come back to the health center every three months. After further counseling from Vitorina, Rosentina chose the IUD, which lasts for five years.

Vitorina was certified to provide long-acting methods of contraception by the National Institute of Health in February 2017 thanks to repetitive practices sessions supported by USAID's Reinforce project. Vitorina is now able to counsel mothers on the full range of family planning methods. "Every woman has different needs and lives in a different situation depending on her age, the number of children she has, where she lives, and her health condition," said Vitorina. This is why USAID's Reinforce project supports the National Institute of Health to build the capacity of Covalima Municipality's midwives to address every woman's family planning needs. Since 2016, USAID's Reinforce project supported the National Health Institute in training 36 services providers in family planning.

ANNEX 6:

Training Local Care Providers to Prevent Maternal Death

Training Local Care Providers to Prevent Maternal Death

By Marianne Viatour

In its efforts to reduce maternal mortality, the Timor-Leste Ministry of Health (MOH) re-activated the emergency obstetric care (EmOC) program. Between 2015 and 2017, a senior obstetrician from MOH, assisted by the United Nations Population Fund and the World Health Organization, formed a team of national clinical experts who conducted a needs assessment and developed several key documents including EmOC standards of care, clinical protocols, and a national costed action plan. An EmOC training package was developed in collaboration with the National Institute of Health, and used to train 12 national trainers in 2018. These national trainers then conducted the first standardization training for midwives from nine focus health centers.

Midwife Ana Maria Bianco Lopes was one of the training participants. She works at Zumalai Health Center, one of the 36 facilities selected as basic emergency obstetric care (BEmOC) centers under the national EmOC improvement plan. Zumalai is in Covalima Municipality, where USAID's Reinforce Project has been providing technical assistance since 2016. During her 26-day training in Timor-Leste's capital, Dili, Ana learned about the seven life-saving signal functions of BEmOC, passed knowledge and laboratory skills tests, and practiced several of these functions on patients at the National Hospital.

Upon her return to Zumalai, Ana's training proved to be timely and effective. On the night of July 25, a young woman named Teresina arrived at the health center, about to give birth. Her first two children were born at Zumalai health center, and during this pregnancy Teresina had all her antenatal care visits with Ana and other midwives. Although about 15 percent of deliveries in Timor-Leste end up with unexpected complications, everyone expected that Teresina would have another normal delivery. However, after several hours her labor still had not progressed adequately. The midwife on call that night called Ana, who applied assisted vaginal delivery by vacuum extractor as she had recently learned. The following week, a woman named Maria had the same complication. A back accident she suffered a few years ago impeded her strength for delivery, and again, Ana's new competence was needed—and saved lives. Both mothers rested a few hours in the health center and returned home with healthy babies in their arms.

Ana admitted that before her training, she would not have been confident using a vacuum. "I would have sent Teresina and Maria to the referral hospital, a one-hour ride from here, and who knows how their condition would have evolved during the ambulance ride," she mused.

Midwife Ana Bianco assisting the delivery of one of the women suffering obstetric complications during delivery at Zumalai Health Center.

Medical Equipment Saves Lives

By Julio Goncalves

Midwife Ana Maria Bianco Lopes was in the middle of a training session on how to use some newly provided medical equipment when one of her patients came to the Zumalai health center for delivery. She left the training to attend to the delivery, which went very well. However, after the birth the newborn baby was experiencing difficulties breathing because mucus and amniotic fluid were blocking his airway. The baby's condition rapidly worsened, but Ana Maria swiftly moved him to the resuscitation table and began to use the new suction pump, which she had just been taught to use in the training. Putting her improved skills and the new equipment to use, Ana Maria was successful in saving the baby. "Using well-functioning equipment made the suction so much quicker; the old pump would have made the process slower and less effective," said Ana Maria.

The training Ana Maria attended was a result of joint planning by USAID's Reinforce Project and the Ministry of Health (MOH) to address the lack of equipment at the national, municipal, and health facility levels. Recently in such planning exercises, the MOH Department of Equipment Management committed to visit Covalima Municipality health facilities, train their staff on using and managing equipment, repair broken parts, and distribute pieces of equipment available at the national level. During the training, Zumalai health center received a new suction pump and a new autoclave.

For the past two years, USAID's Reinforce Project has been supporting the Ministry of Health of Timor-Leste to showcase a model municipality in Covalima. A strong focus has been on improving the clinical skills of health workers, especially for clean and safe delivery, newborn care, and family planning. As more health providers gain clinical competencies, the Project also is providing technical assistance to increase health facilities' readiness to provide services and increase their use by community members.

Like other health facilities in Covalima municipality, Zumalai health center and its health posts have received technical assistance from USAID's Reinforce. Zumalai now has six health professionals trained on family planning, with five competent in inserting at least one of the long-acting reversible contraception methods. Seven other health professionals are competent in providing clean and safe delivery and immediate newborn care and one has gained competency in emergency obstetric care. With an increasing number of well-trained health professionals on staff, the number of women delivering at the health facility has increased by 26 percent in Zumalai over the past two years. However, challenges remain and despite much progress in reaching MOH health facility readiness standards, Zumalai health center still lacked basic medical equipment.

The Department of Equipment Management from the Ministry of Health training the health facility personnel on the use and maintenance of a new suction pump.

Luckily some problems can be resolved and as described in this story, some diseases and disabilities can be treated and prevented. Lives can even be saved. Without the new pump and training, Midwife Ana Maria would have had to use an older, barely functioning pump, which would have possibly caused more problems for the baby and could have been fatal. The Project will continue to encourage national-level experts and decision-makers to ensure health facilities are well equipped, and that its health providers are competent to use the equipment to save lives.

Midwife Ana Bianco Lopes successfully operating the new suction pump to clean a newborn's airway and save him from suffocation.

ANNEX 7:

Community Leaders Discover the Power of Data

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USAID'S
REINFORCE BASIC HEALTH SERVICES
PROJECT

Community Leaders Discover **THE POWER OF DATA**

DECEMBER 2019

How often do you analyze and really look at data before making a big decision? In Timor-Leste, community leaders and health providers now are doing this, together, on a quarterly basis and it's beginning to make a difference in how they make decisions about improving health services in their communities.

Mrs. Modesta da Silva is a village chief who had participated in these quarterly community planning meetings previously, but had not paid much attention when data was being discussed. "Before, when I attended microplanning, I just focused on the action planning session. I did not pay much attention to the data the health officer was trying to show," she said. It turns out that Mrs. Modesta da Silva had never been taught how to read a graph, which was part of the reason why she did not pay much attention to the data portion of the microplanning meetings.

USAID's Reinforce, a health project implemented by JSI Research & Training Institute, Inc. (JSI), developed an orientation for microplanning participants, including Mrs. Modesta da Silva, on how to read and interpret data and make data-driven decisions.

"Now, it is clear for me," said Mrs. Modesta da Silva. "Before I make a plan to mobilize the community, I have to know the health information of my village and what needs to improve."

A39

"Before I make a plan to mobilize the community, I have to know the health information of my village and what needs to improve."

—VILLAGE CHIEF

In partnership with the Ministry of Health (MOH), USAID's Reinforce is working in Timor-Leste's Covalima Municipality to develop solutions to ensure that critical health services reach every person in every community. Helping to improve the microplanning process in communities like Mrs. Modesta da Silva's is one important way the project is doing this.

The microplanning methodology was originally developed by UNICEF and WHO to improve immunization coverage. Microplanning brings together health providers and health users (e.g., community leaders representing community members) on a quarterly basis to analyze, discuss, and use local health data to make decisions that improve health services and the health status of the community.

JSI used microplanning in Timor-Leste in 2012 to increase the number of children nationally who received three doses of the diphtheria, pertussis, and tetanus (DPT3) and measles vaccines. Through USAID's Reinforce, JSI re-introduced and revitalized microplanning in Covalima in 2015, the same year the project began working in the municipality. Both JSI and the microplanning teams noticed that several factors were hindering the effectiveness of the microplanning process. Therefore, to better meet community needs, JSI undertook a revision of microplanning as part of the revitalization efforts.

Why Was Microplanning Revised?

It wasn't just the lack of reading and interpreting data, as was the case with Mrs. Modesta da Silva. Some participants also needed more training in how to analyze and use the data to make decisions for planning. The USAID's Reinforce team knew they needed to better understand these barriers and so they looked into what was and what was not working for microplanning participants.

The team found that the preparation process for the quarterly meetings was too long and too dependent on external support. Participants, especially community leaders, said they did not find the data tables or charts easy to understand; there was too much information to absorb. Follow-up discussions after the quarterly meetings were often one-way: from community health centers to community leaders and not vice versa. Further, the action plans changed little from month to month, indicating that microplanning teams were not responding to variations in the quarterly data.

USAID's Reinforce used this information to revise the microplanning process. The updated process not only leveraged what was working, for example bringing community leaders and health workers to use local-level data, but also introduced a root cause analysis process and a simplified process to enable participants to more wholly own it.

How Was Microplanning Revised?

First, the USAID's Reinforce team streamlined the amount of data participants analyze at each meeting. Microplanning now focuses on indicators in three areas of particular interest to health facilities and communities: immunization, maternal health, and nutrition.

Next, the team created interactive dashboards for each set of indicators. Previously, data was presented in tables and static charts. However, microplanning participants often had trouble understanding and interpreting the data in this format. The new dashboards are more visually appealing and allow users to explore the data in greater detail, e.g., by time, location, and other elements (see Figures 2, 3 and 4).

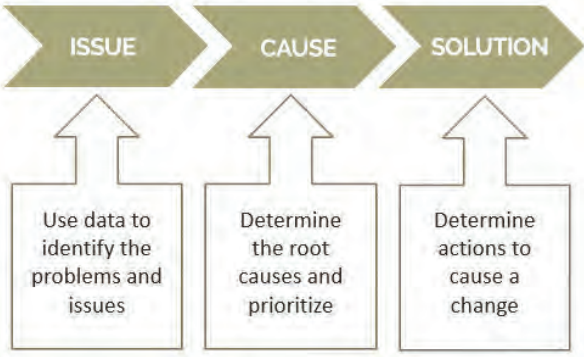
Then the team updated the action planning process and accompanying action plan template. Under the new process, participants first review the previous quarter's activities using current data, which helps them understand whether the activities they implemented made a difference. This also helps participants determine if the activities are complete, need to be continued, or need to be postponed.

Next, participants apply root cause analysis using the current quarter's data to prioritize new actions to be listed on the template. The root cause analysis process involves three steps:

1. Use data to identify the issues
2. Determine the root causes of the problem
3. Determine priority actions to change and create a solution

Previously, solutions clearly weren't working. Root cause analysis seeks to identify the origin of a problem and helps microplanning participants, like Mrs. Modesta da Silva, look deeper to figure out what is causing the problem so that they can agree on workable solutions. It pushes participants to think more about the possible causes behind persistent, recurring problems and develop specific actions to address those causes. For many participants, this was a new way of thinking about and using their data.

FIGURE 1. ROOT CAUSE ANALYSIS PROCESS



Finally, the USAID's Reinforce team developed an orientation to provide participants with the skills they need to conduct microplanning. The orientation covers: (1) understanding data and data-driven decision making (i.e., understanding the distinction between data and information, how data-informed decision- making happens, and what kinds of decisions can be made); (2) interpreting data (i.e., how to interpret different kinds of bar graphs); and (3) root cause analysis (i.e., what root cause analysis means and the three-step process mentioned above).

Through these revisions, the data is a continuous point of reference throughout the entire planning process. Activities require proof in the data to be continued or initiated.

FIGURE 2. IMMUNIZATION

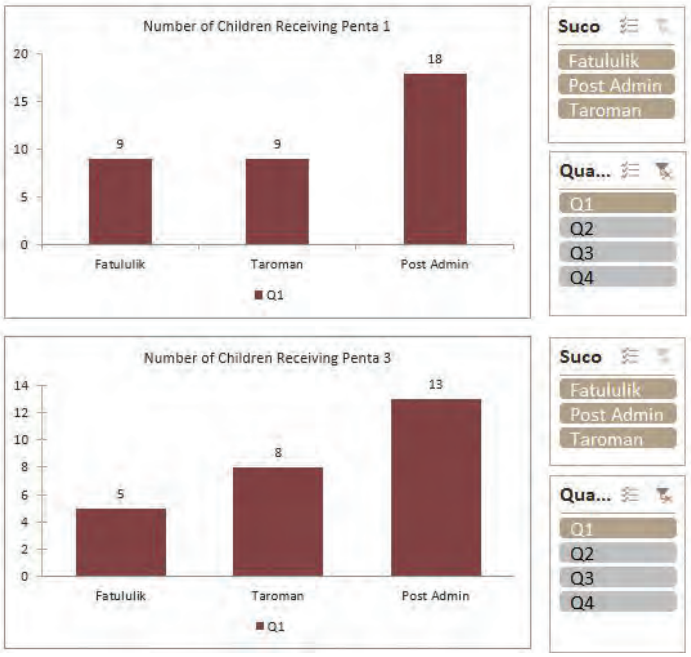


FIGURE 3. % OF <5 CHILDREN WEIGHED

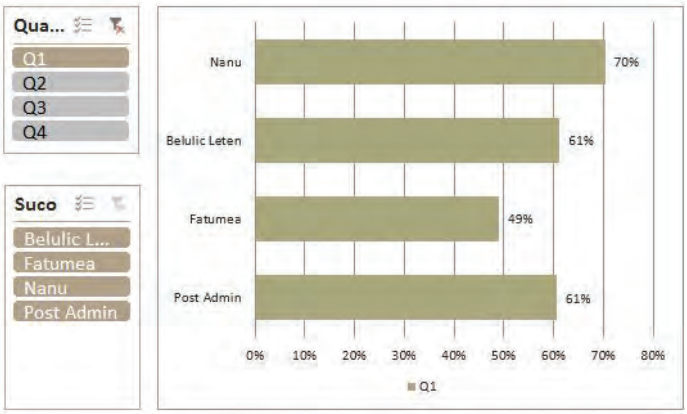
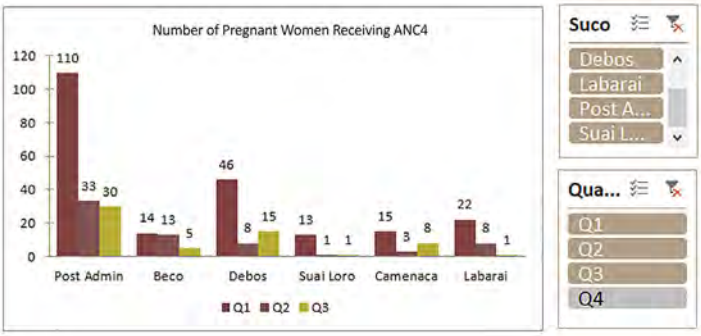


FIGURE 4. NUMBER OF PREGNANT WOMEN RECEIVING ANC4



A Data Awakening

At the request of the Ministry of Health, USAID's Reinforce conducted a pilot of the microplanning process in two of Covalima's seven administrative posts to determine if any further changes to the process are needed. The pilot included the orientation followed by a full microplanning meeting. Given the success of the pilot, the revised microplanning process has now been rolled out to all seven administrative posts.

The first orientation and microplanning meetings were held in Covalima's Tilomar administrative post in May 2018. Mrs. Modesta da Silva, the village chief, participated in the pilot. In addition to better understanding the causes of the health challenges in her village, she said that understanding the data also helps the microplanning team prioritize which activities need to be implemented first and where.

Similarly, the Tilomar community health center manager felt more engaged in the new microplanning process. He even asked for more indicators to be added to the process because the new dashboard makes it so much easier to monitor service progress on a quarterly basis. "The new microplanning tool is a good [way] to capture our information. I think it is really good how this tool can capture our data and automatically generate our data into graphs," he said.

Microplanning focuses on indicators in three areas of particular interest to health facilities and communities in Covalima: immunization, maternal health, and nutrition.

Moving Forward

Revitalizing the microplanning process in Covalima provided lessons for motivating health workers and community members to want to use data to improve the health of their communities:

- **Good data is not enough**. How data is presented is just as important as having good data. Presenting data in a way that is easy to interpret can make the difference between good data being used or not being used at all.
- **Interpreting data is a learned skill**. Just because data is presented in a "digestible" format does not mean it will be understood. Data interpretation is a learned skill and attention must be given to helping people acquire the skills needed to analyze and understand data.
- **Too much data is not always a good thing**. Many community leaders are not accustomed to reading and using data. Further, anyone inundated with too much data cannot easily distinguish between what is "nice to know" and what is "need to know." Tailoring the amount of data helps users focus on key questions and specific areas for improvement.
- **Microplanning must build in data use**. Having good data does not mean the data will be used. Creating a microplanning process with built-in steps that require data to be analyzed before identifying problems and generating solutions helps ensure data is used as an integrated part of the decision-making process.
- **Microplanning must be flexible**. The tool recognizes that each geographical area is unique and may need to collect and use different data. The dashboards are easily customizable to include different kinds of data.
- **Microplanning must be owned by the government**. To sustain microplanning, USAID's Reinforce developed a transition plan to build the capacity of Ministry of Health staff and community leaders to fully manage microplanning moving forward.

ANNEX 8:

Activity Report: 4R Training in Covalima Municipality

Follow-up with Selected Health Workers

USAID's Reinforce Basic Health Services Project

ACTIVITY REPORT: 4R Training in Covalima Municipality Follow-up with Selected Health Workers

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USAID'S REINFORCE ACTIVITY REPORT: 4R Training in Covalima Municipality, Follow-up with Selected Health Workers

Cooperative Agreement No. AID-472-A-16-00001

Prepared by
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Cover Photo: Broad Timorese participation in training, Covalima, Timor-Leste. (Staff photo)

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USAID'S REINFORCE ACTIVITY REPORT: 4R Training in Covalima Municipality, Follow-up with Selected Health Workers

1. Background

During 2018 and 2019, USAID's Reinforce Project contracted PRADET[1] to deliver the 4R training to Covalima municipality health workers, in order to teach them about how to *recognize*, *respect*, *respond* to, and *refer* victims of domestic violence to appropriate psycho-social, medical and legal services. The two-day training used interactive PowerPoint presentations with photos, questions and answers, and group work around case studies. Using examples from PRADET's experience, the facilitators taught participants about non-accidental injuries (physical and behavioral signs), attitudes health workers need to adopt during encounters with victims, and the role of primary health care workers. Finally, the mandate of organizations forming the network of services to assist victims of domestic violence was explained by guest speakers from each of these organizations (police, shelters, social services, legal services, etc.). See Box 1 for the main content of the 4R training.

Box 1. 4R Training Content – Examples

Physical signs of non-accidental injuries – a bruise on the ear showing ear pulling, a bruise around the neck showing strangulation, a bruise around the upper arm showing the victim was grabbed, a sexually transmitted infection (STI), multiple injuries or pattern of repeated injury, a straight wound in the back, bone fractures in infants, weak neck and heavy head in babies showing they were shaken, abdominal pain, etc.

Behavioral signs of non-accidental injuries – (for women) nervous, panic attacks, depression, attempted suicide, sleeping or eating problems, the story of injuries does not match physical symptoms, uncomfortable when husband is there, etc.; (for children) does not trust adults, low self-esteem, delayed speech, acting like a much younger child, fear of parent, anxious, tells someone s/he was sexually abused, etc.

Health workers' attitudes to show respect to patient – listen to him/her attentively, believe what s/he says, do not blame or judge, provide information without telling what she must do, support his/her decision, etc.

Health workers' role during consultation with victims – provide the medical first response (e.g., cleaning wounds); explain and refer the victim to appropriate services (legal, social…); ensure the patient's privacy. S/he can ask what caused the injury, but not question or imply doubts about it, and his/her role is not to mediate between the victim and his/her perpetrator.

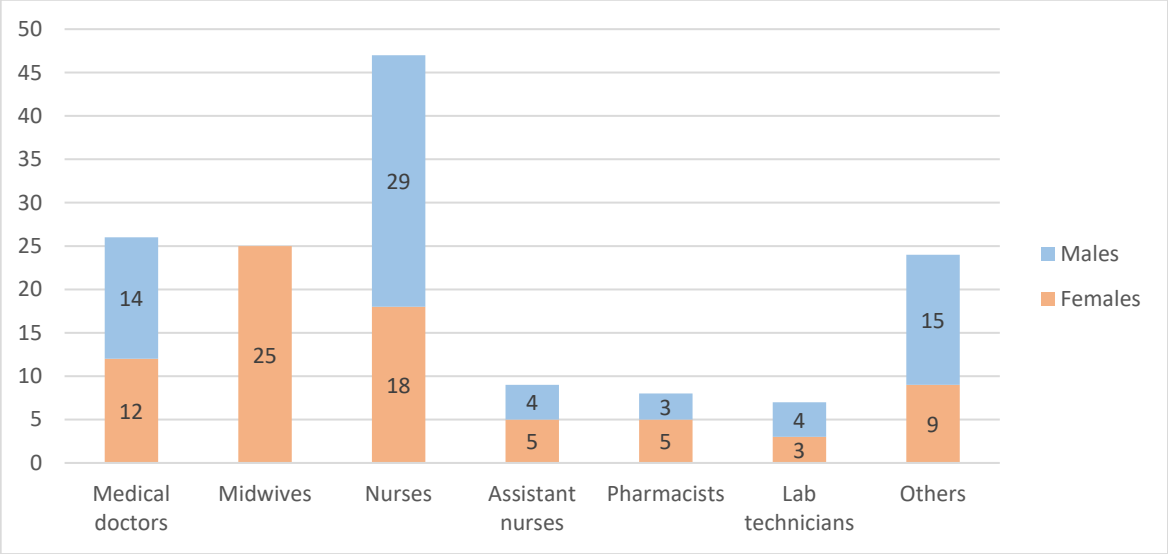
Network of psycho-social, medical and legal services – *Uma Mahon Salele* (shelter/refuge for women and children); *Asisténsia legál ba Feto no Labarik,* or ALFeLa, (legal advice and assistance to women and children and advises on progress of cases); child protection officer (social assistance); Vulnerable Population Unit (VPU) of the police (protection and report crimes); FOKUPERS (shelter/refuge for women and children); and

[1] PRADET or "Psychosocial Recovery and Development in East Timor" provides psycho-social services at the country's five *Fatin Hakmatek* (quiet places) located in Dili and the five referral hospitals. The *Fatin Hakmateks*, including one in Covalima, are staffed with a midwife counselor who has been certified as a medical forensic examiner and who has established networks of stakeholders protecting victims of domestic violence, including the national police, the justice system, and civil society organizations.

PRADET (medical treatment, forensic examination, counseling and temporary shelter with basic food/clothes needs).

As shown in Figure 1, USAID's Reinforce provided training for 146 personnel (77 females and 69 males). While the training was delivered mostly to health workers, it also included administrative and maintenance staff in order to sensitize them to the issue of domestic violence and the role their workplace plays in addressing it. The training was provided to health workers from 17 health posts (HPs), all community health centers (CHCs), the Referral Hospital, and the Municipality Health Services (MHS), split into four batches in 2018 (95 participants) and two batches in 2019 (51 participants).

Figure 1. Number of Personnel Trained per Profession Categories



2. Follow-up after Training

In 2020, USAID's Reinforce conducted interviews with selected health workers trained on the 4R in March and April 2018, and in May 2019, with the objectives of: (1) measuring the knowledge health workers retained one or two years after the training, (2) learning about how their attitude changed following the training, and (3) collecting stories about their experience dealing with victims of domestic violence at their health facility. USAID's Reinforce received exemption from human subject oversight from JSI's Institutional Review Board (IRB) before starting the activity.[2]

Tools and Methods

2 No identifiers or sensitive questions that could result in harm; no participants less than 18 years of age.

Interview guide – The short questionnaire used as interview guide included an informed consent form, questions directly related to the theory taught during training (ability to cite non-accidental physical injuries or behaviors that could indicate that there was domestic violence; knowledge about their role as health workers dealing with victims; and knowledge about the referral network), questions about their attitude toward victims and domestic violence, and questions related to their experience dealing with victims of domestic violence. The guide, initially developed in English, was translated into Tetum, the national language.

Selection of interviewees – Interviewees were selected from the four villages (sucos) where USAID's Reinforce trained community leaders on domestic violence, the ways to prevent it and the referral network: Debos (Suai Vila), Fatuleto (Zumalai), Holpilat (Maucatar), and Maudemo (Tilomar).[3] From that first list, 13 health workers were selected based on their profession (priority being given to medical doctors, midwives and nurses due to their likeliness to have dealt with cases of domestic violence). See Table 1.

Table 1. List of Health Workers Interviewed

No.	Profession	Sex	Workplace	Year of training
1	Midwife	F	Tilomar CHC	2018
2	Nurse	M	Maucatar CHC	2019
3	Medical doctor	F	Matai HP	2019
4	Nurse	M	Tilomar CHC	2018
5	Medical doctor	M	Tilomar CHC	2018
6	Midwife	F	Suai Referral Hospital	2019
7	Midwife	F	Suai Vila CHC	2018
8	Medical doctor	F	Suai Vila CHC	2018
9	Midwife	F	Suai Vila CHC	2018
10	Medical doctor	M	Zumalai CHC	2018
11	Midwife	F	Zumalai CHC	2018
12	Nurse	M	Zumalai CHC	2018
13	Midwife	F	Ogues HP	2019

Training, tool pre-test and field work – Two of USAID's Reinforce staff experienced in conducting interviews were trained on the use of the guide in June 2020. Following the training, both interviewers tested the tool with colleagues and made slight adaptations accordingly. The 13 interviews were conducted during the first week of July 2020.

3 USAID's Reinforce. 2020. Community Leaders Training on Domestic Violence and Health and its Post-Survey.

Results

Knowledge retained from training

Nine of the selected health workers (9/13) could name three non-accidental injuries indicating there was or could be domestic violence. The most commonly cited injury were vaginal tears and STIs (both mentioned nine times), followed by swollen head and/or other parts of the body, cuts over the body, bruises on various parts of the body, and a black eye.

Similarly, most interviewees (11/13) named three or more behavioral signs that could indicate a patient is victim of domestic violence. Most signs cited were fear and cries (mentioned nine times each), followed by trauma and silence (six times each) and stress and depression (three times each), while signs like not acting normal, no willingness to eat, unable to calm down, embarrassment, and distancing from others, were less often mentioned.

Interviewees were also asked to describe how they would show respect to a patient that seems to be a victim of violence. All of them provided more than two examples, using different strategies to establish a respectful relationship with the patient. The most commonly cited strategies were speaking softly, listening to the patient, bringing him/her to a private room to ensure confidentiality, calming down the patient, establishing a trusting relationship and slowly asking about what happened without judgement, and showing belief in his/her story. Several other very relevant behaviors were mentioned such as showing empathy and moral support, providing adequate services including counseling, and looking for solutions with the patient without forcing any decision. A midwife from Suai Vila CHC perfectly summarized the process: *"take the patient separately from others, show a friendly face and establish a trusting relationship, listen without judgement or blaming, and calm the victim before asking questions, without forcing the victim to speak out about her/his problem if s/he's not ready and tell her/him that you will keep all the information s/he gives confidential."*

An important topic of the training was defining the role of primary health care workers, first to attend to victims of domestic violence (they often are the first persons that victims meet following a violence event), and second to refer the patient to appropriate psycho-social, medical and legal services. To measure if they understood well their role, the selected health workers were asked to agree or disagree with a few statements concerning their role and the attitude they should adopt when attending victims. All interviewees correctly agreed that their role was to provide basic medical treatment such as cleaning wounds and refer patients to appropriate services. All of them also mentioned they should ask about the cause of the injury and keep the conversation strictly confidential. However, four interviewees considered they also had a role to play in mediating between the victim and his/her perpetrator, while this is clearly the role of the justice sector. In addition, eleven health workers also mentioned they could or should question the truth of the patient's story.

As stated above, the referral network of services for victims of domestic violence was a key topic of the training, important for health workers to know in order to refer victims to appropriate psycho-social, forensic/secondary or tertiary medical, and legal services. Most interviewees (11/13) could explain the role of *Uma Mahon Salele* and the police; ALFeLa and OPL were correctly defined by nine interviewees, while the role of FOKUPERS and PRADET were less known with six and eight interviewees providing adequate answers respectively. Overall, the details provided for the referral network organizations were

very general, often lacking the key words expected for each, e.g., “legal” for ALFeLa, “forensic” for PRADET, “security” for the police, etc.

Attitudes and feelings

All interviewees stated they have paid more attention to patients who are or might be victims of domestic violence since they followed the 4R training. A midwife from Suai Vila CHC mentioned: *“when I observe physical wounds or behaviors (that could indicate domestic violence), I provide counseling to the victims so that I can refer them to legal organizations, but that depends on the victims’ decision.”* A female doctor from the same facility stated: *“I pay more attention to patients who are victims of domestic violence, and help them find ways to resolve their problems.”*

Eleven interviewees reported feeling safe counseling patients on a sensitive topic like domestic violence. Their main reasons were that it is their duty, they now have the knowledge to provide better counseling, the information is confidential, they have protection from the police, they have the trust from the victims, and feeling solidarity with othr women. These reasons are well summarized by this female doctor from Suai Vila CHC: *“we need to provide support to other women so that they get justice; and we feel for them, we have the security from the police, and this is our role as health provider.”* The two health workers who stated that they did not feel safe feared threats from suspects or the family.

Experience with victims at the consultation

Three health workers out of the 13 interviewed mentioned that since they were trained, they have assisted victims of domestic violence attending their consultation.

A male doctor from Zumalai CHC assisted three victims who came to his consultation. All were women who had been beaten by their husbands. The doctor brought them to a private room to ensure the confidentiality of the conversations, treated their wounds, and provided thorough information on the various organizations, which could help them with legal and psycho-social services, as well as shelter if needed. Two of them decided to report their case – one preferred going back home and resolve the problem among family members – so the doctor prepared letters outlining his observations that the victims brought to the police. The role of the doctor was crucial in these cases as the victims did not know about their rights and had never heard of the support services available to them.

A female doctor from Suai Vila CHC received a mother coming with her baby who was not growing adequately. The mother was barely breastfeeding the baby, who was receiving formula milk instead. During the consultation, she observed that the mother also was malnourished, and through the conversation understood that the cause was domestic violence perpetrated by the husband. The doctor followed what she learned during the 4R training and informed the mother that help was available for her and her baby through the referral network to help victims of domestic violence. However, she did not want to report her problem, concerned that it would get worse. The doctor’s other concern was the malnutrition of both the mother and the baby. She provided counseling to ensure that first, the mother eats nutritious food for herself and to produce sufficient milk for her baby, and then she helped her with her breastfeeding technique. The doctor made sure the mother comes back every month to monitor her

weight and the one of the baby, and slowly their conditions improved. The doctor mentioned that as the baby is almost six months, the next visit will include family planning counseling. This case shows that despite the fact that the doctor could not refer the mother to the network, as a health worker she followed up to improve the victims' nutrition status.

Finally, a midwife from Suai Vila CHC told the story of a patient who came for antenatal care (ANC) with a swollen black eye. She asked about the cause of the wound and found out her husband had hit her. The midwife counseled the patient about the various organizations mandated to assist victims of domestic violence, but the victim refused to bring her case further because she was concerned her husband would be arrested. The woman continued her ANC at Sanfuk HP.

In addition to these cases, two health workers from Tilomar CHC reported occasional encounters with victims of domestic violence – mainly women coming for ANC – coming from the *Uma Mahon Salele* (refuge). While these patients were already taken in charge by the various services of the network, Tilomar CHC personnel trained on the 4R is now better equipped to respond to these patients' needs.

Domestic violence in the community

Seven respondents stated there was domestic violence in their community, and among these, two had discussed the issue with their community leaders. Whether they felt domestic violence was prevalent or not, almost all (11/13) provided ideas about ways to prevent it in their community. The main means proposed were: disseminating information to the community; educating young people; disseminating information on the impact of early marriages; educating young couples; socializing the law on domestic violence; strengthening information on family planning as a way to improve families' finances; and sharing information to the community about organizations helping victims.

These topics were delivered to members of suco councils from Fatuleto, Maudemo, Debos and Holpilat in September and October 2019, who in turn, disseminated crucial domestic violence prevention and health information to their community.[4]

3. Conclusion

Among the 13 health workers interviewed, the content of the 4R training was very well retained. Most interviewees still knew the physical and emotional signs showing non-accidental injuries might have happened. All interviewees could still described how to show respect to patients victim of domestic violence coming to their consultation, and most of them could explain the mandate of the organizations forming the referral network of legal, psycho-social and medical services for victims. The 13 health workers stated they had been paying more attention to patients who are or might be victims of domestic

4 USAID's Reinforce. 2020. Community Leaders Training on Domestic Violence and Health and its Post-Survey.

violence since they followed the 4R training, and 11 felt safe and comfortable discussing this issue with patients.

Among the few health workers who reported assisting victims of domestic violence, the correct procedure was followed, including recognizing there was domestic violence, providing appropriate health treatment, providing counseling in a private room to keep the confidentiality, and informing about the referral network for assistance. Thanks to a Zumalai CHC doctor, two victims accessed support services they were not aware of before discussing with the doctor, while a doctor from Suai Vila maintained very close follow-up with a mother and her baby suffering malnutrition as a consequence of domestic violence. Finally, Tilomar CHC health workers are better equipped to support the women and children living in Uma Mahon Salele and requiring their health services.

ANNEX 9:

Primary Health Care Doctors Help Victims of Domestic Violence

Primary Health Care Doctors Help Victims of Domestic Violence

In Covalima Municipality, 51 percent of women age 15-49 have experienced physical, sexual, or emotional violence committed by their husbands. This is ten percent higher than the already very high national average in Timor-Leste. Victims of domestic violence rarely report to the police, however, they are likely to meet with their primary care providers, either to treat their wounds or to use routine preventive services.

