Marie Stopes International Timor-Leste
PO Box 298, Dili, Timor-Leste (via Darwin, Australia)
Av. Vila Verde
Vila Verde, Dili, Timor-Leste
Telephone: +670 332 2923
Email: msitimorleste1@yahoo.com

INTERIM NARRATIVE REPORT 2011

1. Description

1.1 Name of Recipient	Marie Stopes International Timor-Leste (MSITL)
1.2 Project Name	'CHOICE': Family Planning and Reproductive Health Services in Timor-Leste, AusAID Agreement 37913/10
1.3 Reporting period	**Start Date:** 1 January 2011 **End Date of Reporting Period**: 31 December 2011
1.4 Funding amount	Up to A$900,000 (plus GST if any up to maximum of $90,000)
1.5 Target Area	Timor-Leste (Dili, Baucau, Bobonaro, Ermera, Viqueque, Ainaro, Manufahi[1], and Lautem)
1.6 Objectives	**Overall objective:** To contribute to the achievement of the Timor-Leste National Vision through innovative sexual and reproductive health (SRH) interventions supporting the overall alleviation of poverty. **Specific objective:**Marginalised East Timorese women and young people will be able to access much needed SRH services and information through positive behaviour change and service delivery in eight Districts of Timor-Leste.
1.7 Final Beneficiaries and/or target groups	**Primary beneficiaries:** Women and young people of reproductive age. **Secondary Beneficiaries**: Men of reproductive age; and District Health Service Providers.

2. Executive summary

In 2011, Marie Stopes International Timor-Leste(MSITL) clinical health services reached almost **40,000 clients** in Timor-Leste with 18,425of them accessing a Family Planning (FP) service. FP acceptance resulted in **14,907 Couple Years of Protection (CYPs)** andwill avert an estimated **4,473 unintended pregnancies** and **9 maternal deaths**.[2] MSITL teams also provided education to over 90,000 community members and distributed 175,708 BCC materials.

In addition to direct service delivery, education and advocacy activities, MSITL also supported the Ministry of Health at the national, district and sub-district levels. As one of the few international NGOs engaged in direct service delivery, MSITL plays a key role in demonstrating high-quality outreach clinical services, mentoring government colleagues, and playing an active role in important national working groups.

MSITL expanded coverage to two more districts in 2011 and now has outreach teams in eight of the thirteen districts in Timor-Leste: Dili, Baucau, Ermera, Bobonaro, Ainaro, Viqueque, Lautem and Manufahi; with a Reproductive Health Clinic (RHC) recently relocated to new premises in Dili.In 2011 MISTL launched an adolescent reproductive health pilot project, "Reaching out to young people" aimed at building capacity and direct delivery of provide high quality, confidential SRH information to young people. The rapid growth of the MISTL program in the past two years remains a challenge that is being addressed through a

[1]The MoH has requested MSITL assistance in Manufahi District in 2011, rather than in Oecusse as planned, due to greater need and lower levels of current support for the health sector.
[2]See Marie Stopes International *Impact Estimator*http://www.mariestopes.org/Resources/Tools.aspx

continued focus on strengthening operational systems, maintaining strong clinical governance and providing capacity building support to teams.

3. Progress / Achievements

Expected Results	Description of Activities Undertaken in the Reporting Period
Expected Result 1: Increased awareness of SRH issues among vulnerable and marginalized communities.	MSITL outreach teams provided SRH education to 90,587 community members. A large majority of these people were reached through a total of 2,075 outreach activities conducted by CHOICE teams including almost 500 SISCA activities. However, 6,733 young people in Dili and Bobonaro Districts were also reached with specific 'youth-friendly' education sessions provided by MSITL's Adolescent Reproductive Health (ARH) team. In addition, the Alola Foundation continued with monthly discussion groups across all 8 implementation districts. MSITL's teams distributed 173,346 items of behaviour change communication (BCC) material during 2011 including brochures about family planning, contraception methods, STIs and HIV. 35,111 BCC materials were distributed through the youth program, including the 'Puber' and 'Mehi' brochures developed by the Ministry of Health's BCC working group, in which MSITL plays a strong role. In addition to regular education sessions, a total of 35 SRH promotion events were held during 2011 including two large SRH advocacy workshops held by Alola Foundation and MSITL in Lospalos and Same. Other promotional events included TV and radio interviews and introductory workshops conducted with local authorities and PSFs in new districts and sub-districts.
Expected Result 2: Increased utilisation of SRH services and contraceptives.	MSITL clinical services are closely integrated with MoH services at the sub-district level, with services provided in CHCs, HPs and at SISCA. Referral systems have also been established whereby government colleagues can refer clients to MSITL mobile teams for FP & STI services. ***Client profile (2011):*** • 39,950 total clients (89% female) • 18,425 FP clients • 2,864 FP clients chose longer-term and permanent methods (LAPMs), including tubal ligation, IUDs and implants • More than 99% of FP clients chose modern contraceptive methods • 4,110 STI and other SRH services. Clients reported very high levels of satisfaction through random client feedback surveys. Out of about 150 random client exit surveys conducted during outreach in 2011, almost 100% of clients said that MSITL's clinicians and consultations were good or excellent. By far the most frequent complaint – made by approximately 10% of respondents – was that the places where outreach services were delivered were only 'average' or 'not very good'. 100% of clients surveyed at the Dili RHC responded that the service provided by MISTL was "good" or "excellent". 75% of clients surveyed said the team was efficient and the rooms were clean, and 73% would recommend the services to their friends and family. Almost all clients said that the clinic was not expensive. MSITL outreach teams provide services closer to the people who most need them. They carry all their own outreach medical equipment, including contraceptive