Given the magnitude of the problem, USAID's Reinforce, a project providing technical assistance to improve maternal, newborn and child health and family planning services in Covalima, addressed the issue by including domestic violence in its capacity-building package. In 2018 and 2019, the project collaborated with PRADET, a local organization providing psychosocial assistance to victims of domestic violence, to train 146 health workers on the "4Rs." Health workers learned how to **r**ecognize, **r**espect, **r**espond to, and **r**efer victims of domestic violence to appropriate psychosocial, medical, and legal services.

Cipriano de Jesus dos Santos and Celina de Jesus Nunes are two young medical doctors from Zumalai and Suai Vila community health centers. Like many other colleagues from health facilities in the municipality, Dr. Cipriano and Dr. Celina received intensive training from USAID's Reinforce, and both participated in the 4R training in 2018.

Dr. Cipriano believes that to show respect to a patient who has experienced domestic violence, health workers need to "give trust, listen with respect, and provide a solution to resolve problems." Since he attended the 4R training, three women who had experienced domestic violence came to his consultation in Zumalai Health Center. All three had been beaten by their husbands. Dr. Cipriano brought them to a private room to ensure confidentiality, treated their wounds, and provided information about organizations that could help with legal, psychosocial, and shelter services. Two women decided to report their cases and one woman preferred to resolve the problem among family members. For the women who chose to report, Dr. Cipriano prepared letters outlining his observations, which the women brought to the police. Dr. Cipriano's role was crucial because the women did not know their rights and had never heard of the services available to them.

"I feel safe and comfortable providing counseling to victims of domestic violence because I feel it's one of the duties of health workers." – Dr. Cipriano

In Suai Vila Health Center, Dr. Celina received a mother coming with her baby who was not growing adequately. The mother was barely breastfeeding the baby, who was receiving formula milk instead. During the consultation, she observed that the mother also was malnourished, and through the conversation understood that the cause was domestic violence perpetrated by the husband. Dr. Celina followed what she learned during the 4R training and informed the mother that help was available for her and her baby through a referral network to help people who have experienced of domestic violence. However, the woman did not want to report the violence, concerned it would become worse.

"To show respect to a victim of domestic violence, health workers need to keep confidentiality, establish trust, talk with a soft voice so that the victim can give information (…) we need to provide support to other women so that they get justice; we feel for them and this is our role as health providers."

Dr. Celina's other concern was the malnutrition of both the mother and the baby. She provided counseling to ensure that the mother first eats nutritious food for herself and to produce sufficient milk for her baby, and then she helped her with her breastfeeding technique. Dr. Celina made sure that the mother came back every month to monitor her and her baby's weight, and slowly their conditions improved. Dr. Celina mentioned that as the baby is almost six months old, the next visit will include family planning counseling. This case shows that despite the fact that Dr. Celina could not refer the mother to the network, as a health worker she was able to improve the victims' nutrition status.

Both young doctors stated that it was important to prevent cases like these in their community, and that community leaders had a key role to play by informing the community. Dr. Cipriano proposed that community leaders be trained on the referral network and the law against domestic violence, while Dr. Celina added that it was important to share information about family planning to improve the economy of households and prevent many cases of violence in families.

ANNEX 10:

SBC Materials for BPCR – Benvinda Angela and Home Reminder Poster

INFORMASAUN IMPORTANTE KONA-BA ISIN-RUA NO LORON PARTU !

KONSULTA HO PESOÁL SAÚDE IHA FASILIDADE SAÚDE

Vizita I loron ..... / fulan ..... / tinan .....

Vizita II loron ..... / fulan ..... / tinan .....

Vizita III loron ..... / fulan ..... / tinan .....

Vizita IV loron ..... / fulan ..... / tinan .....

Data partu
loron ..... / fulan ..... / tinan .....

Fatin Partu

☐ Iha fasilidade.....

☐ Iha uma ho asistensia husi pesoál saúde

No. telefone parteira
.....
No. telefone médiku
.....

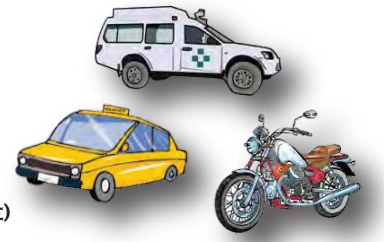
TRANSPORTE EMERJENSIA (BAINHIRA INAN PRESIZA BA LALAIS FASILIDADE SAÚDE)

Ambulancia: ..... (No. telefone)

Policia: ..... (No. telefone)

Transporte emerjensia komunidade: ..... (No. telefone)

Seluk (angguna...): ..... (No. telefone)



BUAT NE'EBÉ FAMILIA TENKE HANOIN KONA-BA LORON PARTU

RAI OSAN

HAHAN NO TERMUS BEE MANAS

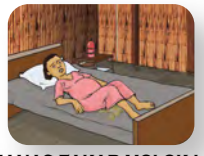
ROUPA BA BEBÉ NO INAN

INAN SIRA TENKE BA LALAIS FASILIDADE SAÚDE BAINHIRA HETAN SINÁL PERIGU !

Sinál Perigu Durante Isin-Rua

RAAN-FAKAR DURANTE ISIN-RUA

ISIN-MANAS MAKA'AS



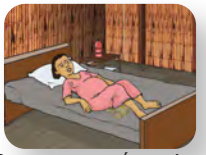
BEE-MANAS FAKAR MOLOK LORON DATA PARTU NIAN

MUTA HELA DE'IT KA LAKOHI HAN KA LA HAN LIU

BEBÉ LADUN BOOK-AN KA LA BOOK-AN LIU

AIN, LIMAN, KA OIN BUBU HO ULUN MORAS NO/KA KONVULSAUN

Sinál Perigu Durante Partu



BEE-MANAS KÓR FO'ER NO DOIS

ISTIKA-AN (KONVULSAUN)

RAAN-FAKAR

BEBÉ NIA LIMAN, AIN KA KA'AN (PLASENTA) MAK SAI ULUK

INAN LAIHA FORSA NATO'ON ATU HAKA'AS-AN

PARTU KLEUR NO HO PROBLEMA (OBSTRUKSAUN)

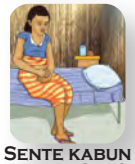
Sinál Perigu Hafoin Partu

ISIN-MANAS

SUSUN-MATAN KANEK HO SUSUN-KULIT MEAN (MASTITIS)

RAAN-MUTIN DOIS SAI HUSI DALAN MORIS

RAAN-FAKAR MAKA'AS HUSI DALAN MORIS



SENTE KABUN KIDUN MORAS

DEPRESAUN (HANESAN TANIS NE'EBÉ LAIHA RAZAUN, NO LAKOHI KUIDADU NINIA BEBÉ)

OIN, LIMAN KA AIN BUBU, AKOMPAÑA HO ULUN-MORAS KA ISTIKA-AN (KONVULSAUN)

USAID HUSI POVU AMERIKANU
JSI
Ministério da Saúde
UNIAUN EUROPEIA
unicef for every child

ANNEX 11:

SBC Materials for FP – FP Wallchart

ITA BOOT HATENE MÉTODU PLANEAMENTU FAMILIAR NE'EBÉ EZISTI IHA TIMOR-LESTE?

Pesoal saúde bele ajuda

MÉTODU OVULASAUN BILLINGS (MOB)

- Métodu ovulasaun Billings hanesan métodu natural ida ne'ebé iha ona inan feton nia isin lolon,hein nia deskobre atu uza
- Bele uza hodi deskobre inan ida nia tempu buras ka maran

Vantajen:

> Métodu ne'e nudar métodu natural, simples, saudavel, diak no laiha efeitu ba isin
> La uza aimoruk
> La gasta osan
> La presiza vizita fasilidade saúde bebeik

Desvantajen:

> Prezisa komprende malu, komunikasaun diak, disiplina no komitmentu
> Iha tempu buras, la bele halo relasaun seksual

MÉTODU STANDAR LORON-LORON

- Uza kolar ne'ebé marka ho kor husi musan sira atu ajuda feto ida hatene wainhira mak nia buras no laburas tuir siklu menstruasaun
- Loron-loron muda kadeli husi musan ida ba musan seluk iha kolar. Wainhira kadeli tama iha musan kor mutin signifika katak labele halo relasaun seksual hodi prevene isin-rua
- Efetivu ba feto kuandu ninia menstruasaun regular ona durante fulan 3 to'o 6

Vantajen:

> La iha efeitu fiziku tanba la uza aimoruk
> La presiza vizita fasilidade saúde bebeik
> La gasta osan

Desvantajen:

> Prezisa komprende malu, komunikasaun diak, disiplina no komitmentu
> Iha tempu buras, la bele halo relasaun seksual

MÉTODU AMENOREIA LAKTASIONAL (MAL)

- MAL hanesan métodu planeamentu familiar ne'ebé bazeia ba fó-susu, husi bebe moris to'o bebe fulan 6
- Métodu ne'e efetivu wainhira inan fó-susu eskluzivu ba nia bebé (fó susu bebeik, kalan no loron, no la fó han ka hemu buat seluk).

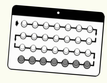
Vantajen:

> La iha efeitu fiziku tanba la uza aimoruk
> La presiza vizita fasilidade saúde bebeik
> La gasta osan

Desvantajen:

> Presiza inan nia motivasaun no disiplina.

PIL ORAL KOMBINADU



- Kontraseptivu ne'e iha hormoniu rua: estrogen no progesteron
- Halo mahar mukus iha servix no prevene ovulasaun atu nune'e inan sei la isin-rua
- Hemu pil ida loron-loron

Vantajen:

> Efetivu wainhira hemu loloos no tuir regras

Desvantajen:

> Haluha hemu pil bele halo isin-rua wainhira halo relsaun seksual
> Nia efeitu bele halo ulun moras ka oin halai, todan aumenta ka menus
> Menstruasaun bele iha mudansa (barak, oituan, ka la regular)

PIL PROJESTIN-DE'IT

- Kontraseptivu ne'e hanesan Pil Kontraseptivu Oral Kombinadu, maibe ho hormoniu ida de'it
- Pil ne'e espesialmente ba inan sira ne'ebé fó-susu ba sira-nia bebé. Bele hahu hemu husi partus to'o fulan 6
- Hemu pil ida loron-loron iha oras hanesan

Vantajen:

> Efetivu wainhira hemu loloos no tuir regras

Desvantajen:

> Haluha hemu pil bele halo isin-rua wainhira halo relasaun seksual
> Nia efeitu bele halo ulun moras ka oin halai
> Menstruasaun bele la regular ka la mai

INJESAUN

- Nu'udar métodu hormonal ne'ebé hetan husi injesaun ho doze ida iha 150mg
- Halo mahar mukus iha servix no prevene ovulasaun atu nune'e inan sei la isin-rua
- Fulan 3 dala 1 simu injesaun

Vantajen:

> Efetivu no seguru durante fulan tolu nia laran

Desvantajen:

> Bele halo ulun moras ka oin halai, todan aumenta, no mudansa iha menstruasaun (barak ka oituan, la regular, ka noda)

INTRAUTERINU COPPER T (IUD)

- IUD mak iha forma plastiku ki'ik ida ne'ebé bele ajuda atu fo espasu ba oan
- Parteira ou médiku ne'ebé treinadu ona mak hatama ba inan nia uterus ou oan fatin
- Satan esperma atu la bele hasoru malu ho óvulu

Vantajen:

> Efetivu no seguru durante tinan 5 to'o 10
> Wainhira hasai IUD, inan bele isin-rua fali iha tempu badak nia laran

Desvantajen:

> Bele halo menstruasaun naruk, ran sai oituan entre menstruasaun (noda), no senti moras oituan iha kabun kidun. Normalmente inan sei senti diak fali iha tempu badak
> Presiza prosedimentu kiik atu hatama no hasai

KONTRASEPTIVU IMPLANTE

- Implante forma husi plastik hanesan kesak ne'ebé iha progesterin ne'ebé hatama ba iha liman kabun kulit okos
- Halo mahar mukus iha servix no prevene ovulasaun atu nune'e inan sei la isin-rua

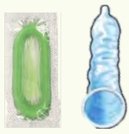
Vantajen:

> Efetivu no seguru durante tinan 3 to'o 5
> Fasil atu uza

Desvantajen:

> Nia efeitu bele halo ulun moras, laran sa'e, mudansa iha todan, no menstruasaun sai oituan de'it ka la regular (bele mosu)

KONDOM



- Kondom ne'e halo husi borraxa latex mihis no uza ba iha penis wainhira eresaun

Vantajen:

> Bele uza hanesan métodu planeamentu familiar hodi prevene isin-rua, no mos atu proteje feto ho mane husi moras sira ne'ebé hada'et husi relasaun seksual, hanesan HIV/AIDS
> Fasil atu uza no lori ba mai
> La iha hormoniu hanesan métodu sira seluk ne'ebé fó efeitu hormonal

Desvantajen:

> Ladun fiar an atu uza

TUBEKTOMIA (BA FETO)

- Tubektomia mak métodu ida atu prevene isin-rua permanente ba feto sira ne'ebé lakohi tan hetan oan
- Sirujia ki'ik ne'ebé seguru no simples

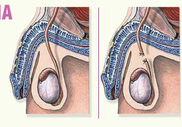
Vantajen:

> Efetivu teb-tebes (kuaze 100%) no permanente
> La iha efeitu konaba abilidade seksual ka sentimentu

Desvantajen:

> Depois de sirujia, bele senti moras, bubu no ran sai oituan-oituan, maibe ne'e sei lakon depois de loron balu

VASEKTOMIA (BA MANE)



- Vasektomia mak métodu permanente ba mane sira ne'ebe lakohi iha oan tan

Vantajen:

> Efetivu teb-tebes hahu fulan 3 depois de prosedimentu (kuaze 100% efetivu) no permanente
> Sirujia ne'ebé simples no seguru, ne'ebé halo de'it iha minutu balu nia laran
> La iha efeitu kona-ba abilidade seksual ka sentimentu

Desvantajen:

> Depois de sirujia, bele senti moras, no bubu, maibe ne'e sei lakon depois de loron balu

Ministério da Saúde

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JSI RESEARCH & TRAINING INSTITUTE, INC.

Ita nia saude iha ita nia liman rasik

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ANNEX 12:

SBC Materials for FP – FP PSAs

Family Planning PSA Scripts

1. PSA 1 (focus on young couples)

Part 1: In the small shop

Client	:	Hello…
Kika	:	Hi there... what do you need?
Client	:	Milk, please.
Kika	:	How much?
Client	:	One dollar.
Kika	:	Thank you.
Community	:	No problem! See you later!
Kika	:	See you!

Part 2: Kika reads a story to Koukou and Nela comes and visits Kika's family

Kika	:	Let me read you a story! This is the story of a horse and a frog. The frog was huge and very hungry. She jumped into the water, looking for food. The frog couldn't find anything to eat… Hi Nela…
Nela	:	Good afternoon, Kika… Good afternoon, Koukou… How are you?
Kika	:	Oh… thanks, we're all doing well!
Nela	:	Here, Koukou, I have an orange for you.
Koukou	:	Thank you, auntie Nela.
Nela	:	You're welcome.
Kika	:	Sit down, Nela.
Nela	:	Thank you.
Kika	:	Whose motorcycle is that? Is it new?
Nela	:	No, that's Jony's… He still has exams. Poor him, he hasn't gone out for the past three weeks, he's studying non-stop!
Kika	:	Did Jony and you decide to get married after you both graduated?
Nela	:	Yes, maybe in a year from now, because we need to find some work first and have enough money to sustain our family.
Kika	:	That's good!

Part 3: Atoy comes back from work

Koukou	:	Daddy…
Atoy	:	Hello, Koukou… oh, you're getting so big now! Hi Nela, how are you?
Nela	:	I'm fine, thank you! I really like Koukou… she looks great, beautiful, and very smart!
Atoy	:	Thanks Nela, she's very healthy indeed! I must say that Kika always teaches her many different things, like drawing, learning about animals, and also how to play ball.
Kika	:	Koukou loves when I read her stories, she's so eager to learn!
Nela	:	She's already more than two, you guys don't want to give her a brother or sister?
Kika	:	Ahhhh… Why is everyone asking us that question all the time?
Atoy	:	Exactly! So Nela, you too now are asking that?
Kika	:	For sure we want to, that's normal, but it's too early. We both decided to wait at least three years before we have another child.

Atoy : This way we make sure we're all healthy and have enough time to spend with our child. And then, we both have time to work and sustain the family, and we have time to look after Koukou's development. Right, mom?
Kika : Right!
Nela : Tomorrow it's Saturday and Jony and I don't have classes. If you want we could all go to the beach… and you too, Koukou!

Voice Over : Family planning is good for parents who just started a family!
It is better to wait at least three years between pregnancies to ensure spacing between your children.
You can get information about the family planning program in all health facilities.

2. PSA 2 (focus on the benefit of FP for the family's nutrition)

Part 1: Joana sits on the veranda and calls her mom to help her with her homework; Joao and his dad play ball in the garden

Joana : Mommy…
Maria/Mom : Tell me sweetie…
Joana : Mom, today at school we learned drawing, I don't really get it, mommy can you help me?
Maria : Sure, mommy's always happy and always has time to help. What do you need to do? You color here… and add color here too…
Joao : Yes! Daddy, stand far from me OK?
Sicu/Dad : Ready!

Part 2: The family gathers on the veranda

Maria : Wow… you're both wet and looking happy!
Sicu : Yes, we're sweating, and that's good for our health. Tomorrow we play again, but Joana will be on my team, and Ajaun will be on mommy's team. Ready for that?
Maria, kids : Yes!
Maria : Great. Tomorrow we play again, but now we need to rest, take a shower… and cook dinner.
Sicu : Mom, I'll prepare tonight's dinner. Today you can have them take their shower!
Maria : Ah that's a good idea, Dad! Thanks Dad! Now let's go take a shower.
Joana : Daddy, I'm hungry, I need to eat.
Sicu : Yes. Let's go wash our hands and we can all go eat.
Joao : I'm hungry, me too, I need to eat!
Sicu : Yes, we can all eat now!

Part 3: At the dinner table

Maria : Dad, I'm so happy with our family, we have time to have fun with the kids, and time to teach them and look after them! It's even easy to find time to share the household tasks.
Sicu : Yes, I also feel blessed with my life, I feel the three of you are the best present for me! OK, we're all hungry, let's eat!

Voice Over : **Family planning makes the whole family happy because parents have time to spend with every child.**
It is better to wait at least three years between pregnancies to ensure spacing between your children.
You can get information about the family planning program in all health facilities.

3. PSA 3 (focus on the benefit of FP for the interaction between parents and children)

Part 1: At the market

Agus : Hi Amanu, how are you?
Amanu : I'm good.
Agus : Buying vegetables? Which ones?
Amanu : I bought this one, then I'll buy another type. Are you also buying vegetables?
Agus : No, Dydy bought some this morning. I just came to buy this chicken and some bananas, because the kids really like them, and this chicken, with the vegetables bought this morning, will be enough for lunch and dinner. That's a lot of vegetables that you bought today!
Amanu : Well… with many children… you know… you need to buy a lot of vegetables. And the problem is that I can't buy what you just bought.
Agus : Sure… with many children, you need money to feed them! So Amanu, see you later… Oh wait Amanu… come… I'm your friend, and I need to tell you and also your wife, maybe you should go to the health facility to get some information about family planning…
Amanu : Thanks a lot. Thank you for the information. I'll think about it.
Agus : OK.
Amanu : OK good. Thank you.

Part 2: When Amanu comes back from the market

Amanu : Azo, Tita… Daddy's back!
Mom : Let's wash hands.
Azo : Mommy, why do we need to wash hands before eating?
Mom : We need to wash hands before eating because it's important for your health. This way you won't be sick, your tummy won't hurt, and you'll stay healthy. OK… hands are clean!
Azo : Mom… I like eating oranges.
Mom : Do you want to eat an orange? Tita, eat your banana, OK? Amanu, I'm really happy about what we both decided. It really benefits our family.
Amanu : Me too, I'm happy.

Voice Over : **Family planning can contribute to good nutrition for the whole family!**
It is better to wait at least three years between pregnancies to ensure spacing between your children.
You can get information about the family planning program in all health facilities.

4. PSA 4 (focus on the required support from grandparents)

Part 1: Ines and Maria meet each other

Ines : Maria! You seem busy, where are you going like that?
Maria : Oh Ines, I'm so busy, because my daughter-in-law just had a baby. But I need to rush home, to look after my other grandchildren. They're alone at home.
Ines : Oh… she had another baby? Didn't she have one last year?
Maria : Yes, she had a baby last year, and now she just had a new one. I'm so lucky with so many grandchildren!
Ines : Maria! You need to think! Having kids too close to each other is dangerous for your daughter-in-law and for your grandchildren!
Maria : Well, OK.
Ines : Fine, you'd better look after your daughter-in-law and your grandchildren! But Maria, before you go back home, try to meet with health workers, so that your daughter-in-law can get on the family planning program! You already have seven grandchildren.
Maria : All right Ines, thank you, goodbye.
Ines : Goodbye.

Part 2: Angela and her mom, Marta, hang out in the garden while Ines comes to visit them

Angela : Mommy, let's go get water, I'm thirsty.
Marta : Are you? Very cute…
Angela : Grandma!
Ines : Angela… I brought some oranges for you. I bought these in the market, just for you and mommy.
Angela : Mommy… I have so many oranges …
Marta : Oh great. Good afternoon mom, how are you mom?
Ines : Good afternoon, I'm good. Happy to see you both well.
Marta : Sit down, mom…
Ines : All right. Earlier today on my way I met Maria, and she said her daughter-in-law just delivered again.
Marta : Really? She has seven kids right?
Ines : Yes, she had six already, so together with the one she just delivered, it makes seven.
Marta : Oh…
Ines : But I'm so happy about your decision, because you decided to follow the family planning program, and all of you are healthy, and Mateus' chicken business is doing well now.
Marta : Yes mom, and all this because you support me, right?

Voice Over : **Parents-in-law support family planning because it's better for the health and economy of the family!**
It is better to wait at least three years between pregnancies to ensure spacing between your children.
You can get information about the family planning program in all health facilities.

5. PSA 5 (focus on high level and health messages)

No.	Script	Visuals
1	(Music)	Some scenes of the PSA 1-4 (selection of the scenes with children)
2	(High level official) • Our children are the future of Timor-Leste. • We need them to be healthy and educated to fulfil their dreams and contribute to the nation's development. • As parents we have the very important role of bringing them up in that journey to adulthood. • We have the duty of providing them with what they need – including good nutrition, education, health care and various skills.	High level official in her/his office
3	(Music)	Some scenes of the first 4 PSAs (selection of the scenes with children)
4	(Director General) • Science tells us that women and infants may get sick or die if: - A pregnancy happens too early or too late, meaning if the woman is younger than 18 years old or older than 35 years old - A pregnancy happens too soon after the last pregnancy or after having had too many children • In fact, women with more than 4 children who have an additional pregnancy are more likely to die or develop complications during pregnancy or childbirth. Their children are also more likely to be ill often or to die before the age of 5. • For this reason we always recommend to women to space their children by at least 3 years.	MOH
5	(High level official, voice over) • When parents ensure good spacing – at least 3 years – between their children: - Children are healthier and better nourished - Mothers are healthier, have better nutrition and produce healthier babies - It allows more time and resources for parents to meet the needs of each child - Families can devote more time on productive activities - It reduces economic strain on family by	Selected scenes from the 4 PSAs: - Scenes of healthy children, healthy mother, and nutritious food - Scenes of parents playing, teaching and hugging children - Scene of one PSA where there is an older child - Scenes of parents working (small shop, father back from office, workers in the field)

	minimizing the demands from large family size • Spacing children also promotes equality between men and women, and enables women to contribute more to family economy • Let's all encourage young couples wait before having their first child until after age 18. Let's encourage our children, our son and daughters-in-law, our nieces and nephews, our grand-children to space their children by at least 3 years	- Scenes of man buying only vegetables at the market Scene where the mother passes baby to father, shares tasks with him, works in the small shop. Scenes of grand-mother Ines and the 2 young couples
6	(Midwife) • To know more about the family planning program, visit the nearest health facility or talk to any health worker living near you • There are many ways to space your children, and we're always ready to discuss the best way for you and for your family.	Hospital
7	(Director General) • Space your children by at least 3 years to ensure the whole family is healthy, has the resources for good nutrition, and to gives time to parents to work and look after the development of their children.	MOH

ANNEX 13:

SCB Materials for FP – FP Booklet

Ministério da Saúde

Ha nia saude iha ita nia liman rasik

FÓ ESPASU BA OAN MINIMU TINAN TOLU HO PLANEAMENTU FAMILIAR ATU SAI FAMÍLIA SAUDÁVEL.

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OINSÁ ITA BELE FÓ ESPASU ENTRE ITA-NIA OAN ?

UZA MÉTODU PLANEAMENTU FAMILIAR !

IHA NE'EBÉ MAK BELE HETAN SERVISU PLANEAMENTU FAMILIAR ?

IHA FASILIDADE SAÚDE HOTU-HOTU IHA TIMOR-LESTE

TAMBA SA MAK PERSIJA FÓ ESPASU ENTRE ITA-NIA OAN?

TANBA INAN NO BEBÉ BALU BELE HASORU PROBLEMA SAÚDE GRAVE NO MÓS MATE, BAINHIRA ISIN RUA AKONTESE :

HO IDADE KI’IK LIU

SEDU LIU DEPOIS DE PARTU IKUS (BESIK-BESIK MALU)

HO IDADE BO’OT LIU

BAINHIRA IHA OAN BARAK LIU ONA

PLANEAMENTU FAMILIAR IHA VANTAJEN OIN-OIN

FAMÍLIA TOMAK
SAUDAVEL NO KONTENTI

FEEN HO LAEN IHA TEMPU HALO SERVISU

PLANEAMENTU FAMILIAR IHA VANTAJEN OIN-OIN

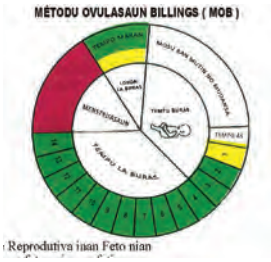
MAE HO PAI IHA TEMPUATU HANORIN NO HALIMAR HO OAN IDA-IDAK

FAMÍLIA TOMAK HAN HAHÁN HO NUTRISAUN DI'AK

MÉTODU PLANEAMENTU FAMILIAR SIRA

MÉTODU NATURAL

MÉTODU OVULASAUN BILLINGS



MÉTODU FÓ SUSU

MÉTODU STANDAR LORON-LORON

MÉTODU MODERNO

PIL ORAL KOMBINADU

PIL PROJESTIN DE'IT

INJESAUN (SONA)

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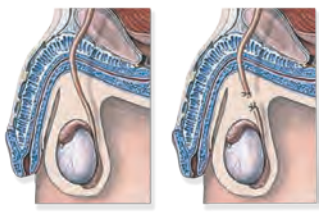
KONDOM

VASEKTOMIA



TUBEKTOMIA

SE ITA-BO’OT HAKARAK HATENE LIUTÁN KONA-BA MÉTODU PLANEAMENTU FAMILIAR

FAVOR VIZITA FASILIDADE SAÚDE NE’EBÉ BESIK HODI HASORU PESOAL SAÚDE

ANNEX 14:

Photo Essay: Engaging Young People as Adolescent Reproductive Health Educators

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USAID'S
REINFORCE BASIC HEALTH SERVICES
PROJECT

PHOTO ESSAY: Engaging Young People as Adolescent Reproductive Health Educators

By age 20, 33% of women in Timor-Leste have had sex, 31% are married, and 20% gave birth. Yet evidence and experience shows that Timorese youth have little knowledge and understanding of what to expect during puberty, the development of their reproductive system, and the health risks of teenage pregnancies. Young women regularly experience sexual abuse but do not know what it is called, and that it is unlawful. Young women and men know little about how to care for their physical and emotional health and how to stay healthy during adolescence.

Youth facilitators worked together to help develop the adolescent reproductive health curriculum.

The youth facilitators are key to the high levels of student engagement with the curriculum.

USAID's Reinforce Basic Health Services Project, implemented by JSI, worked with colleagues in the Ministry of Health and a local youth-led NGO to design and develop an interactive adolescent reproductive health (ARH) curriculum to provide critical information for better, safer reproductive health and gender equity outcomes. Trained youth facilitators, ages 20-23, piloted the curriculum with senior high school students in Covalima Municipality in cooperation with the municipality's health services staff.

The Ministry of Health's strategy of collaborating with young people as co-creators and implementers of the ARH curriculum resulted in a package of creative and relevant materials and tools and an increased potential to improve and sustain adolescent health outcomes.

The sessions focus on relationships; gender and social norms; essential life skills; the human body, puberty, and reproduction; pregnancy and the risks and consequences of teen pregnancy; and sexual and reproductive health including staying healthy in adolescence.

The youth facilitators are undoubtedly a key to the high levels of student engagement due to their creative and fun methodologies and their ability to engage with the students during the educational sessions and in informal discussions. This means that the participants are comfortable asking questions and clarifying issues during and outside the sessions, which is particularly important given the sensitive nature of the materials.

Below, some of the youth facilitators reflect on their experiences.

"The trainings are very empowering, youth-led activities, which give us space to share and learn from each other. I've been surprised to learn that many youth do not know about sexual harassment, reproductive health, gender equality, or even nutrition. I am glad to share what I know and increase others' knowledge."

EKA, 21, fourth year medical student and youth facilitator

"It is not easy to stand in front of people my age and provide them with information, particularly on adolescent reproductive health. Thankfully we prepare for a few months before we facilitate trainings. We have mentors and we assist at trainings first to be more confident."

ELGA, 21, youth facilitator

“ I really enjoy working with people my age. Adolescent reproductive health is one of the most important topics nowadays and youth need to know about it. I see sexual harassment everywhere and we should do something about it. I want people my age to know they should not feel shy to ask questions about these topics and that health workers are ready to respond to their concerns.”

ALDO, 20, youth facilitator

“ Youth don’t openly talk about adolescent reproductive health and most people feel shy or reluctant to talk about it. Our trainings are interactive and we use games, role plays and even songs to help them feel at ease and comfortable to discuss these topics – and it works.”

NELFIA, 20, youth facilitator

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents of this report are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States government.

ANNEX 15:

Technical Brief: Engaging Young People as Adolescent Reproductive Health Educators in Timor-Leste

USAID'S
REINFORCE BASIC HEALTH SERVICES
PROJECT

ENGAGING YOUNG PEOPLE
as Adolescent Reproductive Health Educators in Timor-Leste

OCTOBER 2020

What role can young people play in improving their own reproductive health?

By age 20, 33 percent of women in Timor-Leste have had sex, 31 percent are married, and 20 percent have given birth[1]. However, Timorese youth have little knowledge and understanding of what to expect during puberty, the development of their reproductive system, and the health risks of teenage pregnancies. Adolescents face a range of other serious health challenges, including malnutrition, anemia, misuse of tobacco and alcohol, gender-based violence, and mental health problems. They also are vulnerable to the transmission of STIs, including HIV. When teenagers become pregnant, this often leads to early marriage, at which point young women's chances of finishing their educations, entering careers to which they aspire, becoming financially independent, and taking control of their lives are considerably reduced.

The social environment for young people can be difficult. Young women regularly experience sexual harassment and abuse but do not know how to name it or that it is against the law. Gender-based violence is common, and most Timorese women report they are survivors of violence.[2] Young women and men know little about how to care for their physical and emotional health and how to stay healthy during adolescence.

[1] General Directorate of Statistics (GDS) and ICF. 2017. Timor-Leste Demographic and Health Survey 2016: Key Indicators. Dili, Timor-Leste: GDS, and Rockville, Maryland, USA: ICF.

[2] The Asia Foundation. 2016. Understanding Violence against Women and Children in Timor-Leste: Findings from the Nabilan Baseline Study – Main Report. The Asia Foundation: Dili.

PHOTO ABOVE: *Members of a youth-led NGO in Timor-Leste work together to develop an adolescent reproductive health curriculum, which they will deliver to their peers after school in partnership with the Ministry of Health and the Ministry of Education, Youth, and Sport.*

To begin to address these issues, USAID's Reinforce Basic Health Services Project (USAID's Reinforce) worked with colleagues in the Ministry of Health (MOH) and a local youth-led NGO to design and develop an interactive adolescent reproductive health (ARH) curriculum to provide critical information to improve reproductive health and gender equity outcomes. Trained youth facilitators, aged 20 to 24, field tested and piloted the curriculum with 170 senior high school students in Covalima municipality in cooperation with Municipality Health Services (MHS) staff and the principals, teachers, and students at several schools.

The strategy of collaborating with young people as co-creators and implementers of the ARH curriculum resulted in a package of creative and relevant materials and tools and an increased potential to improve and sustain adolescent health outcomes.

The Need to Act

When the first National Reproductive Health Strategy was developed in 2004, Timor-Leste's fertility rate of 7.8 was the highest in the world.[3] The strategy presented a plan to ensure the accessibility, availability, and affordability of reproductive health services to women, men, and young people, especially adolescents.[4] One of the targets set was to reduce the percentage of births that occur to adolescents by 30 percent.[5] Unfortunately this target was not met and in 2016, seven percent of Timorese women aged 20 to 24 had given birth by their eighteen birthday.[6]

Recently, successive health ministers have focused on family planning through a range of national health policies, strategies, and locally delivered programs and services. Calls for the provision of universal access to sexual and reproductive health services, including modern contraception, to reduce higher-risk pregnancies especially among adolescents, have come from many facets of government and society.[7] However, access to family planning services for young people, especially unmarried young people, remains extremely limited.

These initiatives continue to be developed within a sensitive and complex socio-cultural environment, in which 98 percent of the population are Catholic and the Church is reported to play a significant role in reproductive health and rights decision-making at all levels of society, from policy-making to the reproductive decisions made by individual Timorese women and men.[8]

The critical need for effective reproductive health policies, programs, and services is highlighted by the fact that 31 percent of males and 15 percent of females aged 13 to 17 report having sexual relations[9] and the rates of teenage pregnancy, maternal mortality, and suicide among pregnant teenagers remain consistently high. The maternal mortality rate among young people aged 15 to19 is 789 per 100,000, which is almost double that of women aged 15 to 49.[10] Babies born to adolescent mothers are also at higher risk of death in their first month of life and morbidities that may affect their health in later life.[11]

Between 2012 and 2019, the government launched numerous ARH policy documents and a few programs. The National Guidelines for Youth Friendly Health Services (2012) helped launch a pilot of services and preventive care at community health centers in Dili. United Nations agencies and nongovernmental organizations (NGOs) working on HIV, nutrition, and alcohol and tobacco use provided educational materials and services. Marie Stopes International (MSI) established an ARH advice hotline.[12] The Ministry of Education, Youth, and Sport worked with UNFPA to produce and pilot manuals and toolkits on life skills and pre-parenting and a facilitator manual on "Healthy Relations: Education for Young People."[13] Additional programs and curricula are being developed, adapted, or piloted but most are not in partnership with the MOH. [14]

In the years between the 2010 and 2015 census counts, the percentage of women aged 15 to 19 who had given birth, fell

[3] DRTL 2004: 4 National Reproductive Health Strategy, Democratic Republic of Timor-Leste, Dili Timor-Leste.

[4] *Ibid* page 7.

[5] *Ibid* page 9.

[6] General Directorate of Statistics (GDS) and ICF. 2017. Timor-Leste Demographic and Health Survey 2016: Key Indicators. Dili, Timor-Leste: GDS, and Rockville, Maryland, USA: ICF.

[7] DRTL (2015: 8) Mortality. Summary of the Thematic Report. Timor-Leste Population & Housing Census 2015, Democratic Republic of Timor-Leste, Dili Timor-Leste.

[8] Richards, E (2014) The Catholic Church and reproductive health and rights in Timor-Leste: contestation, negotiation and cooperation, Culture, Health & Sexuality, An International Journal for Research, Intervention and Care, Volume 17, 2015, Issue 3.

[9] WHO (2015: 55) Global School-Based Student Health Survey Results – Timor-Leste. WHO South East Asia.

[10] DRTL: 2016 Timor-Leste Population and Housing Census 2015, Democratic Republic of Timor-Leste, Dili Timor-Leste.

[11] DRTL (2015: 13) National Strategy on Maternal, Newborn, Child and Adolescent Health, 2015-2019, Democratic Republic of Timor-Leste, Dili Timor-Leste.

[12] DRTL (2015) National Strategy on Maternal, Newborn, Child and Adolescent Health, 2015-2019, Democratic Republic of Timor-Leste, Dili Timor-Leste.

[13] DRTL (2018) Healthy Relations: Education for Young People. A draft manual prepared by the Ministry of State for Youth and Sport, Democratic Republic of Timor-Leste, Dili Timor-Leste.

[14] For more information about Stepping Stones, see the official website: https://steppingstonesfeedback.org.

from 6.3 percent to 5.6 percent, respectively.[15] This was not sufficient progress. Intent on doing more to reach adolescents, the MOH asked USAID's Reinforce to assist the Maternal and Child Health (MCH) Department to produce an ARH curriculum for use in secondary schools and communities.

A Youth-to-Youth Learning and Delivery Approach

Programs developed in partnership with youth are more likely to be effective: involving youth in design and decision-making increases the likelihood of improved health behaviors. USAID's Reinforce worked in partnership with Timorese youth to develop and implement this program.[16]

USAID's Reinforce commissioned the national youth NGO *Juventude ba Dezenvolvimentu Nasional* (JDN) and an experienced JDN advisor to develop a package of ARH educational materials for unmarried adolescents to improve their reproductive health knowledge and practices. USAID's Reinforce and JDN worked closely with the MOH to develop an educational package in line with key concepts, topics, and learning objectives of the International Technical Guidance on Sexuality Education.[17] Learning sessions focused on relationships; gender and social norms; essential life skills; the human body, puberty, and reproduction; pregnancy and the risks and consequences of teen pregnancy; and sexual and reproductive health, including staying healthy in adolescence.

[15] DRTL (2015: 5) Fertility. Summary of the Thematic Report. Timor-Leste Population & Housing Census 2015.

[16] Alvarado, G., Skinner, M., Plaut, D., Moss, C., Kapungu, C., and Reavley, N. (2017). A Systematic Review of Positive Youth Development Programs in Low-and Middle-Income Countries. Washington, DC: YouthPower Learning, Making Cents International.

[17] UNESCO (2018) International Technical Guidance on Sexual Education, https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf cited January 25th, 2020.

Juventude ba Dezenvolvimentu Nasional (JDN)

Founded by Timorese youth aged 18 to 24 in 2014, JDN is a youth-led organization focused on employment training and health education. JDN has a translation service and also provides history and culture tours in Dili led by young Timorese tour guides, who use local transport and tell stories from their own experiences. JDN works in reproductive health and nutrition, providing community education and youth peer training. In 2020, JDN successfully added COVID-19 youth and community prevention education to their portfolio.

Youth from JDN work together to develop an adolescent reproductive health curriculum aimed at reducing teenage pregnancies in Timor-Leste.

The consistent and enthusiastic involvement of MOH staff reflected their desire to develop ARH materials to reduce the high numbers of teen pregnancies, as reflected in the MOH strategic plan.

All the presentations, activities, and tools in the educational package were co-developed and field-tested by and with young people. JDN wrote a life skills song and a drama about sexual harassment and made short videos for each of them. Young people from JDN aged 20 to 23 were trained to facilitate three, three-hour workshops that were subsequently field-tested with 23 senior secondary students in Covalima Municipality. Representatives from the MOH's MCH and Health Promotion departments planned and reviewed the daily sessions with the facilitation team and gave the health presentations in each workshop during the field test.

Following the successful field test, the MOH conducted orientation of the ARH materials in four municipalities[18] for nationwide scale-up. A team of three young women and three young men from Covalima, who were trained as ARH facilitators, piloted the materials in the four additional municipalities to 150 secondary students. This facilitation team is now available to scale the ARH program across the country. Doctors and midwives from the MHS, who were oriented to deliver the health presentations in each workshop, worked in partnership with the facilitation team.

[18] The four additional municipalities are Viqueque, Lospalos, Manatuto, and Baucau.

Beneficiaries

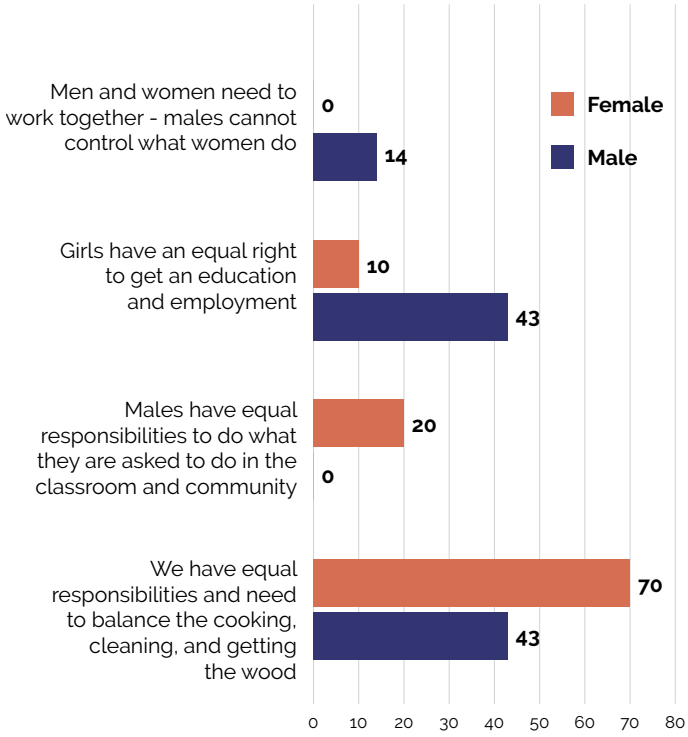
The effectiveness of the materials in achieving learning outcomes was assessed using feedback received from participants during the workshops, informal discussions with individual participants, interviews conducted at one-month intervals after each workshop, and pre- and post-test results.

Timorese youth have fun during a body mapping exercise during an adolescent reproductive health workshop.

The results of pre- and post-tests were compared according to the intervals between each workshop in the series of three workshops. The results showed that students who participated in workshops that were six to eight weeks apart achieved an average increase in knowledge of 30 percent (27 percent for females and 33 percent for males) while students who attended workshops that were held either four weeks or one-day apart achieved an average increase in knowledge of 26 percent. Of course, other factors affected these results. For instance, the baseline knowledge of students varied considerably from school to school and students in some schools were more familiar and therefore more comfortable with interactive learning styles. It does appear, however, that the timing between workshops does not significantly impact the learning outcomes of participants.

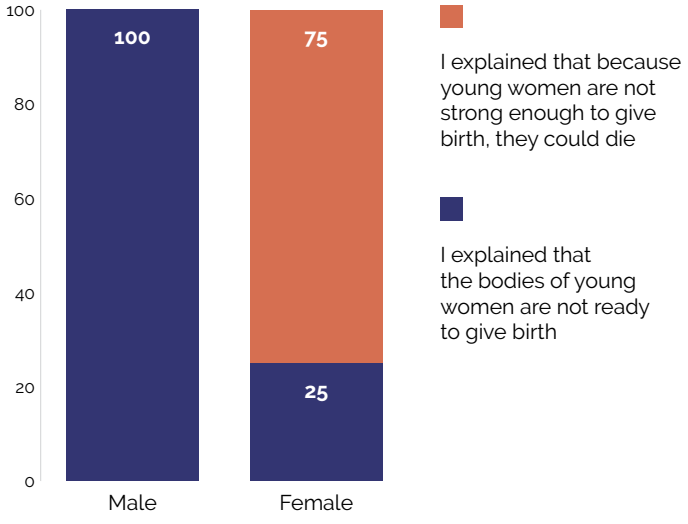
As part of the assessment process, youth facilitators used a series of open-ended questions to conduct interviews with participants at intervals of approximately one month after each workshop. The results were used to assess how students were using new knowledge and skills, including how they were passing along this knowledge to friends and family. The youth facilitators interviewed thirty-one students aged 14 to19, 21 females and 10 males.

FIGURE 1. GENDER ROLES OF FEMALES AND MALES



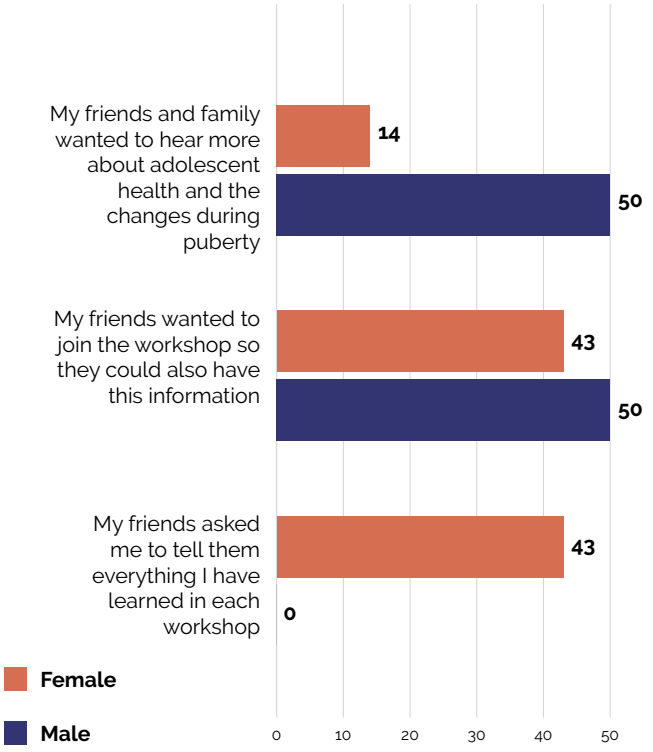
After the first workshop, which focused on the way commonly accepted gender norms affect relationships with the opposite sex, students were asked how they used what they had learned about equal roles and responsibilities of females and males. As shown in Figure 1, 70 percent of female respondents informed family and friends about the need to balance the workload in the family. Forty-three percent of males used this information in the same way and another 43 percent argued that females have an equal right to education and employment.

FIGURE 2. EXPLAINING THE RISKS OF TEENAGE PREGNANCY



One of the main learning objectives in the third workshop was sexual reproductive health, including the risks and consequences of teenage pregnancy. Students were asked what they shared with their friends about this issue. Figure 2 shows that all students explained the health risks of teenage pregnancy including maternal mortality.

FIGURE 3. INTEREST SHOWN BY FRIENDS IN LEARNING ABOUT ARH



When students were asked if they thought their friends would be interested in knowing about the things they were learning in the workshops, the response was overwhelmingly positive as shown in Figure 3.

The notable gender differences in the above results are an important area for further research. Roles and responsibilities, risk of teen pregnancy, and level of interest of friend groups in the workshop content are all significant differences between males and females.

The youth facilitation team, MOH staff, and USAID's Reinforce staff also contributed observations and reflections to the assessment. While students indicated that the content of the workshops was very new to them, they participated enthusiastically in the interactive learning model, which included group work, body mapping, role-plays, songs, and dramas.

Participants recognized the relevance of the education for themselves and others. "I suggest that these workshops should be done in the community because these problems are always happening there, as well as with my family and with my relatives. We can prevent this problem in the community if we can give this information to people with no access to education, including young men who are always sitting in the street with nothing to do," said an 18-year-old female.

The youth facilitators are key to the high levels of student engagement during the workshops due to the creative and fun methodologies they worked into the curriculum and their ability to engage with the students during the educational sessions and in informal discussions. This means that participants are comfortable asking questions and clarifying issues during and outside the sessions, which is particularly important given the sensitive nature of the topics. The facilitators found that participants were eager to use their own ideas in the small group activities, so their role was largely to respond to questions that arose and facilitate additional input from health professionals as required.

The facilitators regularly reflect on how their own behavior has changed as they understand and apply in their own lives the knowledge they are imparting to students. One major challenge is dealing with sexual harassment. Both males and females acknowledge that commonly practiced behaviors, which are accepted as normal by both genders, continue to perpetuate sexual harassment and abuse. They acknowledge that if they are teaching adolescents about respectful behaviors, gender equal relationships, and positive life skills they need to practice consistently these behaviors and skills. They noted that throughout the workshops, participants gain knowledge and skills that put them in stronger positions to demand consensual sexual relationships.[19]

Outcomes: Foundation for National Implementation

In restrictive environments such as Timor-Leste, youth programming requires creative design and strategic partnerships with national and local health personnel. In collaboration with the MOH, the Ministry of Education, Youth, and Sport, and development partners, USAID's Reinforce supported the integration of age-appropriate reproductive health education into a school health program in which health providers deliver extra-curricular training to students after school. This approach was developed and piloted through an innovative collaboration between

[19] Two short videos were produced by the facilitators and other JDN members as additional resources for the workshops, including a music video that is used to teach the life skills song: (https://www.youtube.com/watch?v=FB-M5uAyVVY4&feature=youtu.be) and a film about sexual harassment: (https://www.youtube.com/watch?v=M1qH6h_CeKw&feature=youtu.be).

the MOH and young people, so that the scientific knowledge and health expertise is merged with interactive and creative activities to educate adolescents and young adults. The MOH maintained an enthusiastic lead role during the extended pilot period, building support for nationwide implementation in secondary schools and communities. Despite a range of historical and contemporary sensitivities, competing ideologies, and political constraints, official approval from the Minister of Health was obtained within 18 months of piloting the ARH materials.[20]

By mid-2019, the Ministry of Health introduced the ARH curriculum to other municipalities, sharing the experience from Covalima. USAID's Reinforce oriented additional NGOs to the ARH package, expanding the number of partners ready to assist the MOH with national scale-up

Moving Forward

Before the COVID-19 pandemic, USAID's Reinforce continued piloting the ARH package in Covalima, using flexible models of timing and frequency, which offered the MOH more options for delivery modalities to include out-of-school youth, students, and working youth. Locally trained youth facilitators who implemented the workshop sessions in partnership with MHS staff are now a local resource for highly motivated peer educators in both formal and informal settings. Students introduced to local health personnel were encouraged to use the sexual and reproductive health services provided at community health centers. All of this sets the stage for expanding the ARH program to meet the diverse needs of the youth population in Covalima.

Ensuring that youth led the development and facilitation of activities helped to demystify and de-stigmatize sensitive topics. This creates an environment in which more adolescents are empowered with new skills and confidence to challenge gender and social norms and use improved knowledge and responsible behaviors to benefit their own reproductive health and the sexual and reproductive health practices of their friends and families.

"I want people my age to know they should not feel shy to ask questions about these topics and that health workers are ready to respond to their concerns," said Aldo, 21, JDN youth facilitator.

The MOH continues to collaborate with the Ministry of Education, Youth, and Sport and development partners to support the national expansion of this program. Additionally, the MOH welcomes the addition of new modules to improve the well-being of adolescents and young adults. These come from other partners with expertise in areas beyond the content already developed including HIV, nutrition, non-communicable diseases, mental health, and other MOH priority areas.

The rapid MOH approval of the ARH curriculum means it is available for use throughout Timor-Leste. The interest of young leaders in expanding the ARH program and the interest of partner organizations in providing funding could propel the scale-up under the leadership of the MOH. USAID's Reinforce, with our partner JDN, is proud to contribute to the likely reduction in the maternal mortality rate of girls aged 13 to17, and to help more Timorese young women and men manage their lives to meet their full potential.

[20] Approval was provided by the Ministry of Health in September 2020.

The USAID's Reinforce Basic Health Services Project was launched in 2016 to help the Timorese government improve the quality and use of maternal, newborn, and child health and family planning services through technical assistance to the Ministry of Health personnel working at national level and in the model municipality of Covalima.

ANNEX 16:

Leadership Training with Community Leaders to Sustain Healthy Behaviors

USAID's Reinforce Basic Health Services Project

ACTIVITY REPORT: Leadership Training with Community Leaders to Sustain Healthy Behaviors in 2019

USAID
FROM THE AMERICAN PEOPLE

JSI

USAID'S REINFORCE ACTIVITY REPORT: Leadership Training with Community Leaders to Sustain Healthy Behaviors in 2019

Cooperative Agreement No. AID-472-A-16-00001

Prepared by
JSI Research & Training Institute, Inc. (JSI) USAID's
Reinforce Basic Health Services Project
Dili, Timor-Leste
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Cover Photo: Community leaders participate in Ba Futuru training in 2019. (Ba Futuru Photo)

DISCLAIMER This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the sole responsibility of JSI Research & Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States government.

USAID'S REINFORCE ACTIVITY REPORT: Leadership Training with Community Leaders to Sustain Healthy Behaviors in 2019[1]

The curriculum of USAID'S Reinforce's leadership training with community leaders includes conflict resolution, GBV, anger management, drugs and alcohol risk awareness, and abuse prevention. The four-day training (with an additional day on health promotion materials, not evaluated here) was held in the following locations, including a breakdown of the participants:

September 11- 14: Suco Fatuleto, Zumalai – with 14 participants (male 7, female 7)
September 16-19: Suco Maudemo, Tilomar – with 17 participants (male 10, female 7)
September 30 - October 03: Suco Holpila, Maucatar – with 16 participants (male 9, female 7)
October 22-25: Suco Debos, Suai Vila – with 20 participants (male 14, female 6)

A total of 40 male and 27 female participants representing a range of community and youth leaders attended.

Some of the evaluation comments included:

A 34-year-old male head of a sub village said, "I am very happy and proud with the Ba Futuru NGO method of training during the past four days because it made attending the training interesting. The lessons I learned included conflict resolution, conflict analysis, peaceful and creative conflict resolution, gender-based violence, domestic violence, drugs and alcohol, and anger management. The lessons I have learned helped me choose to change my behavior. When I got angry at my family, I destroyed the television, speaker, and cupboard. This training made me disappointed with my past bad behavior. The

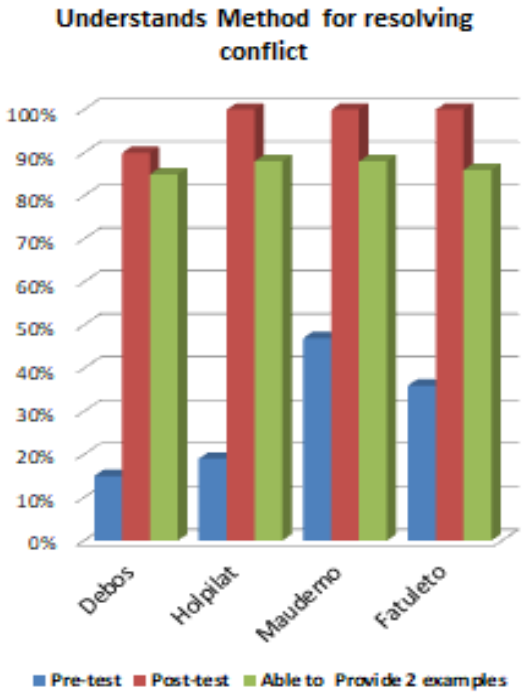
[1] This training was conducted prior to COVID-19 restrictions

information I learned from this training will be implemented in my daily life and I will share it with others in my community when we have a meetings."

A 36-year-old female delegate noted, "I am really happy that I participated in this four day training, because I have learned some new information that I did not have before. The new information I learned during the training is about conflict resolution, gender based violence, types of violence, factors that contribute to domestic and gender based violence, and the impact of alcohol and drugs. The information I have mentioned above expanded my mindset on how to empower myself to change the negative attitudes and behaviors that happen in my family. I know that it is not easy to make change in the short term, but it is an important thing that I have to start myself. I now know a good way to address the problems that are faced by the community. I will share the knowledge and information I have learned from the training with my family, neighbors, and community so they all can understand that using violence is not a good way to solve problems."

A 26-year-old female youth leader said, "I am very happy with this four-day training because it gave me an opportunity to learn about conflict resolution, gender-based violence, domestic violence, anger management, and drugs and alcohol. The lessons I have mentioned above are very important to me and my community. The lessons I have learned can help me change my behavior such as being angry and hitting my children. After attended the training I realized that hitting children is a form of violence. I will implement the lessons I have learned from the training into my life and share them with my family and community."

A 35-year-old male as head of a sub-village said, "I am very happy with and proud of this four-day training because it built my capacity. We were not bored or tired from the training because the topics are relevant to our work in the community. The lessons I have learned include conflict resolution, prevention of gender-based violence, domestic violence, and anger management. The lessons I have mentioned above are very important to me because they can help me to change my behavior. Before, I liked to hit people in the community but after attending this training my behavior has changed specifically in relation to anger management. I will implement the lessons I have learned from this training into my life and will share these lessons with my family and community."


Understands Method for resolving conflict
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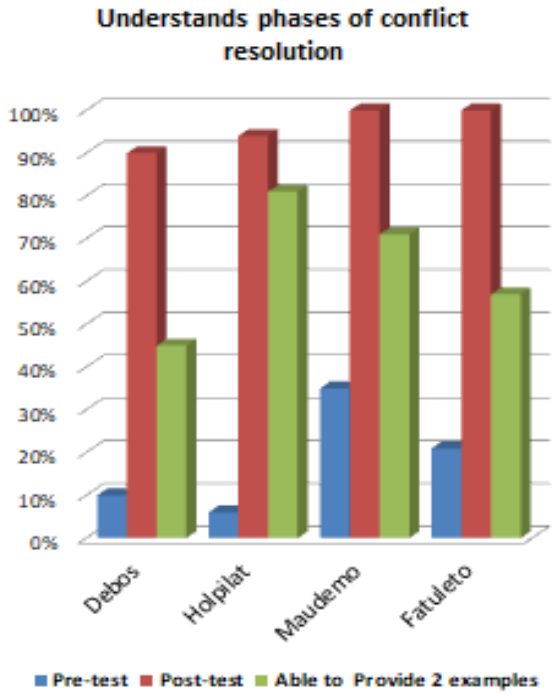
Debos
Holpilat
Maudemo
Fatuleto
Pre-test
Post-test
Able to Provide 2 examples


Understands phases of conflict resolution
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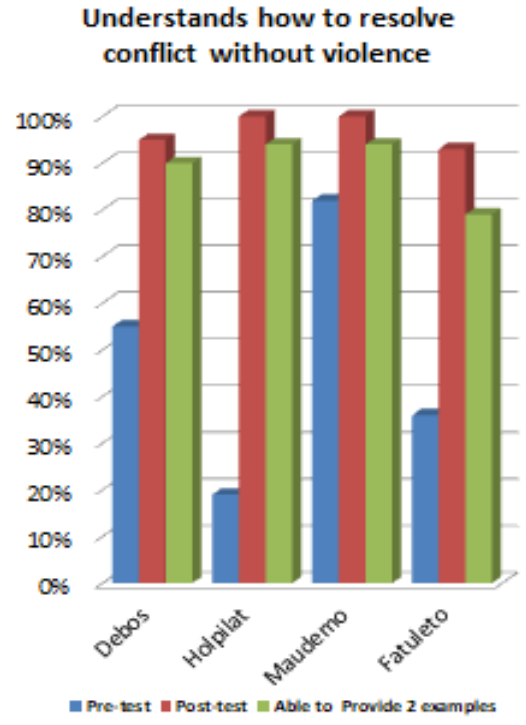
Post-test
Able to Provide 2 examples


Understands how to resolve conflict without violence
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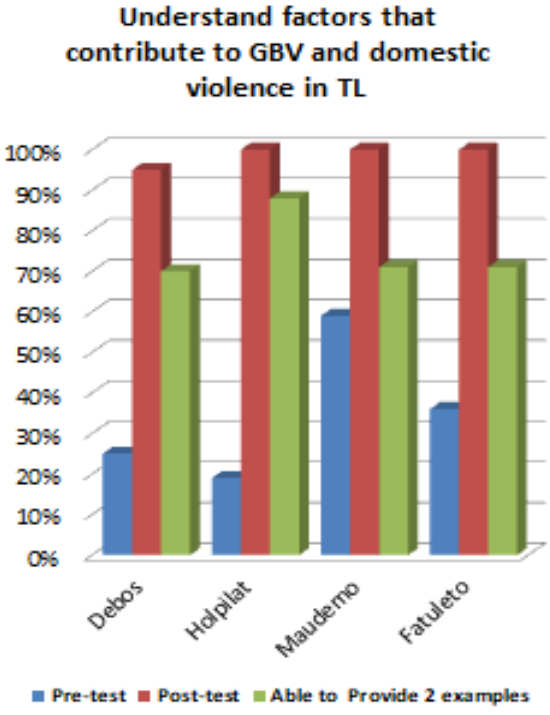
Able to Provide 2 examples


Understand factors that contribute to GBV and domestic violence in TL
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Debos
Holpilat
Maudemo
Fatuleto
Pre-test
Post-test
Able to Provide 2 examples

Recommendation:

"I would like to recommend to JSI and Ba Futuru to facilitate another training with the same topics for other Suco councils in Holpilat. I also recommend that other topics are added to future trainings such as women's economic empowerment and how to write a simple proposal."

A 39-year-old male head of a sub village said, "I am very happy with this four-day training because the lessons I learned could help me resolve conflict that might occur in my sub village. I have learned about important topics to resolve conflict. These lessons can help me support victims of conflict in my community due to lessons on gender-based violence, domestic violence, conflict resolution, and conflict analysis and anger management. Some information that I have learned from the training was new to me and I can use it to help change my behavior because in the past I liked to drink alcohol, was angry with my family, and would punch other people if they provoked me. I will continue to implement the information I have learned with my family and the community."

A 33 year-old female head of a sub village stated, "This training was really good because it improved my capacity. I am really proud with what I have learned from this training because I have learned important things such as what conflict is, what gender-based violence is, and what domestic violence, alcohol, and drugs are. All of this information really helped me as head of a sub village because I have to understand many different topics so I can be strong enough to help my community when a problem happens in their lives. People always come with different ideas from different people; leaders always find these difficult to deal with, so as head of a sub-village I must have a good capacity in finding good solutions for community problems. I am also really happy to continue to share the information I got from the training with my communities, so they know how to do the prevention for themselves."

Participants' Feedback

A 50-year-old male head of a sub village said, "I am really happy with this four-day training because I was able to learn about the issues of conflict resolution, gender-based violence, domestic violence, anger management, and addressing drugs and alcohol. The lessons I have learned in this training have changed my negative emotions and past behavior such as being nervous, being angry, expressing hate, and beating other people. Information I have learned during the training could help me as head of the sub village to resolve conflict or civil cases that occur in my community. I will implement the lessons I have learned from Ba Futuru into my life and share them with my family and other people in my community."

A 28-year-old female youth representative noted, "I am personally happy with this training, because the information is really new for me. I did not get this kind of information before. During the training, I have learned what conflict is, mediation, domestic violence, alcohol, and drugs. All of this information is really important for me, because it increases my knowledge. As a female representative, I also want to share the knowledge that I got from the training with youth, so they can have the same information as me. I will keep sharing this information with not only youth but other members of the community, too. So that all the people in my community will have [good] information."

ANNEX 17:

Community Transport Saves Lives: The TraKom Story

Program Brief: Community Transport Saves Lives: The TraKom Story

I. Introduction

In 2016, before starting its technical assistance to the Covalima Municipality Health Services (MHS) and its 28 health facilities, USAID's Reinforce conducted a baseline survey to measure reproductive health knowledge, attitudes and practices (KAP) among mothers and their partners.[4] The survey highlighted that while antenatal care (ANC) attendance was high, almost half of the pregnant women only had their first encounter with the midwife after the first trimester, and more than half of them delivered at home, mostly without the help of a trained health professional.

This is common across Timor-Leste, where the maternal mortality ratio is still very high at 195 deaths per 100,000 live births.[5] Like in many settings, the causes are partly found in the first and second delays that families face to make the decision to seek and reach health care. Indeed, knowledge of the key danger signs during pregnancy, delivery and the post-partum period was very low in the KAP findings (e.g., only 18% of the women interviewed knew two out of the four key danger signs during labor), 70% of the respondents did not think women can die from pregnancy-related complications, and only 24% of women (and 7% of men) stated having made a written birth plan to give birth at the health facility and prepare for potential emergencies. The women and men who mentioned having made a birth plan reported that it mainly focused on saving money, while arranging for transport and identifying a skilled provider were cited by a much smaller proportion of them.

Twenty-five percent of the women interviewed said that they delivered at home because the facility was too far. Emergency transport and transport in general has many challenges in Covalima. Only 2% of the families own a car and there is no reliable public transport from village (suco) to administrative post level where the community health center (CHC) is located. Every CHC should own a "multi-function car" also serving as an ambulance, however from the first year of the project, only two CHCs had a functioning car, and where and when it is operating, it is also used for other purposes, such as conducting outreach and transporting supplies from the municipal level.

Using the KAP results, Reinforce designed its Social and Behavior Change (SBC) Plan,[6] which included "increasing institutional delivery in Covalima Municipality" as one of the key behaviors targeting pregnant women and their partners with communication objectives such as recognizing danger signs, understanding the importance of maintaining contact with the midwife, and preparing a birth plan for the family to follow during pregnancy, labor, and the post-partum period, therefore reducing the burden of the first and second delays.[7] To fill the critical transport gap while ambulances are not available, the SBC

[4] Ministry of Health of the Democratic Republic of Timor-Leste, with technical assistance from USAID's Reinforce Basic Health Services Project implemented by JSI Research and Training Institute, Inc. under Cooperative Agreement No. AID-472-A-16-00001 (2016). Knowledge, Attitudes and Practices Assessment in Covalima Municipality.

[5] General Directorate of Statistics, Ministry of Planning and Finance and Ministry of Health (2018). Timor-Leste Demographic and Health Survey 2016.

[6] USAID's Reinforce, implemented by JSI Research and Training Institute, Inc. under Cooperative Agreement No. AID-472-A-16-00001 (2016). Behavior Change Communication Plan for USAID's Reinforce Project.

[7] Three delay model: (1) taking the decision to access care, (2) identifying a medical facility and transport to get there, and (3) receiving adequate and appropriate treatment. Ref.: Bull World Health Organ 2015;93:417–423.

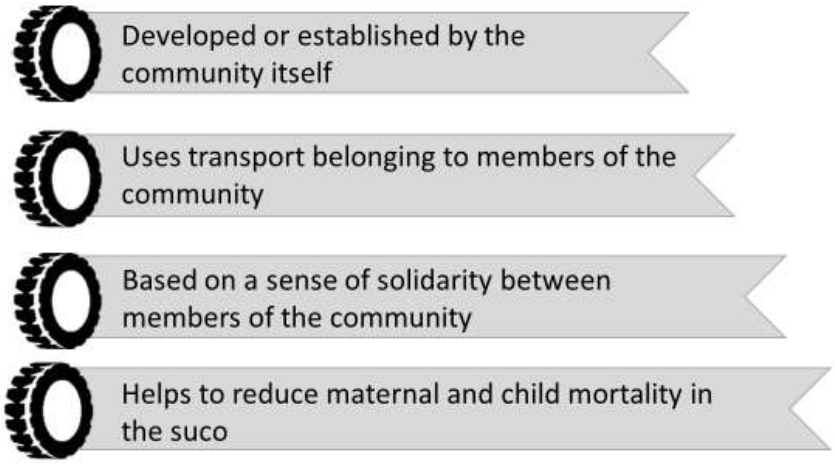
Plan included a communication objective targeting community leaders to **initiate and implement an emergency transport system for pregnant mothers and anyone else in need in their communities**.