	commodities, drugs, sterilisation equipment, and specialised supplies such as a portable gynaecological examination bed and large tents. MSITL's annual Quality Technical Assessment (QTA) result for outreach service delivery in 2011 increased significantly from past performance, demonstrating that international quality standards can be maintained even in rural and remote outreach sites. MSITL's RHC has become a model of excellence for SRH service provision in Timor-Leste. The clinic hosts midwifery and medicine student placements for their practical rotations, during which they are mentored by MSITL staff in SRH service provision, infection prevention and other aspects of clinic and program management.
Expected Result 3: Strengthen capacity of MSITL and establish model of SRH service delivery.	By providing services integrated with government activities, MSITL sets a model example of how FP counselling and clinical services can be provided to clients in an outreach context, particularly at SISCA. MSITL's midwife trainers, educator trainers and outreach team members provide important mentoring and support for government staff while they are working together. Consequently, MSITL methods and initiatives can be observed in some of the CHCs located in MSITL implementation districts, demonstrating the usefulness and sustainability of the action. MSITL also prioritises continuing capacity development for team members to ensure that international standards are upheld. All new staff participated in MSITL induction training and received substantial on-the-job support. Monitoring is conducted regularly (at least monthly) at all sites by the Program Manager, Clinical Services Manager, Project Coordinators and Trainers. Clinical checklists and performance scans in addition to observation, monitoring and trip reports are used to identify issues for follow-up, which are then discussed with the teams during small evaluation meetings. Significant clinical issues are sent to the Medical Advisory Team for further discussion. In 2011 MSITL teams also received a significant amount of formal training. Although attendance at training has led to lower than expected results in the short-term by taking teams out of the field, they are expected to have long-term benefits for the organisation and our clients. In 2011 team members received training on the following topics:: • Family planning counselling • Emergency Obstetric Care (EMoC) • STIs and syndromic management guidelines • Management of medical emergencies • Vocal Local anaesthesia • Infection prevention • Youth-friendly SRH counselling • Client focus • Clinical supervision • Management and leadership • Financial management. MSITL expanded coverage to two more districts in 2011. A local consultant was contracted and conducted a social mapping exercise in each new District (Lautem & Manufahi) covering demographics, a health situation analysis and a mapping

	exercise to identify an appropriate office location. The consultant was accompanied by MSITL project coordinators to initiate coordination and establish relationships with DHS and other local partners at an early stage. Small district offices to support outreach activities in new districts were established in August and the program was launched at the sub-district level in Alas & Same (Manufahi District) and Luro & Iliomar (Lautem District) in September. Full teams for both districts, including midwives, were recruited by the end of 2011. A larger operations team, established in 2011, has strengthened and improved systems for fleet management, drug management and procurement to better support MSITL's program. This allows MSITL teams to conduct outreach activities in difficult-to-reach locations and support the SISCA program. In many places, MSITL transportation and equipment is essential to support successful SISCA implementation. An annual Financial Capacity Assessment (FCAT) and Organisational Development Assessment (ODA), designed to assess gaps in financial and organisation systems and ensure that common standards are maintained across MSI programs, were also conducted in November 2011.
Expected Result 4: Contribute to the development of an enabling environment to promote high quality SRH information and services complementing the Timor-Leste health system	After negotiations, MSITL and the MoH signed a Memorandum of Understanding (MoU) on 8 February 2011, which outlined the services to be provided by MISTL and responsibilities of each party. While this national agreement is essential to MSITL's continuing presence in Timor-Leste, MSITL's closest working relationships are at the sub-district level, where the CHC teams, local authorities and other NGOs are involved in planning and implementation of health sector activities. As mentioned above, MSITL conducts workshops in the districts and sub-districts in which it has recently commenced working, which involve local authorities, traditional leaders, and representatives from religious groups, schools, police, NGOs and of the health sector, including PSFs. These workshops provide basic information about SRH and FP, explain MSITL's program, and include a short planning session for initial activities. As such, the workshops strongly contribute to the development of an environment that enables MSITL to implement SRH and FP services. At the national level, MSITL is an active and vocal member on several working groups, including Family Planning, Maternal & Child Health, SRH-BCC and ARH. It is through these forums where MSITL is able to advocate for change and contribute to the assessment and development of national policies related to FP and SRH. For example, through the FP working group, MSITL & partners were able to obtain permission to train nurses for implant service delivery in order to reduce the burden on midwives. Another example is the relatively young ARH working group, which has relied heavily on MSITL to assist with the discussion and development of new national guidelines and suitable ARH materials and activities.