To fulfill these communication objectives, Reinforce designed SBC materials and interventions around birth planning and community transport. The main materials included a fiction film – where a pregnant woman suffers pregnancy complications and is saved partly because of an emergency transport initiated by the community leader – and a birth plan "home reminder" poster, linked with the MOH "LISIO",[8] providing the required information for household members to plan birth at the health facility and be prepared in case of complications by recognizing danger signs and contacting emergency transport (health facility or community-owned) when these arise.

II. TraKom Initiative

Reinforce contracted *Jurídico Social Consultoria* (JUS) social enterprise to develop materials for health facility staff to conduct advocacy and planning meetings with community leaders on the need to arrange community transport (*transporte Komunitáriu* – TraKom) for pregnant and post-partum women. Two guides were developed for conducting advocacy[9] and for implementing interventions.[10]

TraKom



[8] Maternal and Child Health Booklet, provided by midwives to pregnant women for a healthy pregnancy – including ANC, birth planning, health messages, etc. – as well as caring for the newborn and child (growth follow-up and immunization).

[9] Ministry of Health of Timor-Leste, with support from USAID's Reinforce Basic Health Services Project (2018). Advocacy Guide for Community Transport Promoting Access to Health for Pregnant Women, Newborn Babies and Children.

[10] Ministry of Health of Timor-Leste, with support from USAID's Reinforce (2018). Implementation Guide for Community Transport Promoting Access to Health for Pregnant Women, Newborn Babies and Children.

Content of the Advocacy Guide for Community Transport

- A definition of the concept of Advocacy: "a strategic effort to obtain CHANGE by establishing a political commitment and developing circumstances that can bring about this specific change."
- Important messages about MNCH around birth planning and danger signs, and the need for available transport in cases of emergencies.
- A mapping of key community members, such as community leaders, police, transport owners, etc., and a mapping of transport means available in the community, their strengths and weaknesses.
- Measuring support among community leaders for initiating TraKom, and strategies for conducting advocacy to those not yet convinced.
- An agreement among community stakeholders to initiate TraKom, based on the principles of **solidarity, transparency** and **responsibility.**

Once the community reaches agreement, the Implementation Guide, which includes information on how to conduct proper planning, implementation, and monitoring, can be used.

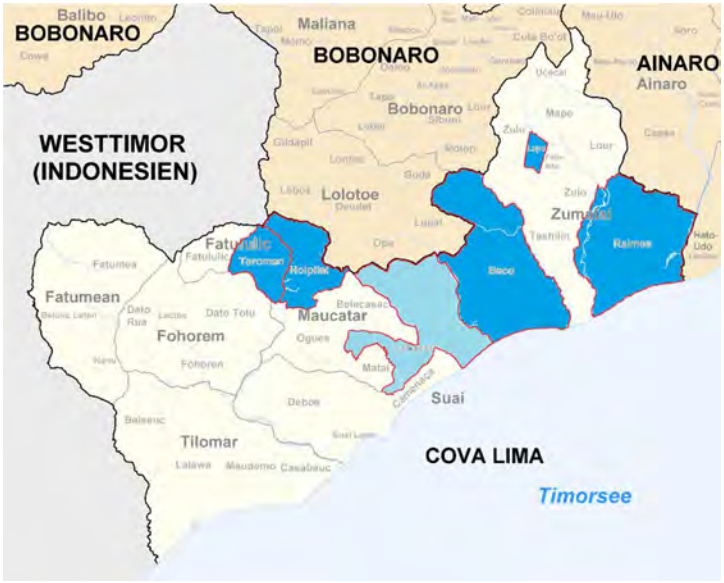
Content of the Implementation Guide for Community Transport

- The importance of community involvement.
- A refresher about TraKom, and the principle of **solidarity** as actions to show mutual understanding, unity and help to deal with social problems over the long term.
- Action planning for community transport for health emergencies.
- Integration of community transport into the suco development plan.
- Socialization with community.
- Definition of the transport modalities (how to use community transport, including cost, schedules, etc.).
- Transparency, reporting, communication and success stories.
- Monitoring.

Following the approval of the TraKom Guides by the MOH, JU,S and Reinforce provided training to Covalima Municipality health promotion focal points from MHS, CHCs and health posts (HPs) on how to conduct advocacy and planning activities with community leaders.

III. TraKom Results

1. Set-up of TraKom in selected sucos



TraKom was initiated in six sucos: Beco (Suai Vila), Lepo (Zumalai), Holpilat (Maucatar), Taroman (Fatululik), Labarai (Suai Vila), and Raimea (Zumalai). See map.

Among these sucos, five continued after a successful advocacy meeting. In Labarai Suco (light blue), despite some consensus in the end of the meeting, the HP staff never managed to obtain the suco's commitment for pursuing with implementation.

As shown in Table 1, below, most advocacy meetings took place in 2018, followed by four planning end-2018 and 2019. A new suco (Raimea) was added in 2020.

It is important to note that most of the time, the HP or CHC staff needed more than one advocacy meeting to ensure a real commitment from suco leaders. Among the five sucos which developed a annual implementation plan, two opted for the a solidarity financial plan and created a community cashbox. However, six months after its implementation, Lepo Suco moved to the "family pays" option as it did not reach sufficient contributions to cover the transport needs.

Table 1. Summary of TraKom Advocacy and Planning Meetings

Suco	Advocacy meeting (date)	Planning meeting (date)	Financial plan selected
Labarai	Quarter 1, 2018	X	X
Holpilat	Quarter 1, 2018	Quarter 1, 2019	Family pays
Beco	Quarter 4, 2018	Quarter 1, 2019	Family pays
Lepo	Quarter 4, 2018	Quarter 1, 2019	Family pays (*)
Taroman	Quarter 4, 2018	Quarter 4, 2018	Community cashbox
Raimea	Quarter 1, 2020	Quarter 2, 2020	Family pays

(*) Initially considered the community cashbox.

Below is an example of an action plan, from the most successful TraKom interventions, implemented in Beco Suco (Table 2).

Table 2. Beco Suco Action Plan

No.	Activity	Responsible
1	Socialize TraKom to the community using any possible mean (SISCa, community radio…)	Suco Chief, Aldeia Chiefs, Delegates
2	Approve the modalities for using TraKom (only for emergencies, and families pay per trip)	Suco Chief, Aldeia Chiefs, transport owners and community representative
3	Approve the transports' cost and schedule (*)	Suco Chief, Aldeia Chiefs, transport owners
4	Use TraKom	Suco Chief, Aldeia Chiefs
5	Collect and send usage data	Suco Chief, Aldeia Chiefs
6	Collect and update data about number of pregnant and post-partum women and children under 5 years old	Suco Chief, Delegates

(*) Between $5 and 15$ depending on the distance from home to HP.

2. Use of TraKom

Although five sucos reached the stage of community agreement and developed an action plan (Table 1), only Beco and Lepo used TraKom. Further investigation will be conducted to identify the reasons why TraKom was not used in Taroman nor in Holpilat, as data show that health promotion was conducted with similar intensity in these two sucos in 2019 and 2020 as in Lepo and Beco. As displayed in Table 3 below, 40 patients used TraKom in Beco, and among them, 12 needed secondary care at the Referral Hospital. Among the 14 patients from Lepo, eight needed secondary care. In regards to population numbers, TraKom was proportionally used the same way in Lepo as in Beco; however, further analysis will be required in order to understand if all community members in need could afford the cost.

Table 3. Number of TraKom Users in Beco and Lepo Sucos

Suco	Population	Number of cases			Referral pathway
		No. of pregnant women	No. of children	No. of other cases	
Beco	4,075	34	1	5	36 reached Beco HP
					8 reached Beco HP and continued to the Referral Hospital with ambulance
					4 referred to Suai Referral Hospital directly
Lepo	1,422	12	0	2	8 reached Zumalai CHC
					4 referred to Suai Referral Hospital directly
					4 referred to Maliana Referral Hospital directly
Total		**46**	**1**	**7**	

The role of community leaders in the dissemination of TraKom information was crucial as 50 users mentioned having heard about TraKom from their Suco Chief. Truck owners, and therefore those managing a small business in the suco, were particularly helpful, as 37 of the patients requiring TraKom used a truck. 17 used a motorbike, which can be great alternatives in case of less serious emergencies when the truck is not available.

3. Success Stories

"**Pedro**, 7 months old, from Aidantuik Aldeia, Beco Suco, used TraKom as he was having convulsions. A truck brought him to Suai Referral Hospital where Pedro got treatment from Midwife **Erlina**."

"**Eugenia**, 34 years old, four children, from Bibi Atan Aldeia, Beco Suco, used TraKom because of pregnancy complications. A motorbike brought her to Beco Health Post where she received treatment from Midwife **Francisca**."

"**Veronica**, **Rosalia**, **Ana Flora**, **Natercia** and **Felismina**, all from Beco Suco, used TraKom because of pregnancy complications. They were transported by truck to Beco Health Post, but because of the seriousness of their condition, the ambulance picked them up from the health post to Suai Referral Hospital."

"**Baltazar**, from Halik Aldeia, Beco Suco, used TraKom following an accident. A motorbike brought him to Beco Health Post, where he received his first assistance from Nurse **Lourenco**, who called the ambulance to bring Baltazar to the Referral Hospital."

TraKom benefisiaries Argentina, Noviana and Jenety, with their husbands and children.

"**Basilio**, from Horba Aldeia, Beco Suco, used TraKom following a buffalo accident. The truck brought him directly to Suai Referral Hospital."

"**Bruna**, 24 years old, from Holbolu Aldeia, Beco Suco, used TraKom because of pregnancy-related complication (prolonged labor). The truck brought her to Beco Health Post where she received a first treatment from Midwife **Francisca**. Her condition required further referral to Suai Referral Hospital with the ambulance."

"**Madalena**, 25 anos, husi Aldeia Lepo Kanua, Suku Lepo, because of pregnancy-related complication (prolonged labor). The truck brought her to Zumalai Community Health Center where she revceived assistance from Midwives **Rosita** and **Lorina**."

These success stories would not have happened without…

- A **community** with the commitment to help the health sector when the ambulance is not available or not functioning.
- **Suco Chiefs** who commit to saving the lives of those facing emergencies.
- Generous **transport owners** who avail their vehicle for the community through solidarity.
- **Families** who recognize danger signs and call for help.
- Trained and competent **health workers**.
- A functioning **referral system** from primary health care facilities to hospital.

IV. Handover Workshop

"TraKom is an aspiration of the community itself to prepare local transport to help pregnant women, women in labor, and young children in a health emergency situation to access the health facility and receive live-saving treatment," Municipality Administrator.

At the end of June 2020, a few months before Reinforce completes its activities, the MOH organized a workshop in Covalima with the objectives of:

- Handing over TraKom to community leaders and health facilities.
- Encouraging community leaders to expand and sustain TraKom.
- Provide an opportunity to openly discuss about the strengths and weaknesses of TraKom implementation.

The activity was attended by 43 participants, including the following key stakeholders: Municipality Administrator; MHS Director; MOH Maternal and Child Health Department Head; Fatululik, Suai Vila and Maucatar post administrators; Beco, Taroman, Raimea and Holpilat suco chiefs; aldeia chiefs from Beco, Raimea, Lepo, Holpilat and Taroman sucos; some transport owners; and MHS officers for health promotion and MNCH.

1. Strengths, Weaknesses, Opportunities and Threats (SWOT)

The participants were split into groups to evaluate the strengths, weaknesses, opportunities and threats of TraKom, with the objective of later work on how to sustain it in sucos where it has been implemented and how to expand it to other sucos of Covalima Municipality.

Table 4. TraKom SWOT Analysis

	STRENGTHS	WEAKNESSES
INTERNAL (FROMTHE PROJECT ITSELF)	**Community leaders:**	
	▪ Have the competency to facilitate information flow and communication whenever there is a case. ▪ Can use existing meetings with the community to discuss TraKom. ▪ Can plan with the community. ▪ Have a strong commitment.	▪ Some community leaders do not cooperate. ▪ Lack of transport available to help. ▪ Lack of control from suco, community and health personnel.
	Community members and transport owners:	
	▪ Are willing to help each other. ▪ Are willing to work as a team. ▪ Know about TraKom (socialized already). ▪ Can contribute to a common cashbox. ▪ Are not only dependent on the ambulance.	▪ Not everyone is aware of TraKom. ▪ Economic constraints (not all families can afford the contribution or payment). ▪ The contribution is not optimum. ▪ Many still lack knowledge about health.
	General:	
	▪ TraKom can reduce maternal and child mortality in the suco. ▪ The community will be healthier. ▪ Increase the number of health facility deliveries, immunization, etc. ▪ TraKom uses the resources of the suco itself.	▪ Some aldeias are not covered by or are far from the community transport vehicle. ▪ The community transport could be either not available or broken. ▪ No commitment from some transport owners. ▪ Lack of communication among players.
EXTERNAL (FROM EXTERNAL FACTORS)	**OPPORTUNITIES**	**THREATS**
	▪ There could be new support from other partners and NGOs. ▪ More options for disseminating information linked with TraKom. ▪ Support from National Suco Development Program (PNDS). ▪ Create a community cashbox for emergency cases. ▪ Experience can be shared in various community meetings.	▪ JSI is closing in Covalima. ▪ No telephone connection in some areas. ▪ Geographical barriers, bad roads, long distances and climate. ▪ Accidents. ▪ No fuel.

As shown in Table 4, the workshop participants identified numerous strengths of the TraKom initiative, particularly the commitment of the community leaders and the support and adherence from the community. They also saw the general benefit of TraKom in terms of saving lives and increasing health services coverage, as well as pointing some possible opportunities for future development of the initiative ('post-Reinforce'). It is however important to note here that most workshop participants were community

leaders and MOH staff, and that the voice of the community itself also needs to be heard. The participants also noted weaknesses in and threats to the program, such as economic and geographic constraints, lack of knowledge and lack of available transport in general, which will need to be addressed.

2. Sustainability and Expansion of TraKom

To sustain TraKom in existing sucos, participants agreed to maintain the contributions (in Taroman), conduct an evaluation, keep the communication with health facilities, get the municipality administration to lend a car when/where needed, looks for other development partners to continue support the initiative, and include TraKom in the municipality annual budget. To expand it, participants suggested disseminating success stories through meetings and media, influence/advocate to other donors for supporting TraKom set-up, and include TraKom in the municipality annual budget.

V. Challenges and Recommendations

Using available project databases, such as the TraKom Users' Tracker, the Health Promotion Database (including community group discussions and home visits), and the Health Facility Utilization Database, as well as the result of the SWOT analysis, the following recommendations could be identified for Reinforce and MOH to consider while TraKom is about to be expanded.

Provide training to additional sucos for TraKom's expansion.

Following the willingness of MOH to expand TraKom in other sucos across Timor-Leste, MOH needs to include TraKom in its annual plans with proper budget, to be found either in the state budget or in other development partners' support. Covalima MHS and Reinforce should be requested to provide training at national level before the project closes.

Seek information to ensure TraKom is reaching the most vulnerable families.

While since the beginning of 2019, 54 community members – mainly pregnant women – benefited from community-organized emergency transportation in Beco and Lepo sucos, further analysis will be required in order to see if TraKom was accessed also by poor families. Available data do not allow this level of analysis, but this is crucial in order to ensure that the 54 users were indeed patients who would have stayed at home if TraKom was not initiated in their suco, and if more potential beneficiaries were not missed due to a lack of information or economic constraints.

Reinforce the concept of solidarity as a foundation of TraKom.

Whether users pay directly the transport owner or contribute to a common cashbox managed by the Suco Council, TraKom implementers must ensure that families with less or no income are supported financially in order to benefit from TraKom services. In sucos where contribution is required, poor families should be exempted, while in sucos where users pay directly, the Suco Council should keep emergency cash to assist them reach the health facility with TraKom.

Understand why TraKom was not used in Taroman and Holpilat sucos.

Health promotion data show that community group discussions were conducted with the same intensity in these two sucos as in Beco and Lepo Sucos, where community extensively used TraKom. Reinforce and MOH should investigate as community members might not be aware or transport costs might be too expensive. The real commitment of these two sucos' community leaders should be carefully assessed in order to avoid spending time and efforts with unmotivated sucos in the future.

Explore further the use of motorbikes.
Seventeen TraKom users were brought to the nearest health facility by motorbike. Reinforce and MOH should investigate if these motorbikes were registered as 'official' TraKom vehicles and if patients were feeling safe.

Get users and community's perspective on TraKom.
Regular feedback from the community is a valuable contribution to our understanding of the challenges and successes in accessing community transport. Success stories are very important and useful for advocacy and to identify best practices. Interviewing community members and leaders will provide a richer understanding of the range of experience and identify the way forward in providing essential transport for women and their families.

ANNEX 18:

USAID's Reinforce Support to the MOH Response to COVID-19

USAID's Reinforce Basic Health Services Project

COVID-19 Activity Report April to September 2020

A108

USAID
FROM THE AMERICAN PEOPLE

JSI

COVID-19 Activity Report April to September 2020

Cooperative Agreement No. AID-472-A-16-00001

Submitted to
USAID/Timor-Leste
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Prepared by
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Cover Photo: Socially-distanced youth leaders in COVID-19 training.

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ACRONYM LIST

Aldeia	hamlet
ANC	antenatal care
BEmONC	basic emergency obstetric and newborn care
BP/CR	birth preparedness and complication readiness
CCC	*Centru Comonidade Covalima*
CHC	community health center
CHO	community health officer
CITL	CARE International Timor-Leste
COVID-19	Commonly used acronym for the disease caused by the novel coronavirus 2019
CPS	clinical practice site
CQI	continuous quality improvement
CVTL	*Vermelha* Timor-Leste or Red Cross Timor-Leste
CYP	couple years of protection
DFAT	Department of Foreign Affairs and Trade
DHIS2	District Health Information Software 2
DPHO	District Public Health Office of Officer
EMMP	Environmental Mitigation and Monitoring Plan
ENBC	essential newborn care
FP	family planning
FUAT	follow-up after training
FY	financial year
GBV	Gender-based violence
GOTL	Government of Timor-Leste
GRACA	name of community organization
HAI	Health Alliance International
HP	health post
HMP	health manager program
HNGV	*Hospital Nacional Guido Valadares* (National Hospital Guido Valadares)
ICFP	International Conference on Family Planning
IFC	International Finance Corporation
IMCI	integrated management of childhood illnesses
INS	*Instituto Nacional de Saúde* (National Institute of Health)
INSP	*Instituto Nasional Saúde Publiku (*National Institute of Public Health)
IPC	Interpersonal communication
IUD	intrauterine device
JDN	*Juventude ba Dezenvolvimentu Nasional* (Youth-led NGO)
JSI	JSI Research & Training Institute, Inc.
JUS	*Jurídico Social Consultoria*
KAP	knowledge, attitudes and practices
KSI	*Kadalak Sulimutu Instituto*
LARC	long-acting reversible family planning contraception
MDSR	maternal death surveillance and response
M&E	monitoring and evaluation
MCH	maternal and child health
MHS	Municipality Health Services
MNCH	maternal, newborn, and child health

MOH	Ministry of Health
NASG	non-pneumatic anti-shock garment
NGO	nongovernmental organization
PERMATIL	Permaculture Timor-Leste
PHC	primary health care
PHD	Partnership for Human Development
PNC	postnatal care
PPE	personal protection equipment
PPFP	postpartum family planning
PSA	public service announcement
PY	project year
QI	quality improvement
RDQA	routine data quality assessment
RH	reproductive health
RHTO	*Ra'es Hadomi Timor Oan*
SBCC	social and behavior change communication
SISCa	*Servisu Integradu Saúde Comunitaria* (Integrated Community Health Services)
SOE	state of emergency
SOP	standard operating procedure
SRH	sexual and reproductive health
Suco	village
TA	technical assistance
TLHIS	Timor-Leste health information system
TOR	terms of reference
TOT	training of trainers
TraKom	*Transporte Komunidade* (community transport)
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UPMA	*Unidade Planeamentu Monitorizasaun no Avaliasaun* (Planning Monitoring & Evaluation Unit under the Prime Minister)
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

USAID's Reinforce received $100,000 in additional funding in April 2020 to provide support to the Government of Timor-Leste (GOTL)'s response to the COVID-19 pandemic. This funding was issued to provide technical assistance to several key COVID-19 activities including improving facility readiness, training and orientation for health workers, prevention messaging for communities, training for youth leaders, and support for peer networks to increase evidence-based knowledge and appropriate COVID-19 behaviors. The funding also enabled the project to procure a new level 2 bio-safety cabinet for the National Laboratory at the request of USAID; it was delivered to the new facility in September 2020.

The purpose of this report is to document the activities and achievements during the six-month period of COVID-19 response support to the GOTL and MOH. Detailed descriptions of activities during the April to June quarter are provided in the quarterly report for that period.[1] This report also includes achievements not included in the monitoring data submitted in the Annual Monitoring Report. The definitions of the original indicators were based on assumptions about what the GOTL priority responses might be to the pandemic. Over time, it became clear that reaching beyond the service providers in the health system would be essential to establish effective prevention measures and quality care. The training indicator listed nurses, midwives, and doctors only; however, the project reached a much broader population of workers in the health system and this is reflected in the updated report on achievements found on page 9.

The emergence of the pandemic during the last year of the project created some challenges. To complete the project's workplan and respond to the emergency facing the GOTL, and especially the Ministry of Health (MOH), Reinforce quickly scaled up its capacity by contracting two partners, *Juventude ba Dezenvolvimentu* Nasional (JDN) and Health Alliance International (HAI). JDN had previously implemented the youth-led adolescent reproductive health (ARH) activities and was positioned well to train youth leaders and their networks quickly on COVID-19 facts and guidance. HAI was also a known partner to Reinforce and, through its home office in Seattle, HAI is an established recipient of USAID funding. HAI works closely with the MOH and the INS and is active in Covalima through its *liga inan* (Mobile Mother) project. HAI also is supporting the establishment of the new skills lab in Oecusse and has coordinated closely with Reinforce on including new members in the trainers' network and introducing SOPs.

This foundation of support and coordination enabled Reinforce to contract HAI quickly to second their staff to the Reinforce team and expand the project's reach in key areas for two months. Both of these partnerships worked very well and enabled USAID's Reinforce to complete all of its work and reach targets, while providing uninterrupted technical support to the MOH, INS, and the Covalima municipality. USAID's Reinforce contributed to orientation and training for health workers, coordination, community education, and community prevention, including a focus on youth leadership and peer networking as part of an effective communication strategy. USAID's Reinforce provided technical assistance and facilitation to Municipal COVID Task Force meetings and significantly contributed to collaboration and planning including among multiple partners supporting the MOH. This enabled the administrator, district public health officer (DPHO), and other leaders to assign and

[1] USAID's Reinforce QR Apr – Jun 2020 AID-472-A-16-00001

coordinate rapid responses, increase knowledge, introduce new behaviors, and share resources to prevent the spread of the virus.

The domestic restrictions under the State of Emergency (SOE) ended late in June and all Reinforce staff returned from remote working to work in the Dili and Covalima offices. All safety measures including physical distancing, hand washing, and wearing masks have been continued.

USAID's Reinforce maintained a high level of visible activity and responsiveness to all requests for assistance throughout the long SOE. Government partners at the municipal and national levels thanked the project publically for the significant contribution to the government's successful efforts.

When an opportunity arose to present COVID-19 work at the American Public Health Association meeting, the project team and JDN were pleased to have their abstract accepted. A video poster presentation was prepared to be viewed by conference participants in October 2020, adding to the global knowledge of USAID Timor-Leste's work to manage COVID-19.

Highlights

- USAID's Reinforce maintained a high level of activity throughout the state of emergency and was thanked by government partners for significant contributions.
- Reinforce used the additional funding to support the GOTL response to COVID-19 and **provided technical assistance to train 187 health workers and staff, orient 330 municipal health officers, facility managers, NGO representatives, and community leaders** during review meetings.
- **Trained 20 youth leaders, who in turn worked intensively with166 youth** who then influenced their families and friends. **Reached 13,000 young people with COVID-19 content over social media.**
- Technical staff contributed to health readiness assessments for COVID-19 and establishing isolation areas in facilities in Covalima.
- The project distributed shipments of equipment donated by USAID to facilities in Covalima, ensuring stronger readiness to cope with the pandemic through improved infection prevention.
- One bio-safety cabinet was delivered to the National Laboratory.

STRATEGY 1 – STRENGTHEN IN-SERVICE PROVIDER TRAINING

Action 1.1: Provide Organizational Development Assistance to INS

USAID's Reinforce technical staff participated in a meeting organized by *Instituto Nacional de Saúde* (National Institute of Health or INS) on a COVID-19 training package with other 25 participants from INS, MOH, CHC Vera Cruz, and other partners. The meeting ensured that participants are familiar with the training package and are prepared to provide further training to municipalities. The package consists of 13 topics covering infection prevention and control (IPC), triage, personal protective equipment (PPE), case management, psychology, transportation, special needs of patients with tuberculosis or HIV also exposed to COVID-19, maintaining essential services, health promotion, patient care, communication, and surveillance. INS and training partners, including Reinforce, established eleven teams to provide training to all municipalities, except Dili and Oecusse. Reinforce participated in the Covalima training.

Action 1.2: Support the Establishment of the INS as the Clinical Training Center for COVID-19

The INS played a leadership role in distributing COVID-19 materials to partners and coordinating support for technical areas including triage (or screening), IPC protocols, antenatal care (ANC), intrapartum and postpartum care, and other priority areas. INS also identified and prepared trainers for conducting orientation on these technical materials in all municipalities.

USAID's Reinforce incorporated this guidance and standards into all routine training, FUAT, supportive supervision, coaching, and other project activities. Community Health Officers (CHOs) were also orientated by senior Reinforce technical staff to ensure appropriate and consistent messages were included in all community engagements.

Project staff also contributed to clinical guidelines and orientation materials for antenatal care for mothers with suspected COVID-19 and the training of 90 health workers to provide these services safely.

STRATEGY 2 – IMPROVE QUALITY OF SERVICE DELIVERY

Action 2.1: Establish a Model of Quality Integrated Health Service Delivery COVID-19

Reinforce participated in an orientation at Dili National Hospital (HNGV) to train health workers to provide standard antenatal and postnatal care for mothers and babies who may be affected by COVID-19. Project staff applied the learning from this orientation to preparations for their own training, FUAT, and supervision roles.

The training was presented by Dr. Jose Antonio Gusmao Guterres, obstetrician; the INS executive director; and the director of HNGV and Covid-19 coordinator. Reinforce staff assisted during this training and then were able to support CHC staff in Covalima as they introduced preventive measures. Follow-up actions resulted in all health workers setting up triage systems in their facilities, reinforcing infection prevention standards, and making plans to ensure adequate PPE.

In coordination with DPHO MCH Covalima and the maternity coordinator of Suai Hospital, Reinforce conducted an orientation at Suai Referral Hospital.

Setting up the Hospital Nacional Guido Valadares (HNGV) screening and triage area for during training.

Health workers practice the use of PPE during training.

Reinforce technical staff gathered all COVID-19 IPC materials, including screening, triage, and setting up isolation areas, provided multiple copies to Municipality Health Services (MHS), and distributed them to all facilities they visited. During the six months of this reporting period, the project conducted 23 supportive supervision visits and 88[2] FUAT visits, all of which included COVID-19 orientation and coaching.

In collaboration with MHS, the project participated in a follow-up to the initial action plan and

[2] Including repeat visits to some facilities where additional coaching was needed.

monitored established triage procedures in health facilities including CHC Zumalai, CHC Tilomar, HP Labarai, HP Beco, HP Lakonak as well as at the border posts.

Project staff also provided assistance to the management and facilitation of bi-weekly coordination meetings and action planning for development partners and government staff in Covalima. There were ten COVID Task Force coordination meetings in all, reaching an average of 33 participants each time. These participants included several development partners along with municipality and community leaders (Cruz Vermelha Timor-Leste, CARE, World Vision, OXFAM, Mercy Corps, Plan, *Kadalak Sulimutu Instituto* (KSI), *Graca*, *Centru Comonidade Covalima* (CCC), Permaculture Timor-Leste (PNTL), *Ra'es Hadomi Timor Oan*, and community radio RCCT). Reinforce provided facilitation and technical support to the municipality and the meetings were led by the municipality administrator.

Reinforce also collaborated with the MOH to deliver health promotion activities on hand hygiene in Covalima. Following an initial orientation to key stakeholders in Dili, the Covalima MHS Director, Filipe Perreira Lemos, led the planning for the campaign in his municipality. The event amplified the messages that health workers need to continue disseminating information on the importance of washing hands to prevent diseases. Health workers were encouraged to be role models and to educate the community and distribute hygiene kits.[3] USAID's Reinforce supported the establishment of 74 hand washing stations and regularly monitored stations wherever they traveled and reported back to the municipality if repairs or supplies were needed.

STRATEGY 3 – IMPROVE COMMUNITY HEALTH-SEEKING AND SERVICE PROVIDER BEHAVIORS

Action 3.1: Support health workers to provide health education to support community members adopting healthy behaviors

From April to September, the Reinforce Project reached 645 women and 341 men through a series of group discussions and other activities. The discussions included FP, immunization, SCD, prevention of COVID-19, hand washing, and other health promotion topics. Health workers participated in and attended many of these activities.

The project's community health officers (CHOs), in collaboration with community leaders and health workers, distributed IEC materials including posters, stickers, and leaflets to households. In collaboration with health workers, the project staff conducted trainings of trainers on COVID-19 prevention for community leaders, organizing smaller groups to ensure physical distancing. After training, community leaders reported being prepared to disseminate this information to their communities.

The project's CHOs collaborated with community leaders and health workers to conduct health promotion activities and distribute IEC materials including posters, stickers, and leaflets to families (including pregnant women, lactating mothers, and children). The project provided hygiene kits and water tanks to several locations.

[3] Hygiene kits consist of a bucket, a bottle of liquid hand soap, and a hand washing job aid poster.

Action 3.2: Support the provision of adolescent health and puberty education

Reinforce partnered with a local youth-led group, JDN, to engage adolescents and young people to provide knowledge and tools to educate other young people, family members, and neighbors about COVID-19 prevention in a community-focused approach.

A total of 21 peer educators began adopting COVID-19 preventative practices, like hand washing, social distancing, and not touching their faces. They demonstrated their changed behaviors and other young people began to do the same and influence their families and communities.

The youth peer educators worked with 166 young people directly and reached over 13,000 young people with COVID-19 education messages posted on Facebook.

Qualitative results showed that 75% of beneficiaries began washing their hands regularly, and influenced behavior change in their families. As one 22 year-old female said, "I put the poster received from JDN on how to properly wash hands on the wall, so that my family also can follow; and I also set up a hand washing station so that everyone coming into the house washes hands."

Youth leaders discuss facts about COVID-19

The project's previous training for youth educators to engage, educate and motivate their peers to adopt health protective behaviors provided a skilled resource base that could readily be equipped to work in epidemic mitigation. Best practice interventions ensure that behavior change is not just among target beneficiaries, but also among friendship networks and family members, as a contribution towards the adoption of health care protective practices in the broader community.

In July 2020, a new call for abstracts for international work on COVID-19 was announced by the American Public Health Association for their annual meeting. USAID's Reinforce and JDN submitted an abstract, which was accepted for presentation. One of the JDN youth leaders prepared a video poster presentation, which was viewed by conference participants in October 2020. JSI is pleased to have added to the global knowledge of USAID Timor-Leste's work to manage COVID-19, especially in the United States.

COVID-19 ACHIEVEMENTS INCLUDING ADDITIONAL ACTIVITIES

The achievements in the table below resulted from a six-month period of support to the GOTL and MOH response to COVID-19. Detailed descriptions of activities during the April to June quarter are provided in the quarterly report for that period.[4] The monitoring data submitted in the Annual Monitoring Report includes what is presented below, however the table below also includes additional work that reflects needs that became more apparent after the indicators and COVID-19 work plan were approved. Over time, it became clear that reaching beyond the service providers in the health system would be essential in order to establish effective prevention measures and quality care.

COVID Indicators with Additional Achievements Included

No.	Indicator Name	Baseline	FY2020 Targets (Apr – Sept 2020)	Achieved	Original FY2020 Targets
	COVID-19				
3.8	Number of medical and paramedical practitioners trained in evidence-based guidelines for COVID-19 prevention	0	177	128[5]	N/A
Total number of staff in the health system trained or orientated in COVID-19 prevention				**187**	
3.9	Number of health workers (nurses, doctors and midwives) who have had FUAT in infection prevention and COVID-19 preparedness	14	106	64[6]	N/A
Total number of FUAT visits conducted with health workers (including repeat visits) that included COVID-19 prevention guidance, information, and coaching				**88[7]**	
Total number of supportive supervision visits to facilities that included COVID-19 prevention guidance				**23**	
3.10	Number of *Suco* and *Aldeia* leaders trained in RCCE for COVID-19 prevention	0	51[8]	70	N/A

[4] USAID's Reinforce QR Apr – Jun 2020 AID-472-A-16-00001

[5] Additional staff in the health system were trained, a total of **187** received COVID-19 prevention training. The achievement noted is in strict adherence to the definition for medical/paramedical practitioners.

[6] The MOH shifted all attention to preventing COVID-19 infections but did not establish a specific checklist for capturing this data. However, all FUAT included guidance on preventing COVID-19 infections.

[7] Each FUAT visit included coaching and guidance on COVID-19 and reached other staff in the facility, depending on who was present at that time.

[8] The target estimates one leader from each of the 10 *Sucos* in Covalima and one leader from the 41 *Aldeias* trained in COVID-19 prevention.

No.	Indicator Name	Baseline	FY2020 Targets (Apr – Sept 2020)	Achieved	Original FY2020 Targets
Total number of municipal health officers, facility managers, NGO staff, and community leaders who attended ten meetings to learn about COVID-19, assess the situation and make action plans				**330**[9]	
3.11	Number of youth leaders and ARH participants trained in RCCE for coronavirus prevention	0	40	130[10]	N/A
Total number young people reached with COVID-19 prevention messages through JDN's Facebook followers				**13,000+**	
Bio-safety cabinet procured and delivered to the National Laboratory in Dili				**1**	N/A

[9] Registers from these meetings indicate an average attendance of 33 participants during a total of 10 meetings supported by USAID's Reinforce.

[10] The project targeted 5 youth leaders and/or ARH participants from each of the eight selected *Sucos*. The final number achieved includes both youth leaders and youth/ARH participants.

ANNEX 19:

Performance Monitoring Plan

Revised FY2020 Performance Monitoring Plan

No.	Indicator Name	Achieved Oct 2019-May 2020	Revised Targets May-Sep 2020	Total Revised FY2020 Targets		Original FY2020 Targets	
1.0	**Maternal and Newborn Care**						
1.1	Maternal Mortality Ratio (impact)[1]	N/A	-	-		300 per 100,000 live births	
1.2	Neonatal Mortality Rate (impact)[2]	N/A	-	-		15 per 1,000 live births	
1.3	Percent of women receiving at least 4 antenatal care (ANC) visits during pregnancy (3.1.6-48). (HMIS)[3,4]	364	180	544	21% (2010) 27% (2015)	680	26% (2010) 34% (2015)
1.4	Percent or number of deliveries at health facilities. (HMIS)[5]	934	443	1,377	58% (2010) 76% (2015)	1,449	61% (2010) 80% (2015)
1.5	Percent of postnatal women receiving postnatal care (PNC) in the first 7 days after delivery. (HMIS)[6]	1,152	571	1,723	72% (2010) 95% (2015)	1,814	76% (2010) 100% (2015)
1.6		1,135	565	1,700	71% (2010)	1,789	75% (2010)

[1] Impact level indicators derived from TLDHS 2009-2010; endline target assumes all Timor-Leste and not specific to project municipality; project not solely responsible for impact indicators.

[2] Individual MNCH HMIS-derived indicators identified an approximate 5-6% decrease between March and April 2020, likely due to the initial COVID-19 concerns and closures around Timor-Leste. In addition to community members likely voluntarily postponing elective facility visits as a protective measure, MOH and facility attention initially turned to infection prevention education and measures. Therefore, reduced targets for indicator #1.4 – 1.7 by 5% to account for the COVID-19 effect. This target also assumes facilities will continue to collect HMIS data for the remaining months of the project period.

[3] Reduced ANC visits by 20% to account for both the COVID-1 effect (discussed in footnote #2); there have also been decreases in ANC visits due to the increased focus on improving the quality and accuracy of data recording at the facility level and ensuring consistent data definitions used across facilities.

[4] For the Total Revised Targets: Numerator is listed (target = 544); denominator the number of pregnant women in the catchment area. 2010 (using "2017 projections based on the 2010 census data") = 544/2626=0.207 x 100 = 21%. 2015 (using "2017 projections based on the 2015 census data") = 544/1,999 = 0.272 x 100 = 27%

[5] For the Total Revised Targets: Numerator is listed (target = 1,377); denominator the number of live births in the catchment area. 2010 (using "2017 projections based on the 2010 census data") = 1,377/2387=0.576 x 100 = 58%. 2015 (using "2017 projections based on the 2015 census data") = 1,377/1,818 = 0.757 x 100 = 76%

[6] For the Total Revised Targets: Numerator is listed (target = 1,723); denominator the number of live births in the catchment area. 2010 (using "2017 projections based on the 2010 census data") = 1,723/2387=0.721 x 100 = 72%. 2015 (using "2017 projections based on the 2015 census data") = 1,723/1,818 = 0.947 x 100 = 95%

No.	Indicator Name	Achieved Oct 2019-May 2020	Revised Targets May-Sep 2020	Total Revised FY2020 Targets		Original FY2020 Targets	
	Percent of newborns receiving postnatal health check within seven days after birth. (HMIS)[7]				94% (2015)		98% (2015)
1.7	Number or percent of children who received Pentavalent-3 (DPT3) by 12 months of age in USG-assisted programs (3.1.6-61). (HMIS)[8]	1,289	650	1,939	98% (2010)	2,041	103% (2010)
					115% (2015)		121% (2015)
2.0	**Family Planning**[9]						
2.1	Total Fertility Rate (impact).					4.5	
2.2	Couple Years Protection in USG supported programs (facilities or outreach supported by USG funds). (3.1.7-4)	2,285	1,172	3,457		5,960	
2.3	Number of counseling visits for FP/RH as a result of USG assistance. (3.1.7.1-2)	5,744	2,915	8,659		11,1001	
2.4	Percent of USG- assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide. (3.1.7.1-2)	4%	No Change	No Change		20%	
2.5	Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (3.1.7.1-3).	100% (28)	No Change	No Change		100% (28)	
3.0	**Capacity Building, Management, and Systems**						
3.1	Number of medical and paramedical practitioners trained in evidence-based	2	38	No Change		40	

[7] For the Total Revised Targets: Numerator is listed (target = 1,700); denominator the number of live births in the catchment area. 2010 (using "2017 projections based on the 2010 census data") = 1,700/2387=0.712 x 100 = 71%. 2015 (using "2017 projections based on the 2015 census data") = 1,700/1,818 = 0.935 x 100 = 94%

[8] For the Total Revised Targets: Numerator is listed (target = 1,939); denominator the number of children < 1 year in the catchment area. 2010 (using "2017 projections based on the 2010 census data") = 1,939/1,973=0.982 x 100 = 98%. 2015 (using "2017 projections based on the 2015 census data") = 1,939/1,680 = 1.15 x 100 = 115%

[9] FP indicators were reduced by 42% for CYPs and 22% for counseling visits to account for the impact of COVID-19. Other factors likely affecting FP indicators over the project year include some stockouts of the injectable method - a favorite method of clients - in several CHCs, and a higher proportion of LARCs selected y clients.

No.	Indicator Name	Achieved Oct 2019-May 2020	Revised Targets May-Sep 2020	Total Revised FY2020 Targets	Original FY2020 Targets
	guidelines for maternal and newborn health and family planning.				
3.2	Number of trained providers (doctors, nurses, and midwives) who have completed competency checks for MNH or FP.	2	38	No Change	40
3.3	Number of health workers (nurses, doctors and midwives) who have had FUAT in MNCH or FP post training.	20	30	No Change	50
3.4	Number or percent of health workers that demonstrate clinical competence against key clinical competency standards at the end of training and/or FUAT for family planning (FP) or maternal newborn health (MNH).	67%	--	75%	90%
3.5	Number of supportive supervision facility visits.	70[10]	No Change	No Change	50
3.6	Number or percent of health facilities that achieve or maintain comprehensive standards in FP or MH according to the MOH FP or MH supportive supervision checklist.	71% (27/38)	No Change	No Change	70%
3.7	Number of annual health *Suco* level implementation plans developed using data.	37	No Change	No Change	23

[10] This achievement represents supportive supervision for Health Facility Readiness (n=38), and clinic-based supervision in family planning (13), IMCI (7), and safe motherhood (n=12).

COVID-19 INDICATORS

No.	Indicator Name	Baseline	N/A	FY2020 Targets (Apr – Sept 2020)	Original FY2020 Targets
	COVID-19				
3.8	Number of medical and paramedical practitioners trained in evidence-based guidelines for COVID-19 prevention	0	177[11]	177	N/A
3.9	Number of health workers (nurses, doctors and midwives) who have had FUAT in infection prevention and COVID-19 preparedness	14[12]	106	106	N/A
3.10	Number of *Suco* and *Aldeia* leaders trained in RCCE for COVID-19 prevention	0	51[13]	51	N/A
3.11	Number of youth leaders and ARH participants trained in RCCE for coronavirus prevention	0	40[14]	40	N/A

[11] Includes doctors, nurses, and midwives

[12] There is an existing MOH FUAT checklist for infection prevention that has been applied with 14 health workers from Oct 2019 to Mar 2020, and serves as a baseline for this indicator. The target assumes 60% of health workers newly trained in the infection prevention guidelines will receive FUAT.

[13] The target estimates that 1 leader from each of the 10 *Sucos* in Covalima plus 1 leader from the 41 *Aldeias* will be trained in COVID-19 prevention.

[14] The project will target 5 youth leaders and/or ARH participants from each of the 8 selected Sucos.

ANNEX 20:

Environmental Mitigation and Monitoring Review

Environmental Mitigation and Monitoring Review

JSI is committed to ensuring minimal impact on the environment in all its activities. An Environmental Mitigation and Monitoring Plan (EMMP) was designed, drawing upon environmental management expertise, USAID regulations, and the applicable environmental policies, regulations, protocols, and guidelines of the Government of Timor-Leste, to address the small proportion of the project's activities that may have an effect on the natural or physical environment. These activities included:

- Training on topics or procedures that, when later implemented by MOH staff, can result in generation, storage, and disposal of medical waste (e.g., sharps, placenta, urine or stool specimens, and other biological samples).
- Activities if they involve procurement, storage, management, and/or disposal of public health commodities that are procured with USAID funds, including pharmaceutical drugs, immunizations, and nutritional supplements.

The EMMP does not anticipated increases for all indicators annually. Rather, the EMMP indicators help to ensure that project activities appropriately follow applicable environmental policies, regulations, protocols, and guidelines to minimize environmental impact.

Training curricula on family planning (FP), Safe and Clean Delivery (SCD), and Basic Emergency Obstetric Services (BEmOC) routinely includes a medical waste management and disposal section. All participants trained in FP, SCD, and BEmOC successfully completed the medical waste management section. Over the life of the project, 91 and 121 health workers completed the medical waste management and disposal sections as part of the FP and SCD/BEmOC trainings, respectively.

The project continued to conduct supportive supervision specific to FP (13) and SCD (12) during the project year. Over the LOP, 139 total supportive supervision visits took place – 69 for FP and 70 for SCD.

Waste disposal equipment for FP and maternal health (MH) was available in the relevant service areas. Among all assessments conducted in PY5, 97% had appropriate waste disposal equipment in both the FP and MH service areas. Over the LOP, 99% of FP service areas and 90% of MH service areas had appropriate waste disposal equipment. Assessments included those made at the same facility (to ensure continuous availability of required waste disposal equipment) as well as new assessments made to a facility.

A high proportion of health workers appropriately followed management and disposal procedures for medical waste management related to FP methods (22 out of 22) and safe/clean delivery (28 out of 28) when assessed during FUAT in PY5. Over the LOP, 93% and 100% of health workers followed the management and disposal procedures for FP and MH, respectively.

At a facility level, continued efforts have focused on ensuring available and accessible MOH guidelines for waste management and disposal of medical waste related to FP methods and MOH guidelines for management and disposal of blood and medical waste related to safe and clean delivery and obstetric emergencies. Significant improvements were made to ensure that these guidelines were not only available at facilities, but were also easily accessible during each readiness check made.

While improvements have been made in the availability of handwashing equipment in the FP and MH service areas during each assessment point, emphasis is still needed to help ensure facilities are properly equipped at each assessment point.

Facilities continue to receive support to assist with planning and budgeting for waste disposal and sanitation standards through the Quality Improvement Workshops. All 29 facilities received this assistance during the project year.

No	Project Activity	Monitoring Indicators	PY1 Results	PY2 Results	PY3 Results	PY4 Results	PY5 Results	Project Results	Description
TRAINING ACTIVITIES REQUIRING MITIGATION MEASURES									
E1	Training for health workers in the provision of family planning (FP) methods.	Number of healthcare workers who receive training on the management and disposal of medical waste related to FP methods.	17	30	10	20	14	**91**	The project trained 14 health workers in a MOH approved FP curriculum that includes a component on sanitary practices and waste management related to FP in PY5 and 91 over the LOP.
E2	Training for health workers in the provision of maternal health (safe and clean delivery and obstetric emergencies).	Number of healthcare workers who receive training on the management and disposal of blood and medical waste related to safe and clean delivery and obstetric emergencies.	0	77	28	4	12	**121**	The project trained 12 health workers in a MOH approved Safe and Clean Delivery (SCD) and 2 in Basic Emergency Obstetric Care (BEmOC) curriculum that includes a component on sanitary practices and waste management related to safe motherhood (SM) in PY5 and 121 over the LOP.
CAPACITY BUILDING ACTIVITIES REQUIRING MITIGATION MEASURES									
FAMILY PLANNING									
E3	Support health workers in the provision of family planning (FP) methods.	Number of facilities receiving FP supportive supervision.	5	22	6	23	13	**69**	The project supported 13 FP supportive supervision visits during PY5 and 69 over the LOP.
E6		Percent/Number of healthcare workers assessed who appropriately follow management and disposal procedures for medical waste	100% (5/5)	90% (26/29)	92% (23/25)	90% (10/11)	100% (22/22)	**93% (86/92)**	The project utilized the MOH's Follow Up After Training (FUAT) competency checklists to determine healthcare worker adherence to

		related to FP methods as verified through supportive supervision visits.							management/disposal procedures associated with FP methods. Out of 22 FP FUATs implemented, 22 assessments showed competency on the necessary FP medical waste management parameters (100%) in PY5 and 93% (86/92) over the LOP.
E8		Percent/Number of facilities assessed with relevant MOH guidelines for management and disposal of medical waste related to FP methods available on-site and accessible to all health Workers (during facility readiness checks).	14% (2/14)	10% (12/117)	88% (57/65)	95% (36/38)	92% (35/38)	**52% (142/272)**	The project utilized the MOH's Facility Readiness Format/Assessment to determine the guideline availability for management and disposal of medical waste related to FP Methods. Out of 38 separate assessments implemented, 35 assessments demonstrated that the appropriate guidelines were available at the time of the visit in PY5 and 52% (142/272) over the LOP.
E10		Percent/Number of facilities assessed with functioning waste disposal equipment (e.g. sharps boxes, incinerators) available and inventoried (FP service area)	100% (14/14)	100% (117/117)	95% (62/65)	100% (38/38)	97% (37/38)	**99% (268/272)**	Out of 38 assessments implemented, 37 assessments showed waste disposal equipment was available in the FP service area in PY5 and 99% over the LOP.
E12		Percent/Number of facilities assessed with	57% (8/14)	43% (50/117)	51% (33/65)	75% (28/38)	63% (24/38)	**53% (143/272)**	Out of 38 assessments implemented, 24

		appropriate hand-washing equipment (water, soap) available and inventoried (FP service area)							assessments showed handwashing equipment was available in the FP service area in PY5 and 53% (143/272) over the LOP.
MATERNAL HEALTH									
E4	Support health workers in the provision of maternal health (safe and clean delivery and obstetric emergencies) through supportive supervision.	Number of facilities receiving safe/clean delivery or BEmOC (safe motherhood) supportive supervision.	5	21	6	26	12	**70**	The project supported 12 SM supportive supervision visits during PY5 and 70 over the LOP.
E7		Percent/Number of healthcare workers assessed who appropriately follow management and disposal procedures for medical waste related to safe/clean delivery or obstetric emergencies as verified through supportive supervision visits.	N/A	100% (34/34)	100% (16/16)	100% (47/47)	100% (28/28)	**100% (125/125)**	The project utilized the MOH's Follow Up After Training (FUAT) competency checklists to determine healthcare worker adherence to management/disposal procedures associated with SCD. Out of 28 SCD FUATs implemented, 28 assessments showed competency on the necessary safe motherhood medical waste management parameters (100%) in PY5 and 100% (125/125) over the LOP.
E9		Percent/Number of facilities assessed with relevant MOH guidelines for management and disposal of blood	20% (1/5)	7% (8/117)	89% (58/65)	95% (36/38)	92% (35/38)	**52% (138/263)**	The project utilized the MOH's Facility Readiness Format/Assessment to determine the guideline availability for management and

		and medical waste related to safe and clean delivery and obstetric emergencies available on-site and accessible to all health workers (during facility readiness checks).							disposal of medical waste related to SCD. Out of 38 separate assessments implemented, 35 assessments demonstrated that the appropriate guidelines were available at the time of the visit in PY5 and 52% (138/263) over the LOP.
E11		Percent/Number of facilities assessed with functioning waste disposal equipment (e.g. sharps boxes, incinerators) available and inventoried (MH Service area).	80% (4/5)	86% (101/117)	88% (57/65)	100% (38/38)	97% (37/38)	**90% (237/263)**	Out of 38 assessments implemented, 37 assessments showed waste disposal equipment was available in the MH service area in PY5 and 90% over the LOP.
E13		Percent/Number of facilities assessed with appropriate hand-washing equipment (water, soap) available and inventoried (MH service area).	40% (2/5)	41% (48/117)	49% (32/65)	74% (28/38)	63% (24/38)	**51% (134/263)**	Out of 38 assessments implemented, 24 assessments showed handwashing equipment was available in the MH service area in PY5 and 51% over the LOP.
OTHER									
E5	Support facilities in the implementation of the Facility Readiness Format (FRF).	Number of facilities receiving Facility Readiness Format supportive supervision.	13	61	86	38	38	**206**	38 supportive supervision visits specific to assessing the basic services package via the MOH's Facility Readiness Format (FRF) were conducted in PY5 and 206 over the LOP.
E14		Percent of facilities that meet sanitation and waste disposal standards according to	29% (2/7)	95% (20/21)	88% (24/27)	100% (21/21)	100% (12/12)	**90% (79/88)**	Based on the MOH's FRF for CHCs and the Referral Hospital, which contain a waste disposal

		scoring of the FRF.							question. Out of 12 assessments implemented, all 12 indicated that the facility met the sanitation and waste disposal standards in PY5 and 90% (79/88) over the LOP.
E15		Number of facilities receiving assistance in planning and budgeting for appropriate waste disposal and sanitary equipment related to FP and/or safe/clean delivery and obstetric emergencies.	0	23	25	28	29	**105**	Through the Quality Improvement workshops based on the Service Availability and Readiness Assessment (SARA) data, all facilities have received assistance in planning for identified priority areas.
E16		Number of facilities receiving assistance in planning and budgeting for appropriate waste disposal and sanitary equipment related to safe/clean delivery and obstetric emergencies.	N/A	23	25	28	29	**105**	
E17		Number of facilities receiving guidance in their planning and budgeting procedures to ensure the facility provides for health worker protection, appropriate medical waste disposal, and provision of other related materials (e.g., sharps boxes, cleaning supplies, incinerator repairs/maintenance, etc.) as indicated in the FRF.	N/A	23	25	28	29	**105**	

ANNEX 21:

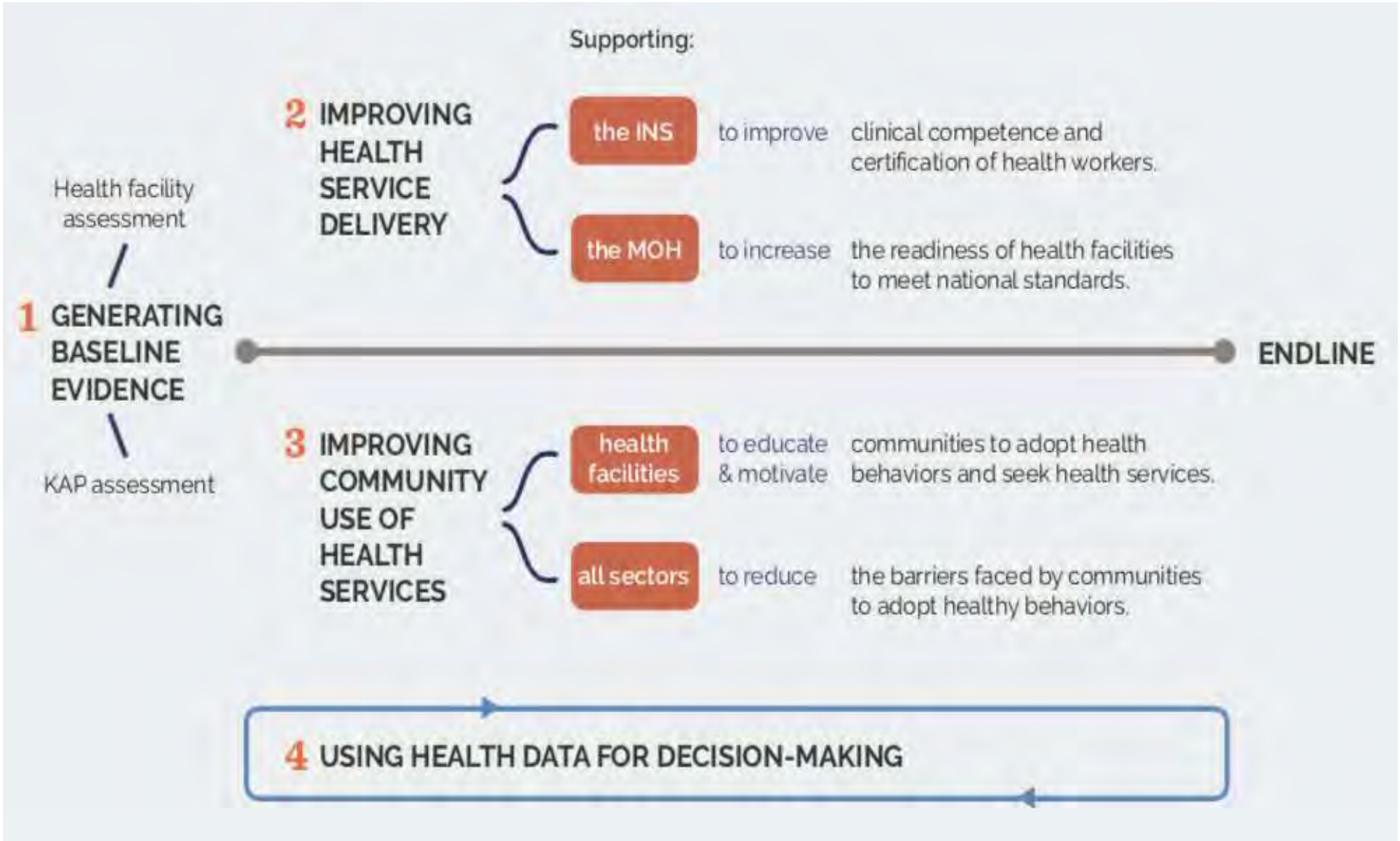
Results Presentation: End of Project Conference

USAID's Reinforce Basic Health Services Project
A PRESENTATION OF PROJECT RESULTS

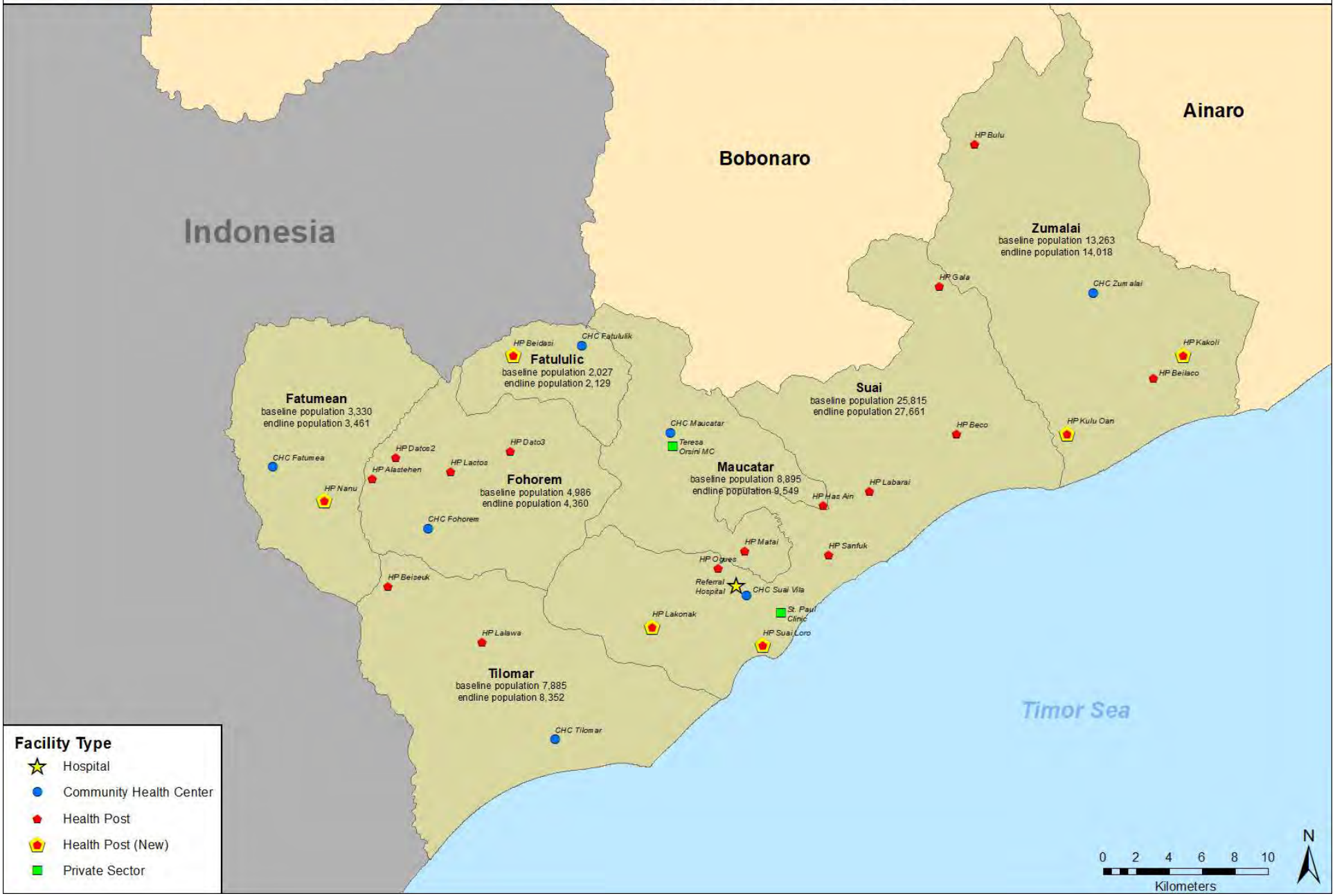
About USAID's Reinforce

- Five-year cooperative agreement
- 2015 – 2020
- Implemented by JSI Research & Training Institute, Inc.
- Worked at national level and in Covalima Municipality

Our Approach and Objectives



Covalima: Health Facilities and Population by Sub-District



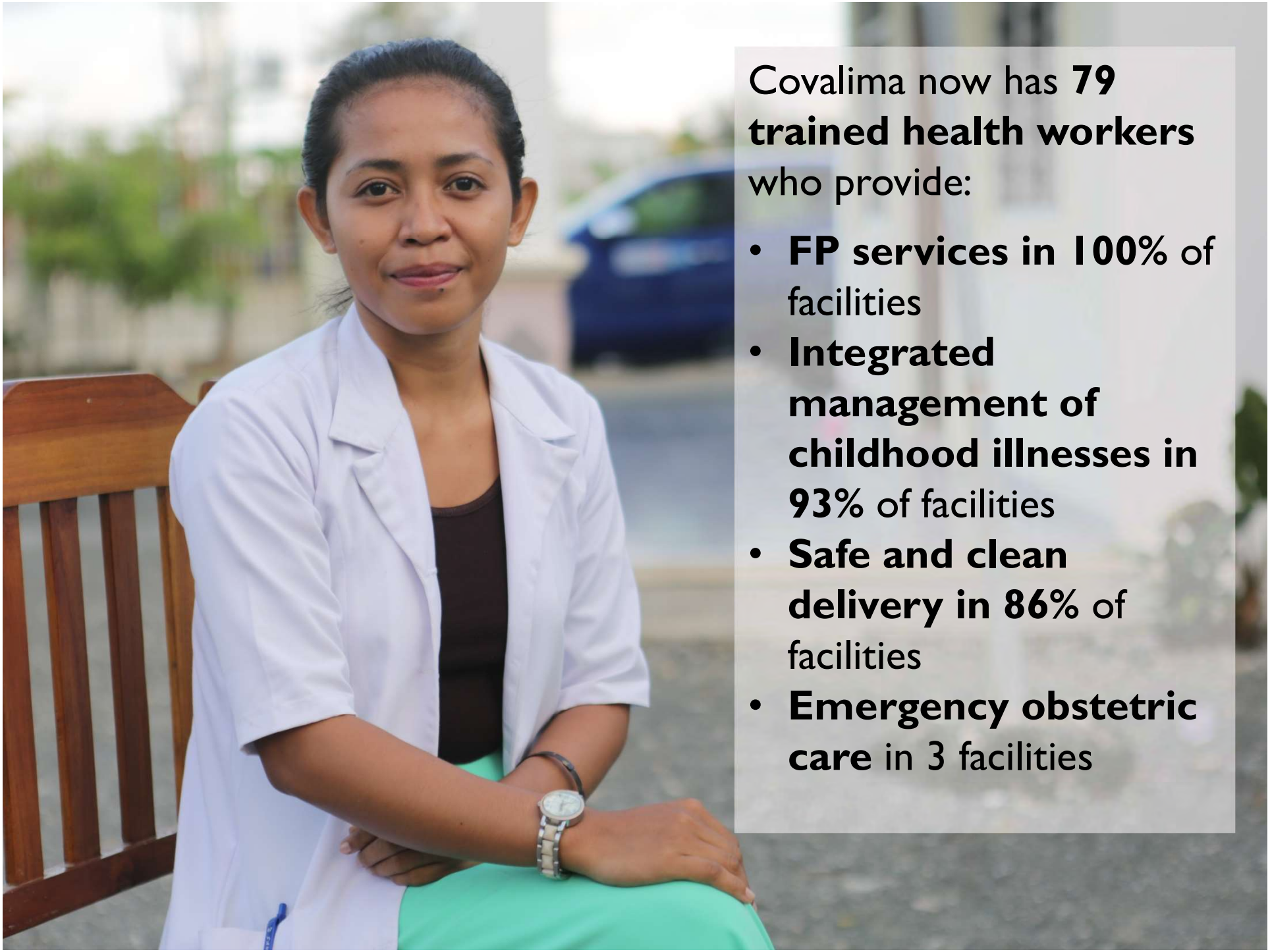
Partnership with INS

- **Updated curricula** and supporting materials
- **Increased trainings** and follow up after trainings
- **Trainers' discussion forum** meets quarterly

Models for competency-based training

USAID's Reinforce helped introduce **competency-based training** at INS, which is now supported by **four skills labs** and **three clinical practice sites**.

USAID's Reinforce worked with INS to **increase the availability of MNCH and FP services**

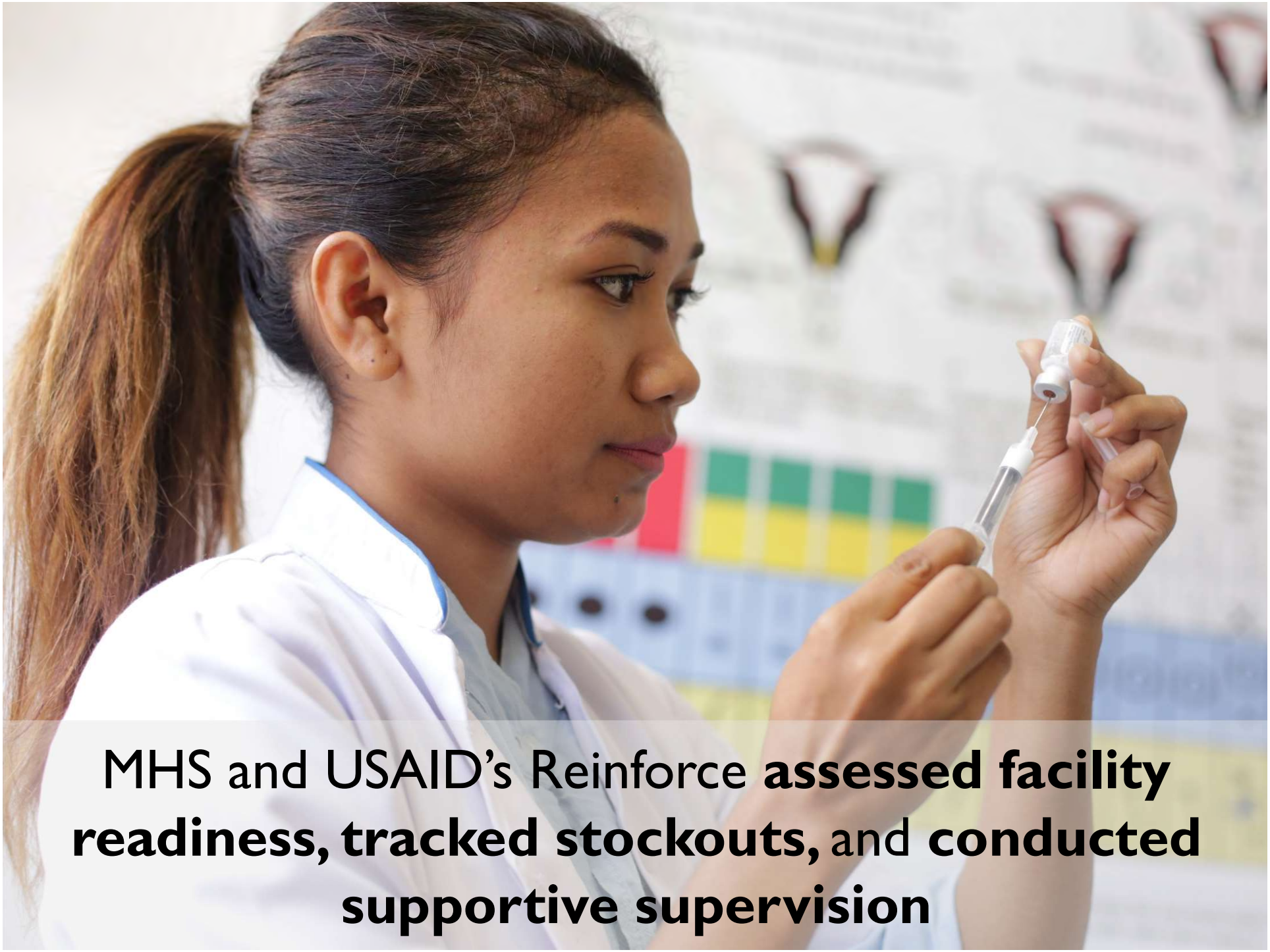


Covalima now has **79 trained health workers** who provide:

- **FP services in 100%** of facilities
- **Integrated management of childhood illnesses in 93%** of facilities
- **Safe and clean delivery in 86%** of facilities
- **Emergency obstetric care** in 3 facilities

• **Seven INS trainers** now based in Covalima
• **22 new trainers** trained with project support

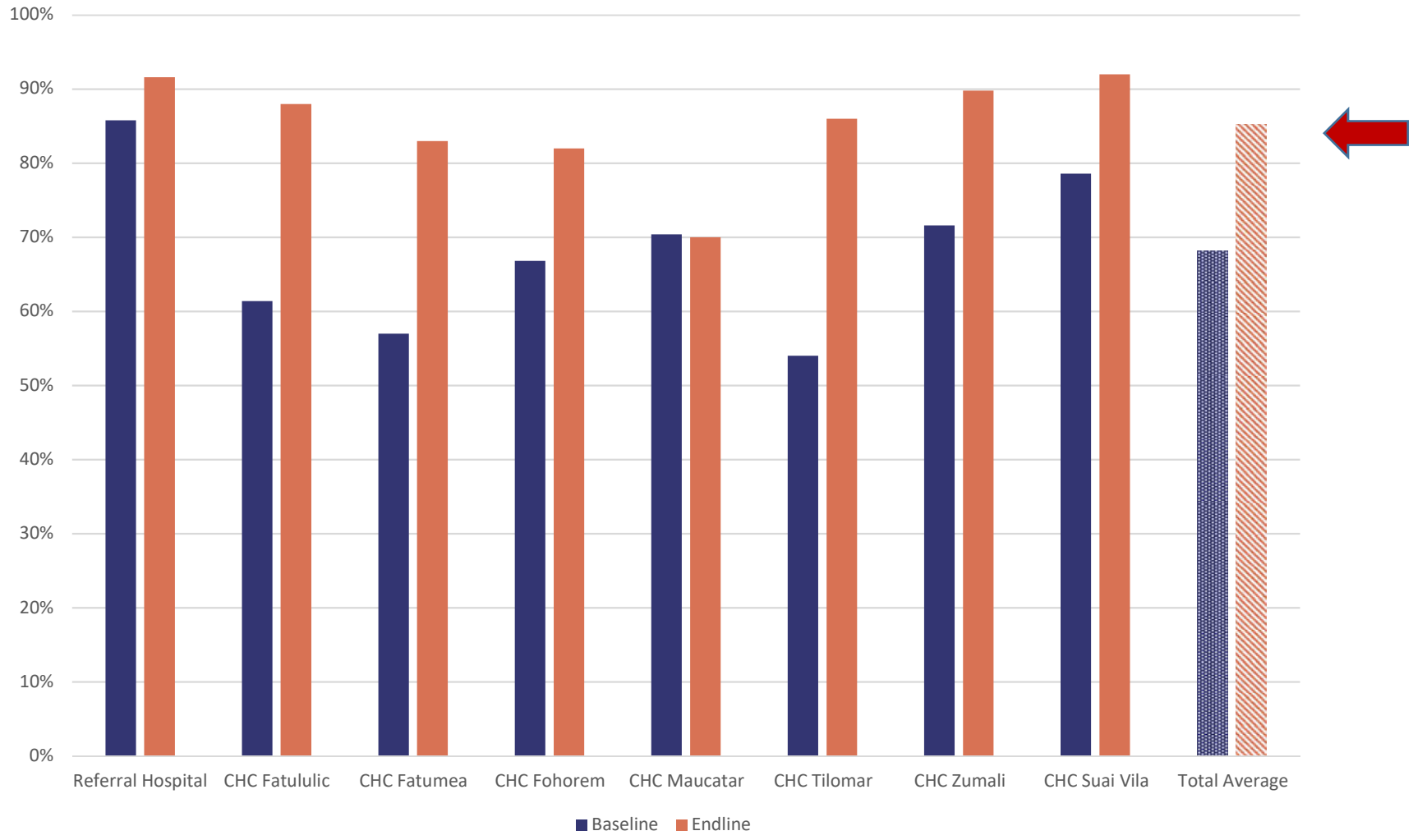
Improved Facility Readiness



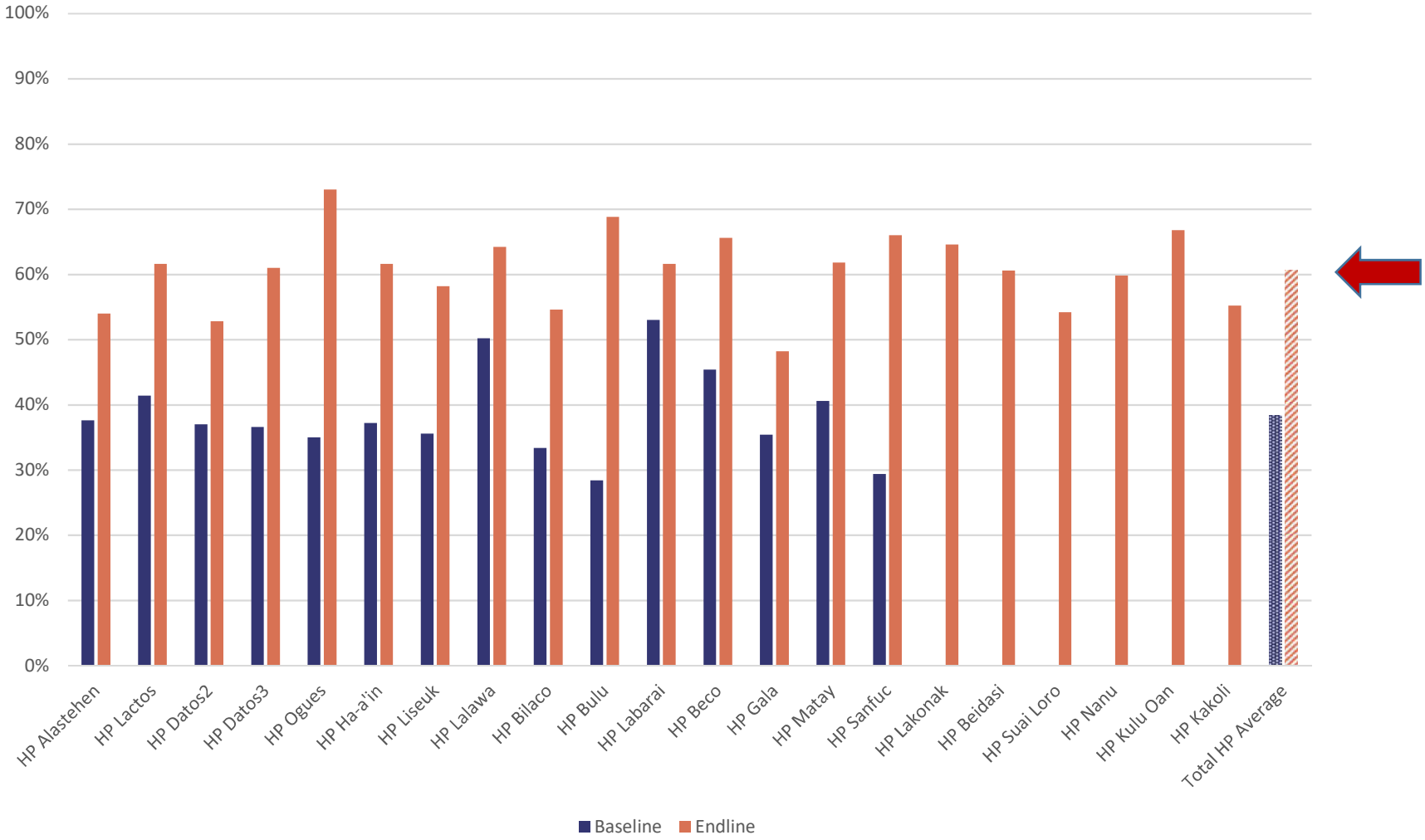
MHS and USAID's Reinforce **assessed facility readiness, tracked stockouts,** and **conducted supportive supervision**

USAID donated medical equipment, which was distributed to all health facilities in Covalima, helping to improve facility readiness

The **average readiness score across CHCs and the hospital** improved from **68% at baseline to 85% by endline**.

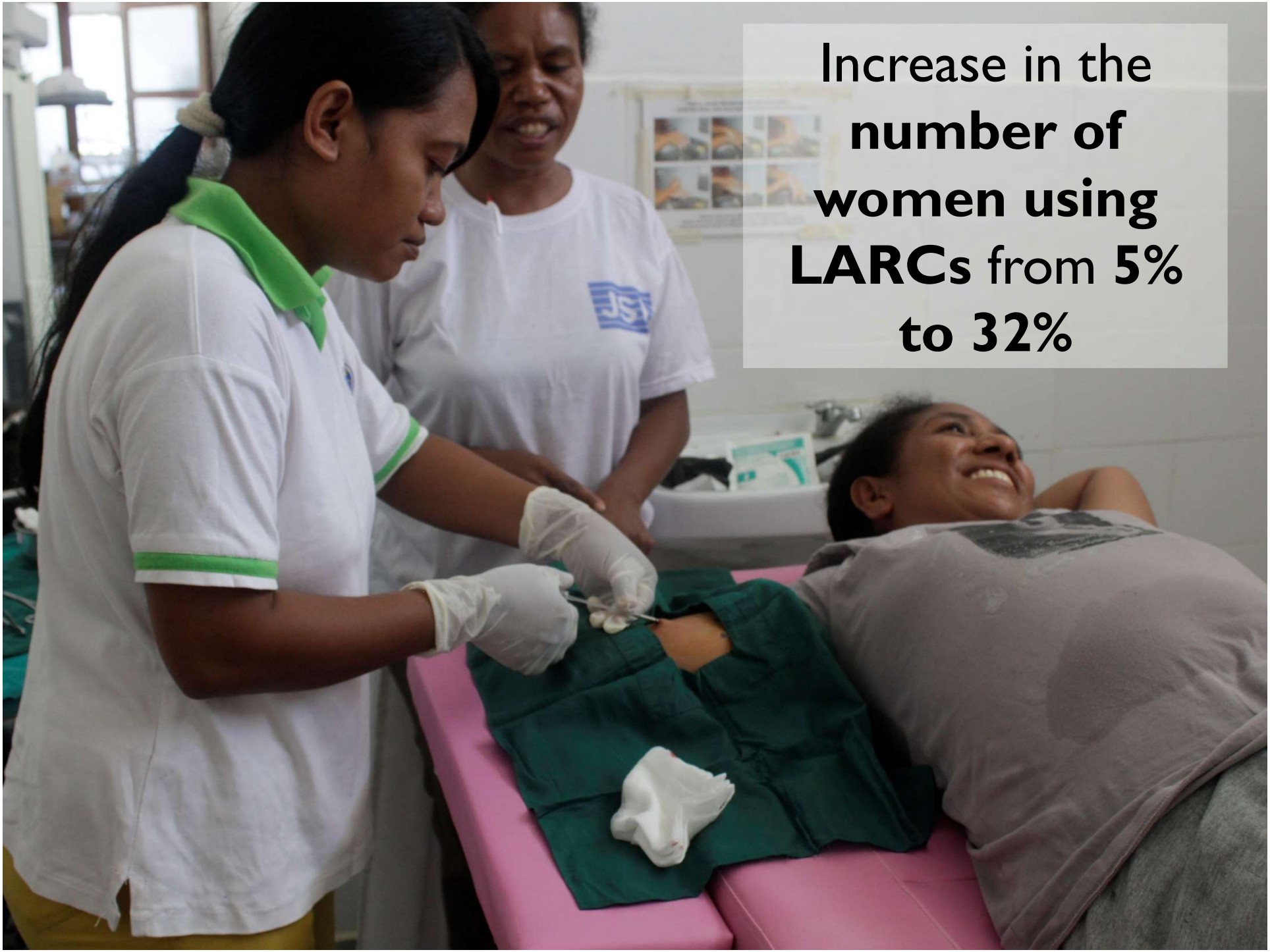


The **average readiness score across health posts almost doubled** from 38% at baseline to 61% by endline.



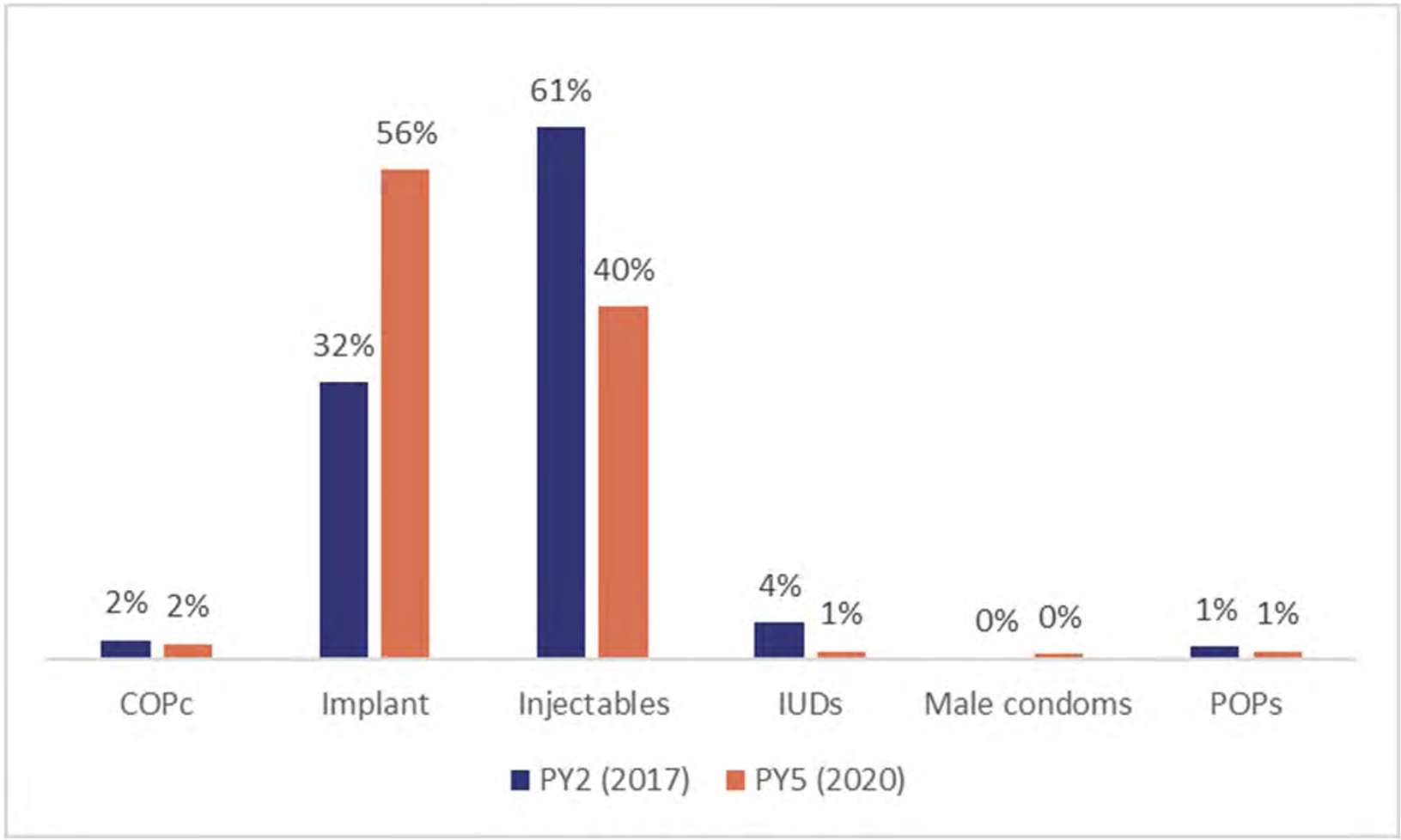
Community Use of Health Facilities Improved

Reached 122 communities with health information via discussion groups, films, PSAs, and other social and behavior change efforts



A153

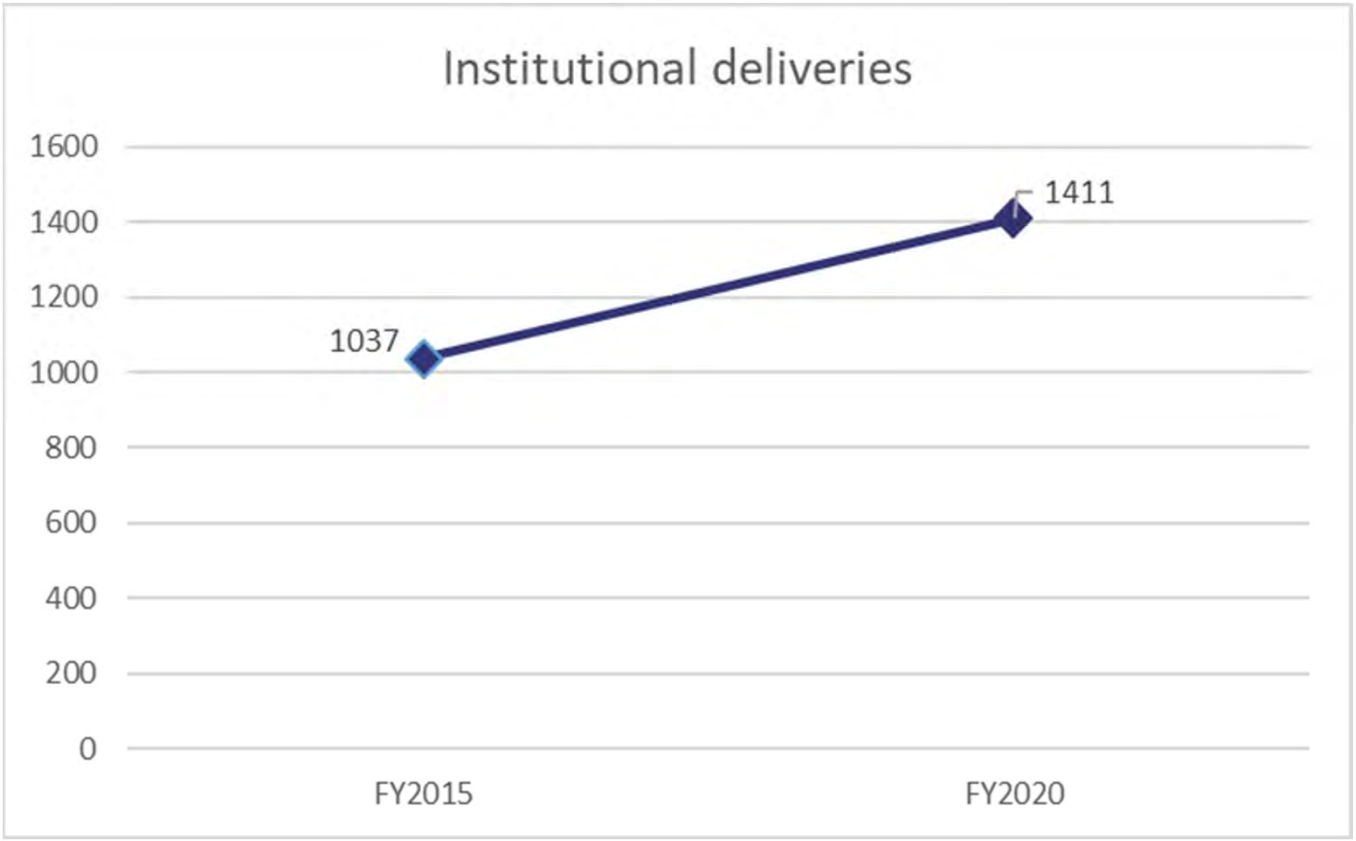
Change in FP Method Mix



Increase in
facility-based
deliveries from
32% to 40% in
the hospital and
8% to 22% in
CHCs

A155

Increase in facility-based deliveries

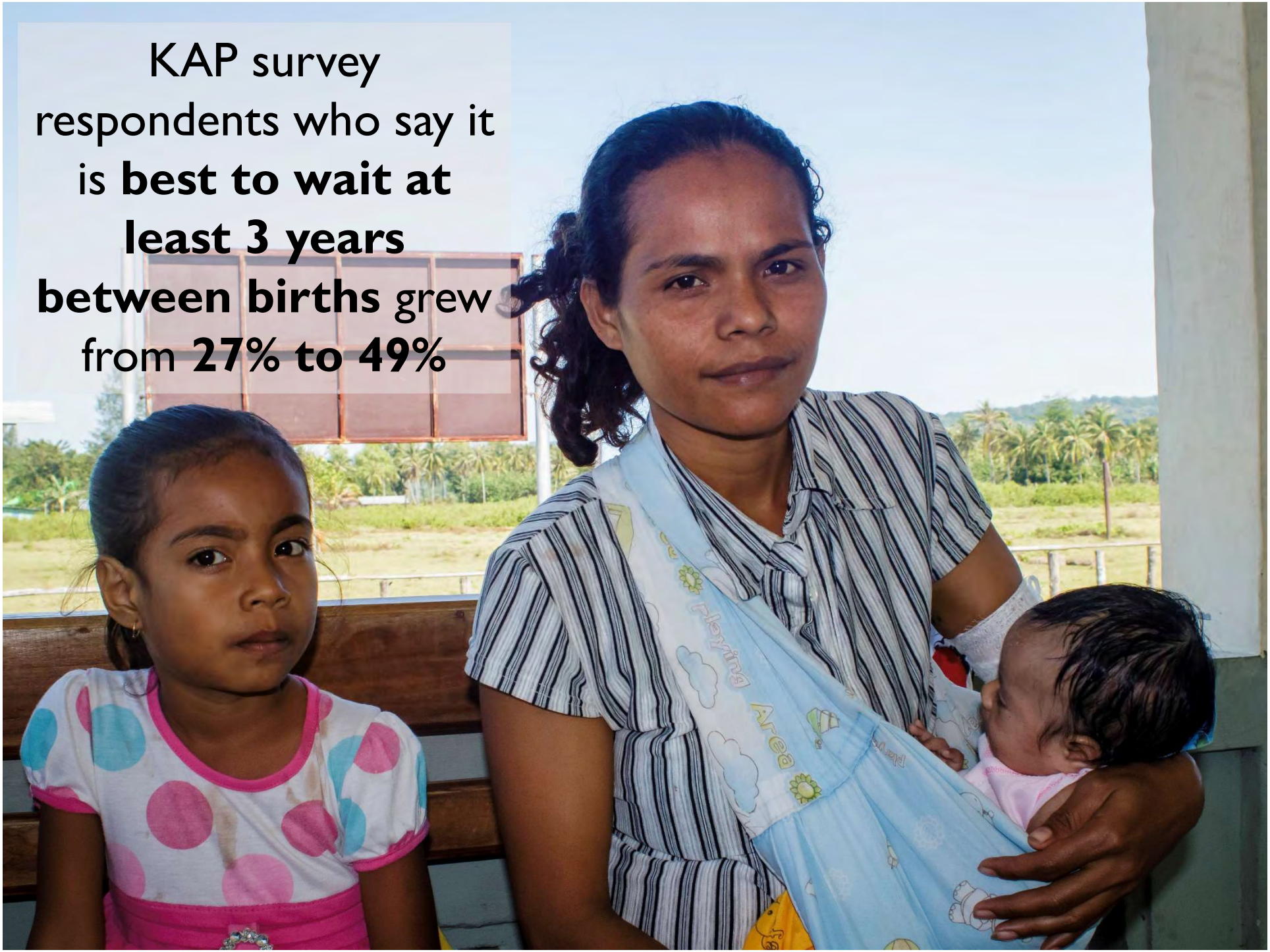


AD5

All health facilities now have trained staff to deliver IMCI, greatly **improving diagnosis and treatment for several childhood diseases**.

Slide 23

AD5 In a previous slide, we say only 93% of facilities have trained IMCI providers -- which is correct?
Andrea Dickson, 10/13/2020


KAP survey respondents who say it is **best to wait at least 3 years between births** grew from **27% to 49%**

Reaching Adolescents with Health Information

- **Youth helped design and pilot** the ARH curriculum in Covalima
- **188 youth** participated in ARH workshops
- MOH piloted the ARH curriculum in **four additional municipalities**
- **MOH approved** the ARH curriculum in 2020 for nationwide use

A161

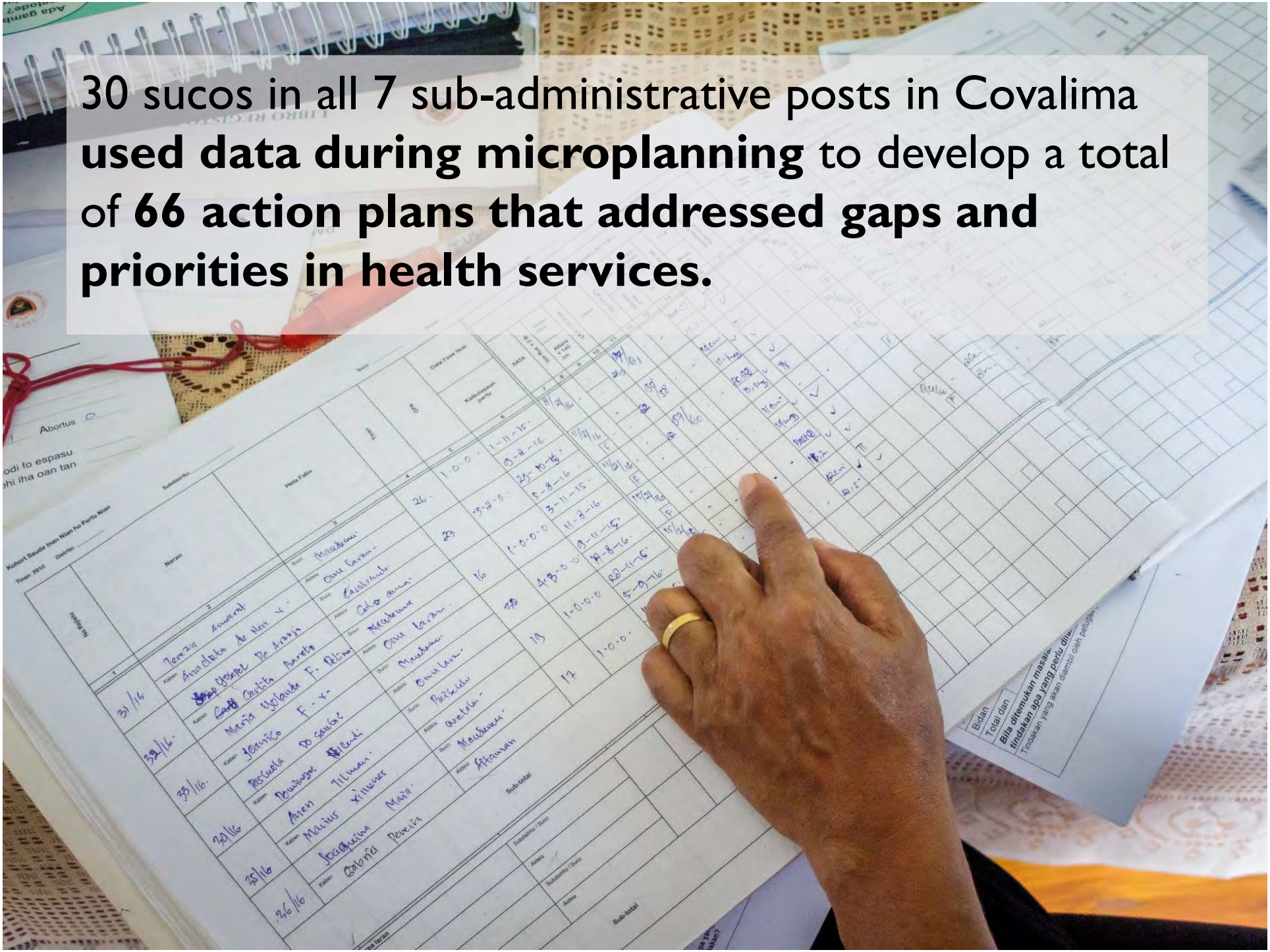
Youth Leadership Key to Communicating COVID-19 Messages

- **Four youth** who participated in ARH workshops **stepped up to lead COVID-19 workshops** for peers
- **129 youth were reached with information about COVID-19** through peer-led workshops

Data for Decision-Making

The **quality of reporting in Covalima has improved** as a result of conducting **data quality assessments.**

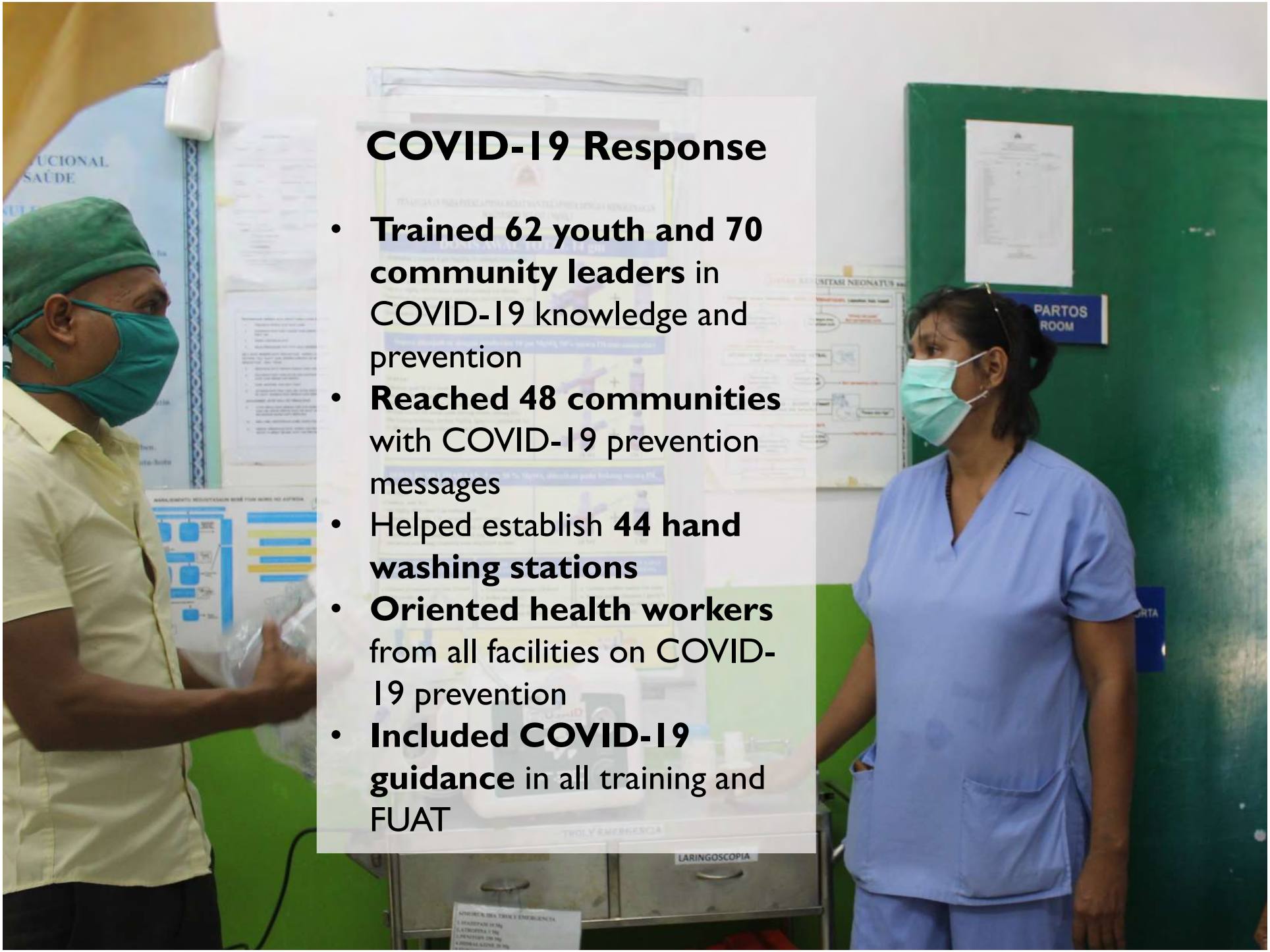
A164


30 sucos in all 7 sub-administrative posts in Covalima **used data during microplanning** to develop a total of **66 action plans that addressed gaps and priorities in health services.**

WORKSHOP HAMETIN KOOPERASAUN
ENTRE INSTITUTO NACIONAL DE SAÚDE
HO PARSEIRU DEZENVOLVIMENTU
DILI, 27 TO'O 28 ABRIL 2017
USAID
JSI
MARIE STOPES
TIMOR-LESTE
ST JOHN OF GOD
unicef

Innovations

- TraKom
- Skills labs
- Management training for QI
- Youth leadership
- Response to COVID-19



COVID-19 Response

- **Trained 62 youth and 70 community leaders** in COVID-19 knowledge and prevention
- **Reached 48 communities** with COVID-19 prevention messages
- Helped establish **44 hand washing stations**
- **Oriented health workers** from all facilities on COVID-19 prevention
- **Included COVID-19 guidance** in all training and FUAT

A169

The Journey to Self-Reliance

- Changing attitudes at the community level
- More skilled health workers
- Better equipped and managed facilities
- Committed leadership at all levels of the health system
- Government has invested in capacity development and has begun to scale key inputs, e.g., skills labs, ARH program

Recommendations for the Way Forward

Recommendations for the Way Forward

1. **Prioritize transport** for patients to reach care and for health managers to support staff, collect data, and follow-up after training.
2. **Strengthen waste management** systems.
3. **Strengthen human resources** systems, including job descriptions, clear career paths, and salary scales.
4. **Improve management training** at all levels of the health system to impact quality and sustainability.

Partnerships

Thank you!

This presentation was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents of this presentation are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States government.

ANNEX 22:

Report on Dissemination of Model Municipality Results at National MOH Review Meeting

USAID's REINFORCE REPORT ON DISSEMINATION OF MODEL MUNICIPALITY RESULTS AT NATIONAL MOH REVIEW MEETING

Following USAID's Reinforce close-out meeting in Covalima, the Director General of Health Services Delivery, Dr. Odete Da Silva Viegas, asked the project team to share the impressive results and learning with all municipal MOH representatives during the upcoming national review meeting so that other municipalities could apply the learning from the Covalima model municipality.

The national review meeting was held on November 16-18, 2020 in the Manufahi municipality. The objectives of the meeting were (a) to review the MOH strategic plan 2011 to 2030, (b) to measure progress using indicators and identifying achievements, and (c) to provide input from all participants regarding successes and challenges. Meeting participants included MoH Vice Ministers Sr Bonifácio Mau Coli dos Reis, former MOH Vice Ministers Sr Luis Lobato and Sra Ana Isable. Also in attendance were 13 MHS Directors, all CHC managers, national directors from Quality Improvement, Public Health, Planning and Policy, and Finance. Chiefs of all MOH departments attended, as did several development partners including UNICEF, WHO, MSTL (Marie Stopes Timor-Leste), PHD (Partners in Health Development) and HAI (Health Alliance International).[i]

USAID's Reinforce Deputy Chief of Party, Mr. Julio Goncalves presented the results on the third day of the meeting. Copies of the presentation slides were provided to participants in both Tetun and English and the presentation was in Tetun.

Comments from MHS directors, the Finance Director and the Chief of the HMIS Department included an appreciation for the use of baseline and endline data to use in design of interventions and to measure the achievements. The identified it as a good learning approach that could be further modeled by others.

Participants also noted the implementation design and effective partnership with government. An Advisor for the Minister of Health expressed appreciation for the presentation and the approach of the project. She noted that it could be also be replicated by selecting one CHC in order to model this systems approach.

The project results were applauded and Mr. Goncalves was encouraged to share final reports with MOH directors. Other partners such as PHD and HAI also requested copies.

[i] 1) Vice Minister, Bonifacio Maucoli Dos Reis.
2) Director General Service Delivery, Dr. Odete Da Silva Viegas
3) Director General Corporative, Victor Soares Martins
4) Director of Cabinet Policy, Planning and Cooperation, Narciso Fernandes
5) Former Vice Minister IV Constitutional Government, Luis Lobato
6) Former Vice Minister VII Constitutional Government, Ana Isabel F.S.S (Attended project launch)
7) National Director of Public Health, Isabel Maria Gomes
8) INS Executive Director, Domingas Pereira.
9) National Ambulance Director, Dr. Nilton Da Silva

10) Finance Director, Marcelo Amaral
11) HMIS Department Head, Ivo Cornelio Guteres
12) M&E Department Head, Carlito Freitas
13) HP Department Head, Misliza Vital
14) Director of Quality Control Cabinet, Feliciano Pinto
15) National Laboratory Director, Dr. Endang Da Silva
16) SAMES Executive Director, Santana Martins.
17) Director of Medical Equipment and Medicines, Dr. Alipio Gusmao.
18) Other national directors, Hospital Directors, 13 MHS Director, CHC managers, Department Heads attend

ANNEX 23:

USAID'S Reinforce Report to the Ministry of Health

USAID's Reinforce Basic Health Services Project

Final Report to the Ministry of Health
December 2015 – December 2020

USAID
FROM THE AMERICAN PEOPLE

JSI

A178

Final Report to the Ministry of Health
December 2015 – December 2020

Submitted to
Ministry of Health Timor-Leste
December 15, 2020

Prepared by
JSI Research & Training Institute, Inc. (JSI)
www.jsi.com

Cover photo: Midwife practicing counseling on the whole range of contraceptive methods during one of the numerous family planning trainings support by Reinforce.

DISCLAIMER
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ACRONYM LIST

ANC	antenatal care
BEmONC	basic emergency obstetric and newborn care
BPCR	birth preparedness and complication readiness
CHC	community health center
COVID-19	commonly used acronym for coronavirus 2019
CPR	contraceptive prevalence rate
ENBC	essential newborn care
FP	family planning
FUAT	follow-up after training
GBV	gender-based violence
HP	health post
HMIS	health management information system
IMCI	integrated management of childhood illnesses
INS	*Instituto Nacional de Saúde* (National Institute of Health)
IP	infection prevention
IUD	intrauterine device
JDN	*Juventude ba Dezenvolvimentu Nasional* (Youth for National Development)
JSI	JSI Research & Training Institute, Inc. and John Snow, Inc.
KAP	knowledge, attitudes and practices
LARC	long-acting reversible method
LISIO	*livriñu saúde inan no oan* (maternal and child health booklet)
LMIS	logistic management information system
M&E	monitoring and evaluation
MHS	Municipality Health Services
MMR	maternal mortality rate
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
PHC	primary health care
PNC	postnatal care
RDQA	routine data quality assessment
SARA	service availability and readiness assessment
SBA	skilled birth attendance
SBC	social and behavior change
SCD	clean and safe delivery
TLDHS	Timor-Leste demographic and health survey
TraKom	*Transporte Komunitáriu* (Community Transport)
USAID	United States Agency for International Development
WRA	women of reproductive age

INTRODUCTION

Since it gained independence in 2002, Timor-Leste has made substantial progress in maternal, newborn and child health (MNCH). Between 2009 and 2016, years of the last two Timor-Leste demographic and health surveys (TLDHS),[1] the percentage of pregnant women attending at least four antenatal care (ANC) consultations increased from 55 to 77 percent, institutional delivery increased from 22 to 49 percent, and the maternal mortality ratio (MMR) decreased from 557 to 195 deaths per 100,000 live births.

Despite these positive trends, the MMR remained very high (second highest in South-East Asia), the neonatal mortality rate stagnated at 19 deaths per 1,000 live births, and the percentage of women getting the first postnatal care (PNC) within 2 days after delivery reached just 35 percent coverage in 2016. While the contraceptive prevalence rate (CPR) progressed significantly during the first five years of the family planning (FP) program implementation (2004-2009), it slowed down during the following years to reach 24 percent in 2016, with an unmet need of 25 percent.

For more than 15 years, the Ministry of Health (MOH) has prioritized MNCH programs, as outlined in numerous policies, strategies and plans, and while this focus translated into encouraging results, more efforts needed to be made in order to improve the quality of care and reach the population not accessing services. These were the objectives of the Reinforce Basic Health Services Project (Reinforce), implemented over a period of five years (2016-2020) by JSI Research & Training Institute, Inc. (JSI), with funding from the United States Agency for International Development (USAID). Reinforce focused most of its support in one municipality, Covalima, to showcase a functioning and strengthened municipal health system able to achieve and sustain increased quality and coverage for MNCH and FP.

Figure 1. Municipal Health Systems Strengthening Approach

[1] National Statistics Directorate, Ministry of Finance, Democratic Republic of Timor-Leste. (2010). *Timor-Leste Demographic and Health Survey 2009-2010 (TLDHS 2009-10)* and General Directorate of Statistics, Ministry of Planning and Finance, Ministry of Health, Democratic Republic of Timor-Leste. (2018). *Timor-Leste Demographic and Health Survey 2016 (TLDHS 2016).*

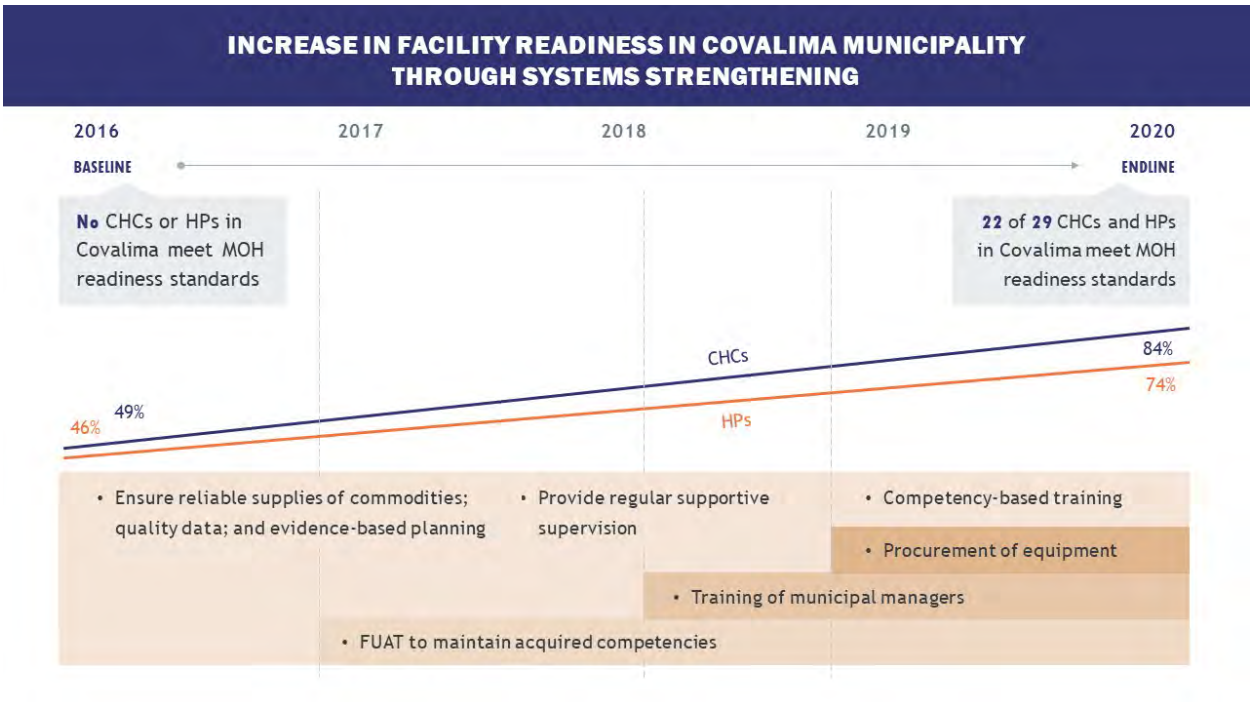
USAID's Reinforce worked with the MOH and the *Instituto Nacional de Saúde* (INS – National Institute of Health) to implement a package of health systems strengthening activities provided in the form of training, coaching and mentoring, which led to (1) improved quality services provided by skilled health workers in well-prepared facilities and (2) increased access and use of services by women, their families and communities, as illustrated in Figure 1 above. This report presents a summary of the project's main results, quantified with data from the project's baseline and endline assessments, the project's monthly monitoring, and the MOH's health management information system (HMIS).

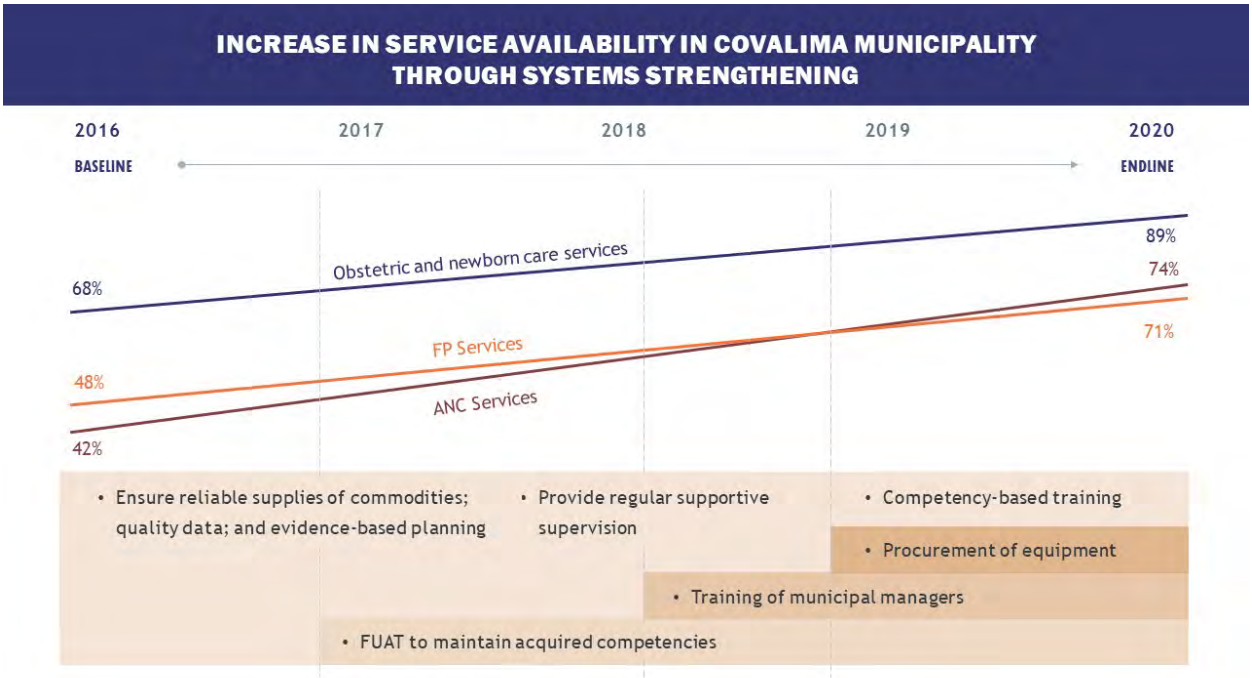
RESULTS

Outcome 1: Quality Services Provided by Skilled Health Workers in Well-prepared Health Facilities

Between 2016 and 2020, the readiness of community health centers (CHCs) improved from 49 to 84 percent and the readiness of health posts (HPs) improved from 46 to 74 percent. By the end of the project's five years, 22 out of Covalima's 29 health facilities (76 percent) met the MOH readiness standards. The availability of services also improved significantly, as see in the second graph. (Figure 2).

Figure 2. Facility Readiness Improvements in Covalima Municipality





The 'readiness' was measured with the standard MOH checklist, which includes the various elements necessary for providing quality services: trained and competent providers, well-equipped facilities (furniture, equipment, medicines, commodities), functioning infrastructure (electricity, water, sanitation), skilled managers and supportive supervisors, quality data, and evidence-based planning. Figure 2 also shows how Reinforce addressed these elements at different phases of the project's implementation, with some activities spread across the five years and others more restricted in time, all informed by the findings of the baseline service availability and readiness assessment (SARA).[2]

1) Facility Readiness Baseline Assessment

The baseline SARA (2016) highlighted several weaknesses in Covalima's facilities, particularly the HPs (details can be found in the baseline and endline SARA reports). For example, among Covalima health facilities:

- Less than half had electricity available and water piped into the building, and about one-fourth had no sanitation facilities available or non-improved sanitation facilities.
- Most were largely lacking functioning basic and infection prevention (IP) equipment.
- Only half had key selected medicines.
- Around half were staffed with a service provider trained in FP and ANC in the past two years, 40 percent with a provider trained in safe and clean delivery (SCD) and essential newborn care (ENBC), and one fifth with a provider trained in the integrated management of childhood illnesses (IMCI).
- The availability of modern FP commodities in the service area was generally low in HPs.
- Most were lacking standard guidelines, standard operating procedures and protocols.

[2] The Ministry of Health, with technical assistance from USAID's Reinforce Project implemented by JSI. (2020). *Service Availability and Readiness Assessment in Covalima Municipality: Baseline-Endline Report 2020.*

2) Competency-based Training and Follow-up After Training

Reinforce worked with the INS to ensure that all health facilities in Covalima have the required number of trained and competent health workers in key MNCH and FP programs, and to ensure that the municipality is able to sustain these competencies. To this end, the project supported the establishment of a competency-based clinical training system at national and decentralized levels, which included:

- Providing institutional capacity assistance to the INS.
- Preparing training courses based on national standards.
- Preparing training facilities for clinical practice.
- Delivering in-service training and conducting follow-up after training (FUAT).
- Certifying health providers.

Providing Institutional Capacity Assistance

The project provided institutional capacity assistance to the INS' systems to implement its Five-Year Strategic Plan 2015-2019. At project-end, more than 70 percent of the Strategic Plan was successfully implemented through establishing new procedures at the INS and reinforcing coordination and sustainable partnerships with governmental and non-governmental stakeholders.

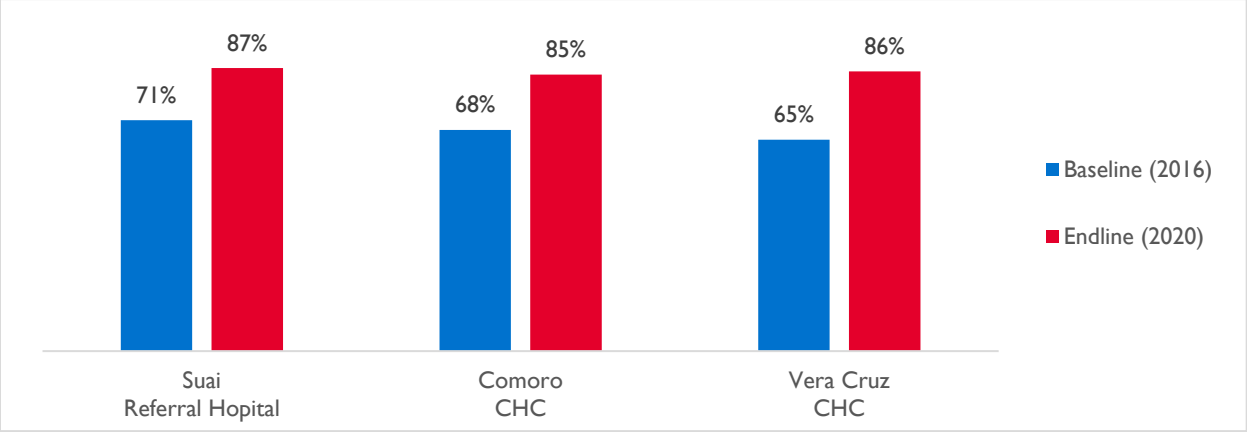
Preparing Training Courses Based on National Standards

USAID's Reinforce assisted the INS to establish the Training Discussion Forum, attended by all trainers and development partners every quarter to discuss all stages of the competency-based training modalities. The Forum allowed the INS to coordinate courses development among partners and finalize all MNCH courses, such as the SCD, the basic emergency obstetric and newborn care (BEmONC), the ENBC, the FP, and the IMCI courses.

Preparing Training Facilities for Clinical Practice

INS' revised training courses were designed to allocate much more time to practice than their previous versions, and required training participants to demonstrate acquisition of competencies on models and in a clinical setting before being certified. Reinforce supported this process through the preparation of the training facilities, including one Skills Lab at the INS, and three clinical practice sites in Comoro and Vera Cruz CHCs (Dili), as well as in Suai Referral Hospital (Covalima). A second Skills Lab was established in Suai Referral Hospital. Following four years of training and mentoring during supportive supervision, and the donation of models and equipment, all three practice sites reached more than 80 percent readiness (Figure 3).[3]

Figure 3. Improvements at the three Clinical Practice Sites from 2016 to 2020



Reinforce expanded the number of trainers at the INS and at the clinical practice sites through trainings of trainers. With 8 advanced trainers and 22 additional trainers available at the national level and in Covalima (Table 1), the INS managed to significantly increase the number of trained and competent providers at the clinical practice sites in Dili, as well as in facilities across the country. In Covalima, six new trainers ensured continuous training and FUAT at the Referral Hospital and all primary health care (PHC) facilities (see below).

Midwife practicing intrauterine device (IUD) insertion at the Skills Lab, under the trainer's close supervision (above).

INS trainer coaching junior midwife in providing essential care to the newborn immediately after delivery (below).

Delivering In-service Training and Providing FUAT

As displayed in Table 1, Reinforce collaborated with the INS to provide SCD, BEmONC, ENBC, IMCI and FP training for a total of 339 participants. Trainers measured the achievement of competencies using program-specific checklists completed during practice on models at the Skills Labs and with real patients/clients at the clinical practice sites. In total, the project facilitated the conduct of 417 sessions of FUAT for health workers to support them either reach or to maintain competency levels.

By the end of the project, competency on real patients/clients was achieved by:

- 99 providers for SCD (114 on models).
- 38 providers for ENBC (46 on models).
- 89 providers for FP counseling.
- 48 providers for inserting implants and/or IUDs (67 on models).

Table 1. Number of Trained Health Providers from the Clinical Practice Sites and Covalima PHC Facilities

Health facility	No. of new trainers	No. of personnel trained in				
		SCD	BEmONC	ENBC	IMCI	FP
Clinical practice sites:						
Comoro CHC	3	14	- (3)	8	-	8
Vera Cruz CHC	2	5	- (3)	4	-	2
HNGV	4	11	-	-	-	-
Suai RH	4	25	-	9	3	17
INS and partners	7	11	-	2	4	1
Administrative post (total No. of PHC facilities):						
Fatululik (2)	1	4	-	3	4	4
Fatumea (3)	-	3	-	4	7	4
Fohorem (4)	-	5	2	3	6	8
Maucatar (4)	-	8	-	8	9	12
Suai Vila (6) (1)	-	11	-	12	12	13
Tilomar (3)	-	7	2	6	9	9
Zumalai (4)	1	10	3	6	9	12
Total	**22** (2)	**114**	**7**	**65**	**63**	**90**

- (1) Suai Referral Hospital not included.
- (2) Among the 22 trainers, 8 were trained to the level of advanced trainers and thereby qualified to conduct training of trainers.
- (3) Midwives from Comoro and Vera Cruz CHCs were trained in BEmONC with other partner's funding.

Carmen de Jesus, Suai Referral Hospital midwife and Head of the Maternity, receiving her certificate as one of Covalima's six trainers.

Certify Health Workers

The training participants who passed the theory and achieved competency (at least) on models received a training certificate. As advised by Reinforce, INS is currently in the process of setting up procedures for delivering competency certificates.

Additional Training in Responding to Domestic Violence Cases

In Covalima Municipality, 51 percent of the women age 15-49 have experienced physical, sexual or emotional violence committed by their husband.[4] Health providers are likely to meet victims of domestic violence attending consultation for treating wounds or attending routine preventive services. To prepare these health workers to address that challenge, Reinforce collaborated with PRADET to deliver training to 146 health workers (covering all facilities) and teach them how to "recognize, respect, respond to, and refer" victims of domestic violence to appropriate psycho-social, medical and legal services.

[4] General Directorate of Statistics, Ministry of Planning and Finance, Ministry of Health, Democratic Republic of Timor-Leste. (2018). *Timor-Leste Demographic and Health Survey 2016 (TLDHS 2016).*

3) Reliable Supplies of Drugs and Equipment

Aside from clinical training as described above, Reinforce worked closely with the Municipal Health Services (MHS) to train health facilities in the management of essential medicines, commodities and equipment. During quarterly supportive supervision visits to the CHCs and HPs, Reinforce and MHS staff trained, coached and mentored health workers so that stocks are properly managed, that requests are sent on time to prevent stockouts and that the national level is alerted about issues that cannot be resolved at the municipal and facility levels. Due to the MOH not being able to procure essential equipment during the project's implementation period, Reinforce received the exceptional authorization from USAID to fill this gap. To do so, the project collaborated with the MOH Department of Equipment Management so that they are involved in every step of the procurement process, including the identification of equipment and specifications, the quantification, the distribution and the training of health providers in maintaining the equipment.

By the end of the project, all facilities were fully equipped, and stockouts of essential medicines and commodities had significantly decreased (see Figure 4 as an example from the SARA). Through continuous training and mentoring on the logistics management information system (LMIS) (38 FP providers were trained), HMIS data showed that commodity stockouts reduced from 36 to 4 percent (Figure 5).

Figure 4. Increase in Basic Equipment Availability in Covalima Health Facilities

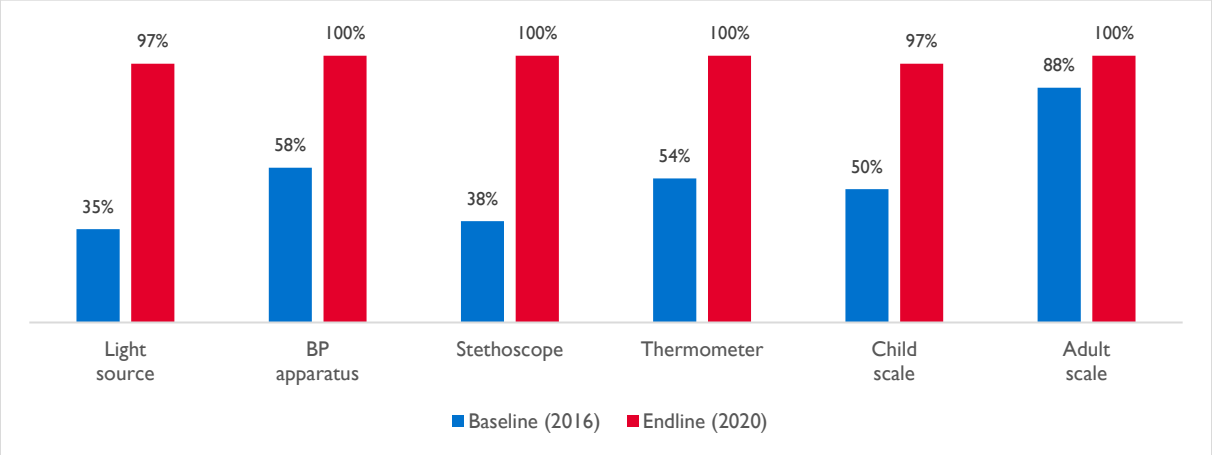
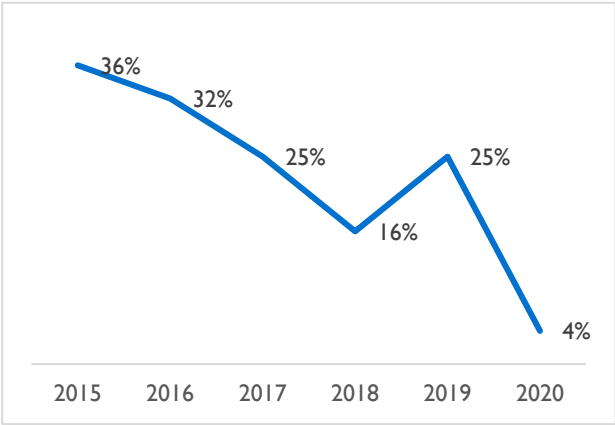


Figure 5. Decrease in FP Commodity Stockouts



4) Quality Data and Evidence-based Planning

Reinforce strongly encouraged health providers and managers to improve the quality of the collected data. The project collaborated with the MOH Health Statistics Department to provide training to health facility staff on how to properly fill the HMIS registers and with the Monitoring and Evaluation (M&E) Department to conduct routine data quality assessments (RDQAs) to improve their quality. The M&E Department also trained and mentored managers from MHS and CHCs to fill the supportive supervision formats at CHCs and HPs.

MOH FP Officer delivering LMIS training to FP providers.

As the quality of data was improving, Reinforce worked with health facility staff and their managers to ensure the data is analyzed and used to plan and inform decisions. The project used different platforms for promoting the use of data for decision-making:

- The quarterly microplanning, which brought CHC managers, CHC and HP providers and community leaders together to analyze coverage data and use them to increase access to health services, especially in remote and underserved communities. On average, 64 outreach activities were implemented every quarter as a result of the microplanning, reaching hundreds of pregnant women, mothers and children under five for preventive services.
- The quarterly and annual quality improvement planning, attended by MOH, MHS, health facilities, and community, administrative post and municipal leaders, used supportive supervision data to distribute respective level's responsibilities in improving the readiness of Covalima facilities.

Planning workshop around facility readiness supportive supervision data in Covalima Municipality.

5) Skilled Management and Supportive Supervisors

While much emphasis was put on health providers (through training and mentoring activities), Reinforce also ensured that facility and program managers acquire the managerial and supervision skills required to

sustain a strengthened municipal health system. The project took advantage of all opportunities to train and coach managers, such as:

- Training MHS and CHC managers on the conduct of supportive supervision (and use of the tool).
- Training CHC managers on the use of the microplanning tool.
- Delivering the Health Managers Training to CHC managers (in collaboration with St. John of God and MOH Health Quality Control Cabinet).
- Training managers in their role of ensuring quality of data in CHC level.

6) Functioning Infrastructure

As mentioned above, the SARA highlighted several infrastructure problems. While Reinforce did not have the financial capacity to address those directly, several activities encouraged health facilities and MHS to advocate for repairs to entities with infrastructure funding available, e.g., suco chiefs, post administrators, the Municipal Administrator, and donors, to support electricity, water and sanitation repairs and building of new HPs. In five years, Covalima:

- Built six new HPs.
- Renovated the nutrition warehouse, installed a new generator and a 5,000-liter water tank, fixed windows, doors and ceilings, and re-painted of the walls of Has Ain HP.
- Renovated the ceiling, replaced the hand washing sinks, doors and fans, re-painted the walls, and repaired the water pump and water pipe connections at Tilomar CHC.
- Installed new electricity connections and water pumps at Suai Referral Hospital.
- Renovated the ceiling, replaced the hand washing sinks, doors and fans, re-painted the walls, and repaired the water pump and water pipe connections in the MHS meeting and training room.

Outcome 2: Increased access and use of services by women, their families and communities

This second part of this report highlights how Reinforce strengthened the system to encourage and sustain healthy behaviors in Covalima Municipality.

First, the project conducted a baseline assessment to measure the community's knowledge, attitudes and practices (KAP), covering maternal and newborn health, birth preparedness and complication readiness (BPCR) planning, reproductive health, FP, and gender. Some of the issues included that (more detail to be found in the main report):[5]

- Almost half the women did not attend ANC until at least the fourth month of the pregnancy.
- Forty-seven percent of the deliveries took place at a health facility.
- Around half of the women and around 40 percent of the men agreed that unforeseen complications could occur for the mother during pregnancy, delivery and the post-partum period, as well as for the newborn within the first seven days after birth.
- Twenty-eight percent of the women reported they made birth plans for their last pregnancy.
- The vast majority (85 percent) of the women using contraceptives were using injectables (only 5 percent used implants).

[5] The Ministry of Health, with technical assistance from USAID's Reinforce Project implemented by JSI. (2020). *Knowledge, Atitudes and Practices: Baseline-Endline Report 2020.*

- A significant proportion of women were not informed about contraceptives side effects or other method options that were available when they obtained their last method.

Second, Reinforce used these KAP findings to develop a Social and Behavior Change (SBC) Plan with the MOH, outlining interventions to change practices and create an environment supporting the adoption of these new behaviors.

A. Institutional Deliveries

Between 2016 and 2020, the proportion of women delivering in health facilities significantly increased from 47 to 71 percent, while the proportion delivering at home with skilled birth attendance (SBA) decreased from 10 to 5 percent. The proportion of women delivering at home without SBA also decreased from 43 percent in 2016 to 24 percent in 2020.

As described in Figure 6 below, Reinforce addressed the barriers faced by women and families to overcome the "three delays". The three delays, which can affect maternal (and newborn) health and survival in the event of emergencies, include: (1) the decision to seek care, (2) the identification of – and access to – a health facility, and (3) the receipt of adequate and appropriate treatment.

Figure 6. Changes in Delivery Practices in Covalima Municipality

1) Well Informed Individuals and Supportive Families to Overcome the First Delay

Reinforce worked with the MOH Department of Health Promotion and Education to design printed and audio-visual materials to promote BPCR planning: a fiction film and a home reminder poster linked with the MOH Livriñu Saúde Inan no Oan (LISIO – Maternal and Child Health Booklet). These materials were used in mulitple settings, for various audiences, to educate the community about healthy practices.

Settings included the health facility itself (at the waiting rooms and during consultations), and audiences included all mothers in Covalima, as well as their husbands, family, neighbors and community leaders.

Community group discussion among mothers and fathers, watching the fiction BPCR film Benvinda Angela.

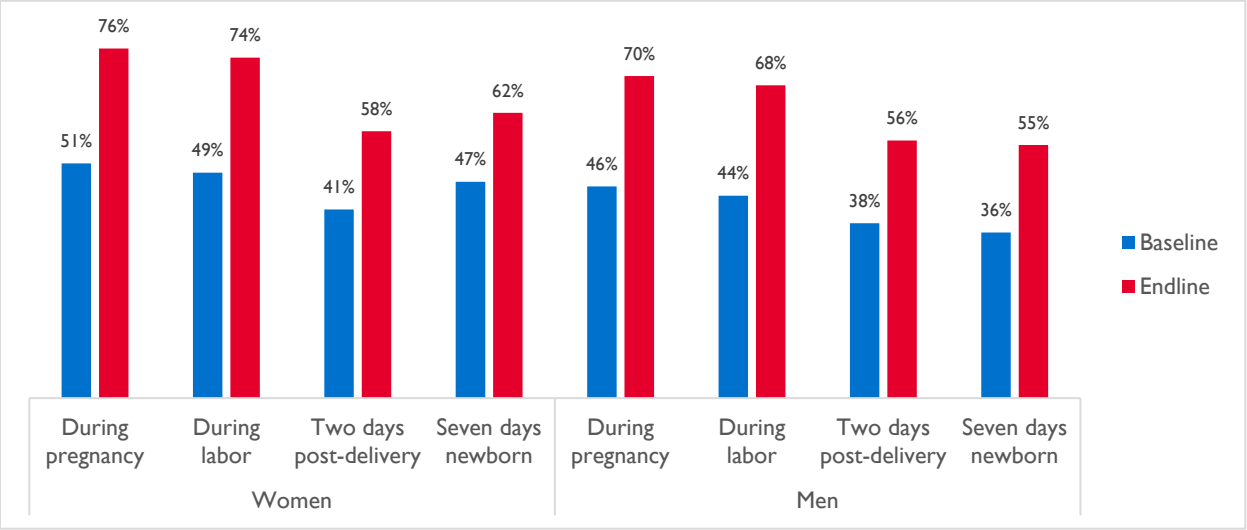
The project staff encouraged and coached PHC workers (doctors, midwives and nurses) to facilitate group discussions in the community with these different audiences. On average, more than 1,600 women of reproductive age (WRA) and nearly 400 men were reached every quarter, while an average of 300 persons attended film events (Table 2). Covalima also benefitted, like all municipalities, from the 'Liga Inan' project.

Table 2. Number of Health Promotion Activities and Population Reached

Project Year	Group discussions				Film events			
	No.	WRA	Men	Home follow-up	No.	WRA	Men	> 50 years
2017	136	1,401	129	-	1	29	17	9
2018	784	9,783	2,615	174	82	651	233	49
2019	507	6,932	1,386	740	84	758	466	163
2020	259	4,532	1,292	241	45	911	746	202
Total	**1,686**	**22,648**	**5,422**	**1,155**	**212**	**2,349**	**1,462**	**423**
Quarterly average	**120**	**1,618**	**387**	**116**	**15**	**168**	**104**	**30**

As a result, the project observed significant improvements in the community's awareness. For example, women and men were significantly more aware that complications could occur during pregnancy, labor and during the post-partum period (Figure 7); an increase likely to help them seek care in the event danger signs arise.

Figure 7. Awareness that Complications Can Occur During Critical Times



In addition, endline showed that more couples developed BPCR plans: 38 percent of the women in 2020 vs. 28 percent in 2016. Among them, 62 percent included transport as an element of the plan (they were only 35 percent in 2016).

2) Caring and Engaged Community Leaders to Overcome the First and Second Delays

While mothers, their partners and the extended family were being educated, the project heavily focused on establishing an enabling environment through involving community leaders as role models, facilitators, and influencers. With the 'TraKom' (community transport) initiative, community leaders managed to create a sense of solidarity in selected sucos and convince transport owners to avail their vehicle for health emergencies. The project counted at least 54 community members benefiting from TraKom, many of which overcame the second delay and reached the health facility in time thanks to transportation made available by the community. At endline, 64 percent of women and 61 percent of men mentioned their community was helping with transport (vs. 32 and 29 percent respectively at baseline).

Reinforce also worked with MOH and MHS to deliver a one-week training to 67 community leaders (40 men and 27 women including suco chiefs, aldeia chiefs, male and female delegates, women representatives, and male and female youth representatives), in order to equip them with the skills to positively influence their community's practices. Part of the training focused on gender-based violence (GBV) and domestic violence – facilitated by local organization Ba Futuru – while the second part focused on key MNCH and FP behaviors and the organization of health campaigns. Post-training assessments conducted three months later showed that most leaders had retained their knowledge and actively used their new skills to influence their community.

Maria Fatima, the only female suco chief in Covalima, interviewed by Reinforce in 2020 about her achievements in Maudemo.

"One of my roles as a suco chief is to remind the community to visit the health facility for preventive and curative services."

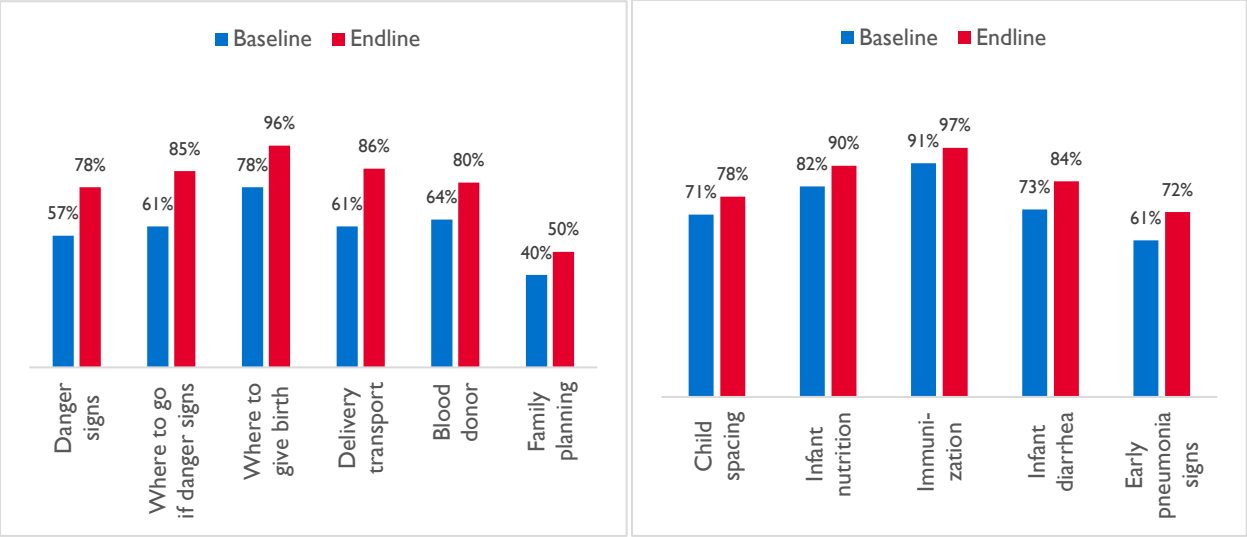
Besides formal training, Reinforce acknowledged the crucial role played by community leaders and involved them in most routine activities, such as supportive supervision, microplanning, MHS review and planning meetings, community health promotion, and outreach services. Community leaders also witnessed the equipment donation, guaranteeing their oversight so that it benefits the community.

3) Training of Health Providers to Overcome the Third Delay

As described in the first part of this report, Reinforce heavily focused its support in improving the quality of care. The 73 health providers trained in SCD, the seven midwives trained in BEmONC, and the 22 health facilities meeting MOH standards contributed to reducing the burden of the third delay (receiving quality care), while former patients/clients reinforced their positive experience among their families and friends.

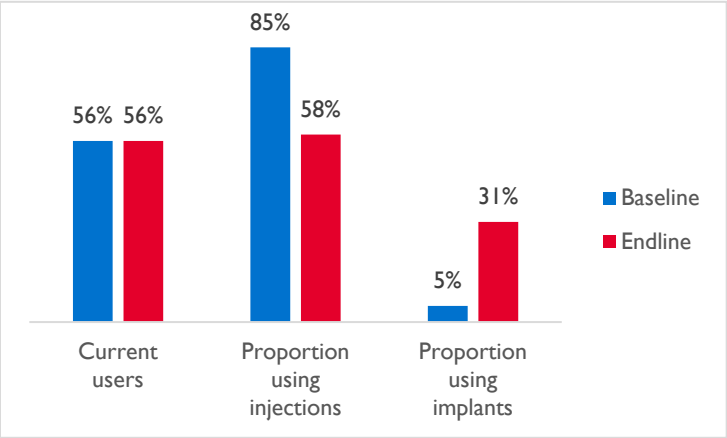
While training improved clinical competencies, it also emphasized counseling and interpersonal communication, so that clients are treated with empathy and respect, and they understand health providers' instructions. As showed in Figure 8, more women reported having discussed key topics during ANC and PNC consultations, indicating improvements in counseling from baseline to endline.

Figure 8. Discussion Topics During ANC and PNC



B. Improvements in FP knowledge, Attitudes and Practices

Figure 9. Current FP Users and Methods Used

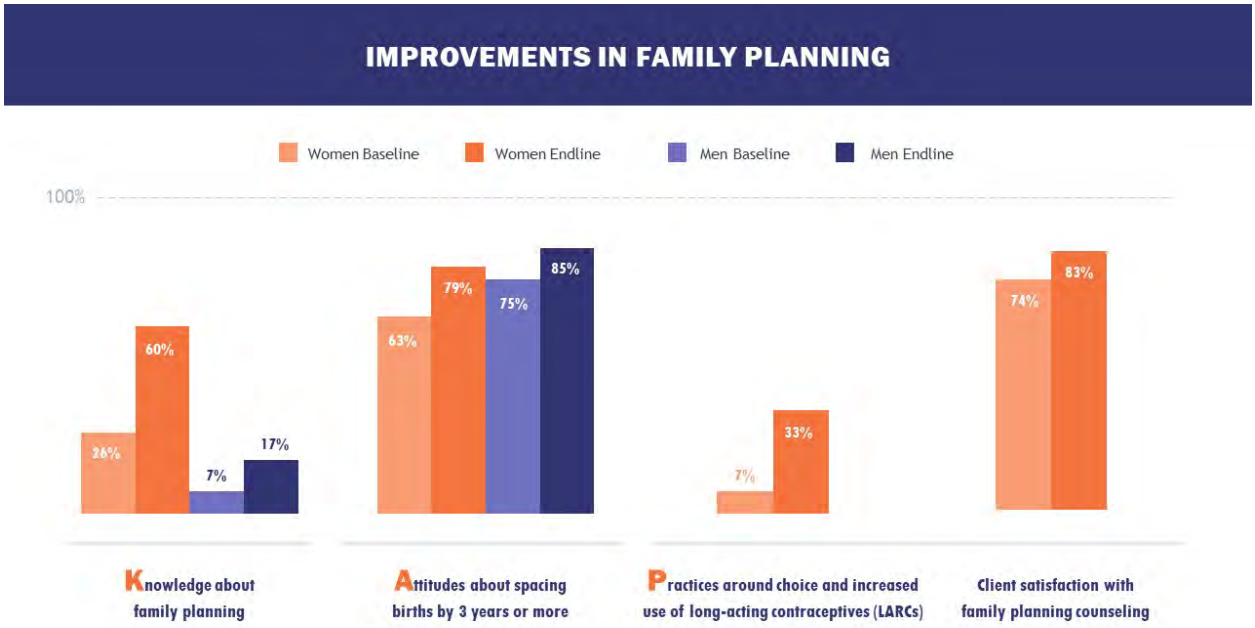


Between 2016 and 2020, the proportion of women using contraceptives remained at the very high level identified during baseline (56 percent), however, the endline highlighted a switch in the method mix. While at baseline only five percent of the FP users opted for implants, they were 31 percent at endline. At the same time, the preferred method, injectables, reduced from 85 to 58 percent between 2016 and 2020 (Figure 9).

Reinforce's approach to increase the methods mix was similar to increasing institutional delivery: (1) educating individuals about the options available to them, and educating their family members likely to influence decisions; (2) engaging community leaders to promote the benefits of child spacing; and (3) improving health providers' clinical and counseling skills.

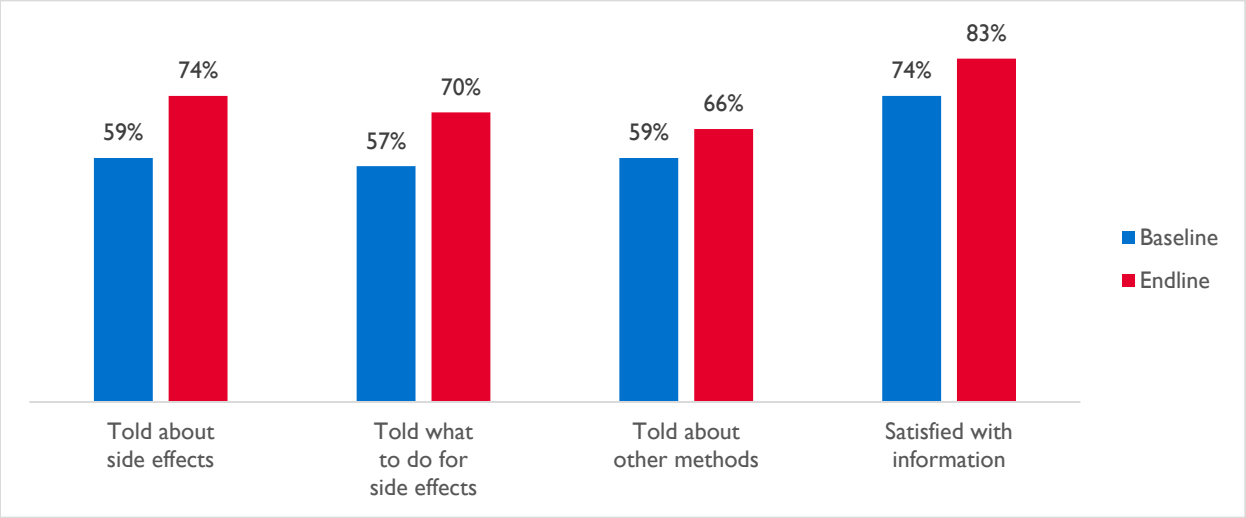
Through intensive education – using a variety of settings, media and audiences (see above for BPCR) – communities' knowledge about FP increased, and their attitude toward child spacing changed. For example, by 2020, 93 percent of women knew at least one FP method and 79 percent thought that at least three years spacing between children was ideal (Figure 10).

Figure 10. Women and Men's Knowledge about FP Methods and Child Spacing Preferences



The endline also highlighted improvements in women's experience with FP encounters (Figure 11). More women reported having been told about contraceptives side effects and other available methods, indicating better counseling from the 89 providers trained in FP counseling in Covalima.

Figure 11. Women's Experience with FP



Finally, as midwives achieved certification for inserting implants and IUDs (48 in total in Covalima, covering most facilities in the municipality), they could propose a wider choice of methods to women seeking FP services, including LARCs requiring higher clinical competencies.

C. Health Education for Young People

Reinforce partnered with a local youth-led organization – *Juventude ba Dezenvolvimentu Nasionál* (JDN) – and developed the Reproductive Health Education Guide in collaboration with the MOH. JDN and MOH piloted the guide in Covalima high schools, reaching 146 boys and girls with life skills, reproductive health, gender and nutrition education. The guide was approved by MOH, which has started introducing the program in other municipalities. Several partners have showed high interest in funding this successful intervention in their project area.

Members of local organization JDN in the process of developing the Reproductive Health Education Guide, before piloting it in Covalima Municipality with MOH (above). High school students participating in one of the many games to learn about gender (right).

Responding to the COVID-19 Pandemic

Young people from Covalima practicing hand washing in an interactive activity facilitated by JDN.

In March 2020, the project assisted the Government in its response to the COVID-19 pandemic, through increasing knowledge and practices among health workers and communities, and increasing the availability and use of handwashing materials in key locations of Covalima Municipality. The project also distributed posters, stickers and leaflets for nearly 300 households and hygiene kits to 28 locations; trained community leaders as trainers; and supported infection prevention and control training for around 230 health providers.

In addition, Reinforce partnered again with JDN to reach youth aged 15-24 across Covalima through workshops, group discussions and social media, and involve them in the national efforts to prevent from the coronavirus.

RECOMMENDATIONS

To increase the readiness of health facilities:

- Ensure MHS officers and CHC managers have the budget, transport and skills needed to conduct supportive supervision to CHCs and HPs respectively, using the readiness format. Supportive supervision must include the planning of corrective actions, coaching whenever necessary, and the follow-up and commitment from supervisors and supervisees to implement the planned actions before the next visit.
- Provide municipalities with sufficient numbers of competent providers. To fast-track and sustain this, work with the INS to set up a decentralized training system at municipal level, with available trainers and standardized training facilities. Utilize expertise from other training organizations such as St. John of God and Maluk Timor in topics not yet mastered by the INS.
- Ensure the quality of data collected through the HMIS. Establish clear accountability for data management and identify appropriately skilled staff for this function. Conduct regular RDQAs, and required health providers and managers to use the data for planning and decision-making. Institutionalize planning meetings at administrative post (CHC) and municipal levels to improve coverage and quality of services.
- Continue to plan for equipment maintenance and replacement as required, and advocate for appropriate infrastructure improvements where needed.
- Involve community, administrative post and municipal leaders in all planning processes, so that they can contribute to problem-solving and they understand the needs for and allocate sufficient resources for the health sector.

To improve the adoption of healthy behaviors by the community:

- Use available survey and coverage data to prioritize the behaviors to improve.
- Ensure PHC workers are proactively promoting preventive services at the health facility (including reducing missed opportunities by promoting cross-referrals among services) and in the community. Continue to improve interpersonal communication and counseling skills.
- Educate influencors, e.g., husbands, parents-in-law and other close family members, and community leaders. Community leaders can create a sense of solidarity among the population and should be provided with the knowledge and skills they need to fulfil their role of supporting the health sector.
- Reach more community members using existing expert organizations such as JDN, Ba Futuru, etc. to reach specific target groups or to supplement MOH work in specific messaging.

ANNEX 1: USAID's Reinforce Presentation of Project Results

USAID

JSI

USAID's Reinforce

Outcomes of the Model Municipality Approach

Presented by:
JSI Research & Training Institute, Inc.

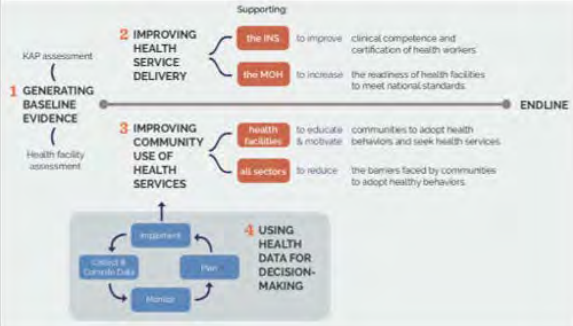
16 November 2020

Introduction

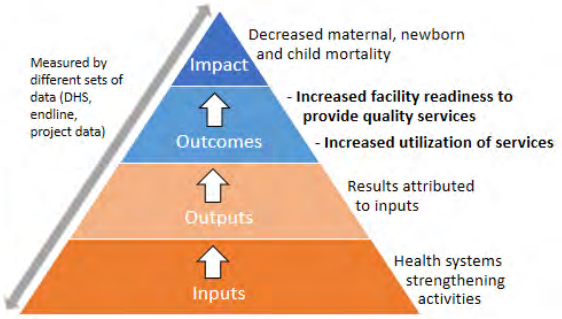
About Reinforce

- Five-year cooperative agreement
- 2015 – 2020
- Implemented by JSI Research & Training Institute, Inc.
- Worked at national level and in Covalima Municipality

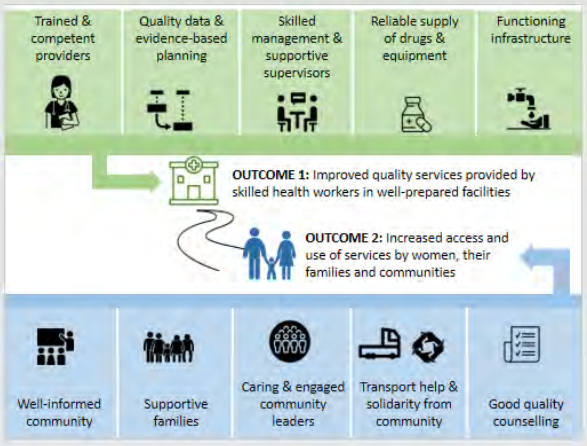
Approach

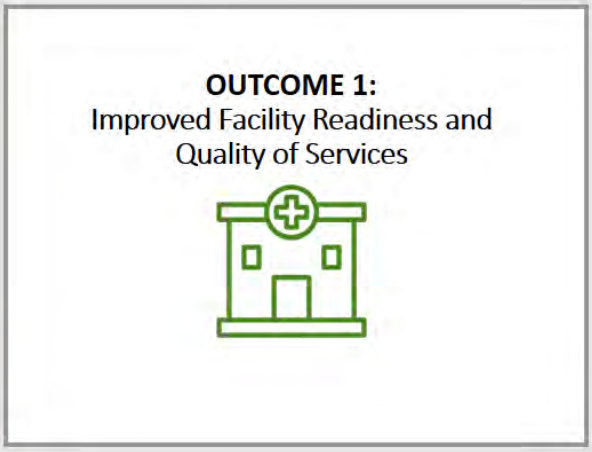


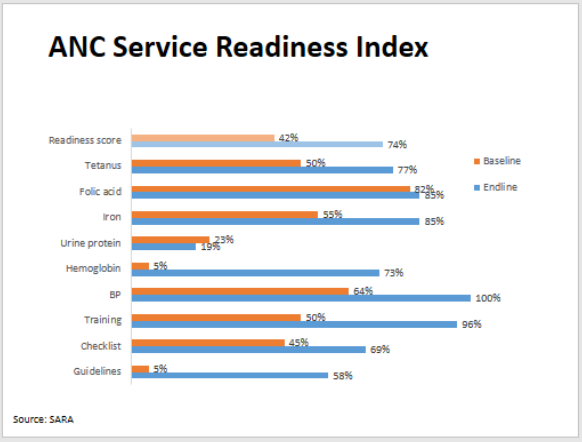
Measuring Achievements

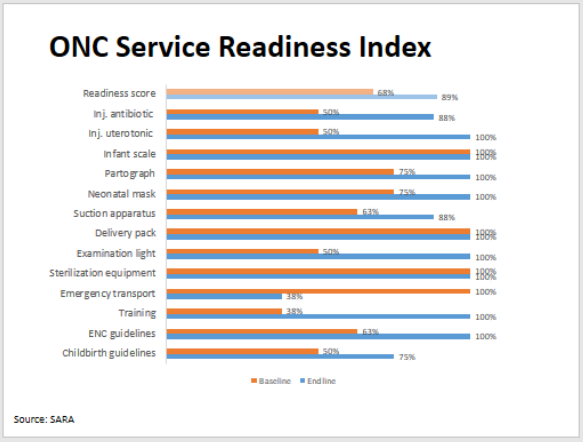


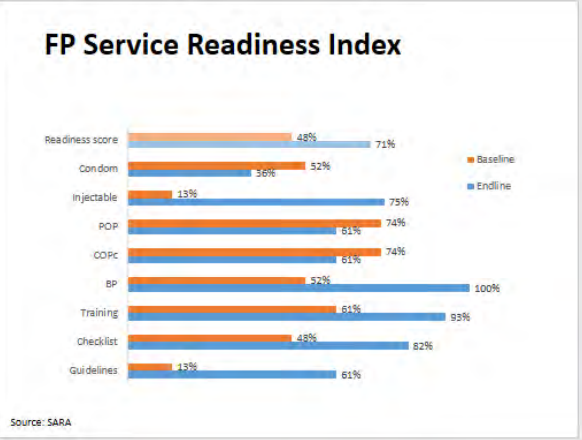
Package of Activities Leading to Outcomes

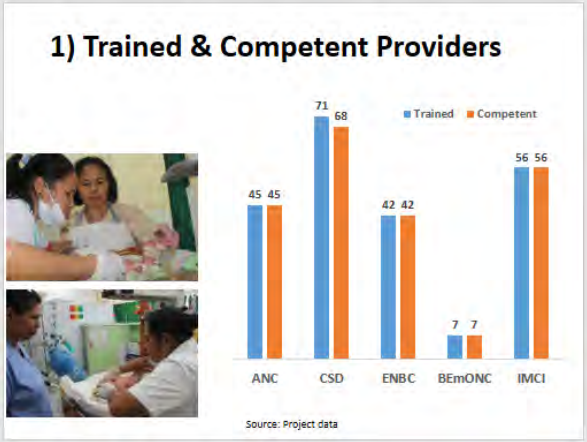

Trained & competent providers
Quality data & evidence-based planning
Skilled management & supportive supervisors
Reliable supply of drugs & equipment
Functioning infrastructure
OUTCOME 1: Improved quality services provided by skilled health workers in well-prepared facilities
OUTCOME 2: Increased access and use of services by women, their families and communities
Well-informed community
Supportive families
Caring & engaged community leaders
Transport help & solidarity from community
Good quality counselling

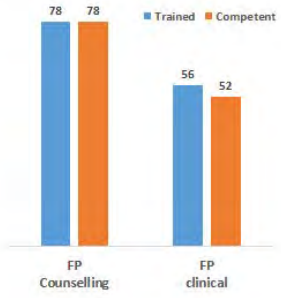

OUTCOME 1:
Improved Facility Readiness and Quality of Services


ANC Service Readiness Index
Readiness score 42% 74%
Tetanus 50% 77%
Folic acid 82% 85%
Iron 55% 85%
Urine protein 23% 19%
Hemoglobin 5% 73%
BP 64% 100%
Training 50% 96%
Checklist 45% 69%
Guidelines 5% 58%
Baseline
Endline
Source: SARA


ONC Service Readiness Index
Readiness score 68% 89%
Inj. antibiotic 50% 88%
Inj. uterotonic 50% 100%
Infant scale 100% 100%
Partograph 75% 100%
Neonatal mask 75% 100%
Suction apparatus 63% 88%
Delivery pack 100% 100%
Examination light 50% 100%
Sterilization equipment 100% 100%
Emergency transport 38% 100%
Training 38% 100%
ENC guidelines 63% 100%
Childbirth guidelines 50% 75%
Baseline
Endline
Source: SARA


FP Service Readiness Index
Readiness score 48% 71%
Condom 52% 36%
Injectable 13% 75%
POP 74% 61%
COPc 74% 61%
BP 52% 100%
Training 61% 93%
Checklist 48% 82%
Guidelines 13% 61%
Baseline
Endline
Source: SARA


1) Trained & Competent Providers
Trained
Competent
ANC 45 45
CSD 71 68
ENBC 42 42
BEmONC 7 7
IMCI 56 56
Source: Project data



Source: Project data

2) Quality data & EB Planning

Improving quality of data and use data for planning (micro-plan) and decision-making

3) Skilled Management & Supportive Supervisors

Quarterly Supportive supervision from MOH and/or MHS

Managers training

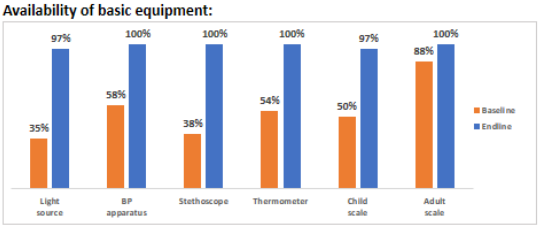
4) Reliable Supply of Drugs & Equipment

Technical assistance from MOH key departments

38 providers trained on LMIS

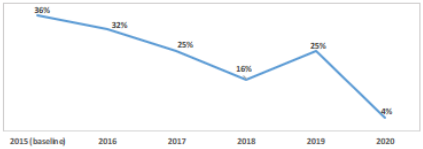
Equipment procurement

Availability of basic equipment:



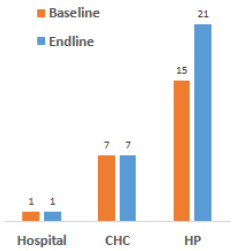
Source: SARA

FP commodity stockouts:



Source: HMIS

5) Sufficient & Functioning Infrastructure



Source: SARA

Advocacy for needed repairs and renovations:

- To MOH
- To other donors
- To State Administration and Suco Chiefs
- To US Navy

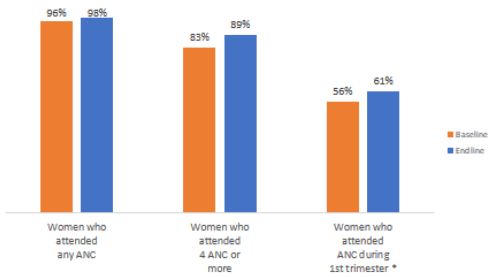
Summary Outputs

- **68** competent providers in CSD and 7 in BEmONC
- **42** competent in ENBC and 56 in IMCI
- **78** competent providers in FP counselling and 52 in LARCs
- **Quarterly** micro-plans implemented
- **Quarterly** supportive supervision conducted by MOH/MHS
- **Ongoing** technical assistance for quality data, essential supplies & infrastructure

Increased facility readiness to provide quality services

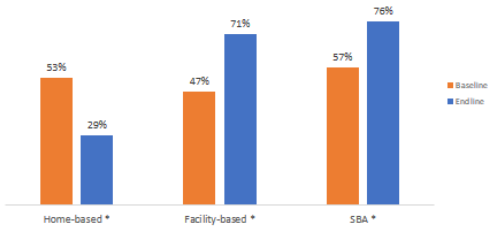
OUTCOME 2:
Increased Utilization of Services

Antenatal Care Attendance



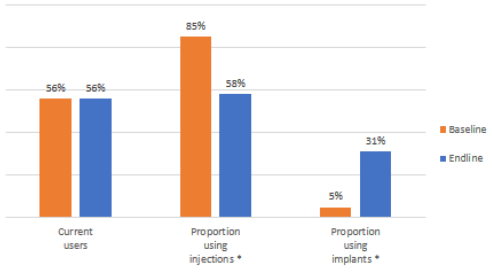
Source: KAP

Skilled Birth Attendance



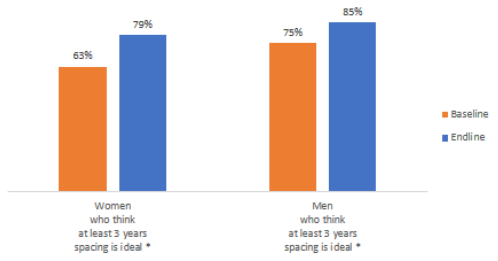
Source: KAP

Family Planning Use



Source: KAP

Attitude Towards Child Spacing

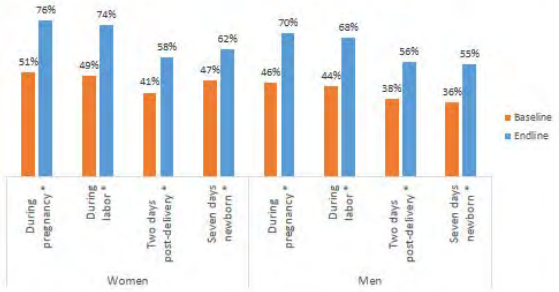


Source: KAP

1) Well-informed Community

120 community group discussions per quarter organized by PHC workers

Awareness Complications Can Occur



Source: KAP

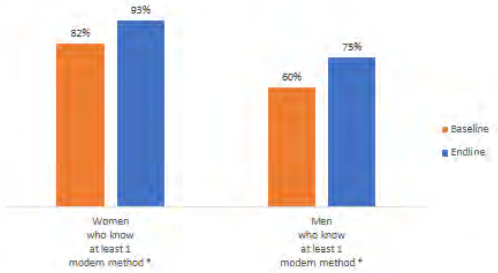
Birth Preparedness and Complication Readiness

At endline, 38% of women made a birth plan (28% at baseline) *

Among them, 62% planned transport as part of the plan (35% at baseline) *

Source: KAP

Family Planning Knowledge



Source: KAP

2) Supportive Families

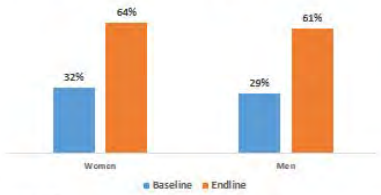
Community owned transport TraKom to support women in labor and other emergencies

TraKom cases:

Pregnant women	Children	Other
46	1	7

Source: Project data

Community support around transport:



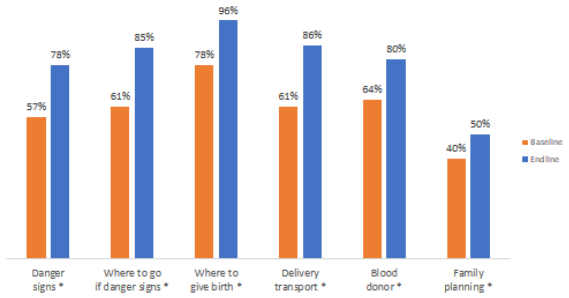
Source: KAP

3) Caring & Engaged Community Leaders

4) Counselling Training for Health Workers

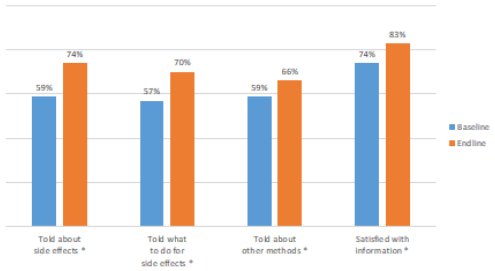
Practicing FP counselling

Counseling From Midwife During ANC



Source: KAP

Family Planning Counseling



Source: KAP

Summary Outputs

- **120** community group discussions held
- BCC materials developed around FP and birth planning
- **35** PHC providers trained on interpersonal communication
- **54** community members used TraKom for emergencies
- **67** community leaders trained to support gender and health
- **64** outreach activities/SISCa per quarter

Increased utilization of services

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Thank you!

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