4. Challenges/Lessons Learned

Several key challenges to project implementation are described below. Further information on a range of strategic, legal, political/cultural, operational and financial risks associated with the implementation of MSITL's program in Timor-Leste, and strategies for risk management and mitigation, can be found in MSITL's *Risk Assessment Matrix* provided in **Annex 1.**

Transport logistics

Transport logistics are a major challenge for the delivery of outreach services in Timor-Leste due to difficult terrain and poor roads, which worsen considerably and can become impassable during the rainy season. At the beginning of the CHOICE Project it was clear that motorbikes alone are not an adequate means of transport; and suitable vehicles are required not only to ensure that team members reach outreach locations safely but also to guarantee the safe transport of all equipment required to provide the highest quality services in these locations. Over several years MSITL has increased its fleet of vehicles to include several 4WD vehicles, however this fleet is rapidly deteriorating due to wear and tear from poor conditions. Some vehicles cannot be used outside Dili and vehicle maintenance costs are high. Combined with MSI's rapid expansion to new districts, a lack of suitable vehicles continues to limit the ability to provide outreach services and adequate monitoring and support as frequently and easily as would be possible if adequate vehicles were available. Two more new 4WD vehicles will be purchased in early 2012.

Commodity security

MSITL should receive all contraceptive commodities from UNFPA through the MoH's decentralised stock procurement system. This system is not yet functioning effectively and consequently cannot be completely replied upon for secure supply of contraceptive commodities. MSITL has explored other options for procurement, particularly for implants and IUDs, which are often unavailable at the sub-district level. Unfortunately MSITL has been able to receive only a small number of free contraceptives supplies from MSIUK and in 2011 had a very limited for purchase of additional stock. As the continued availability of donated stock is not guaranteed, commodity supplies have been realistically budgeted for in 2012.

FP competencies

Longer acting and permanent methods (LAPM) of contraception, including implants, IUDs and tubal ligations may only be provided by specifically trained and competent clinicians. During 2011 MSITL worked towards ensuring that all midwives were competent in implant and IUD insertions and all female nurses were competent in providing implants. However, due to the difficulties of coordinating the attendance of a sufficient number of LAPM clients, the service provider andmaster trainer in one place at the one time, this has not yet been achieved. Consequently midwives who are competent in delivering implant and IUD services must rotate between teams. The recruitment of two more experienced midwives towards the end of 2011 and a plan for ensuring competency of all midwives means that each district should have at least one service provider competent in LAPM service provision by end of Q1 2012.

Inability to provide tubal ligation

In 2010 an experienced MSI doctor from Myanmar was employed as MSITL's Clinical Services Manager in order to provide services, mentor MSI staff and train local doctors in tubal ligation. However following her commencement, the MoH made a formal decision that MSITL must conduct tubal ligation procedures in National and Referral Hospitals. MISTL has been unable to access surgery facilities at the National Hospital in Dili as they are consistently fully booked for hospital referred procedures. This is an issue that MSITL is currently trying to resolve through negotiations with MoH. Upgrades to the clinic procedures room will also be conducted as required.

Utilisation of family planning services

Utilisation of FP services in 2011 did not continue to increase as sharply asthe period after initial expansion to districts in 2009 and early 2010. This is partly attributable to the challenges identified above as well as time spent supporting government activities such as SISCA and campaigns, which are of course important but nevertheless reduce the focus on FP activities. It is essential for MSITL to develop new and creative demand generation strategies to ensure that FP client numbers continue to increase. While consistent demand for FP (and other SRH services) has been seen, growth in FP service delivery is crucial in order to improve maternal health outcomes. In 2012 BCC messages and materials will be reviewed and education activities will be more carefully targeted for key decision makers such community and religious leaders, mothers-in-law, and males. Diverse methods of conveying key FP messages, such as through drama, advocacy workshops, various media, local 'ambassadors' and other NGO partners will also be trialled.

5. Proposed Work Plan 2012 (Draft)

	Q1			Q2			Q3			Q4		
Main Activities	***Jan 2012***	***Feb 2012***	***Mar 2012***	***April 2012***	***May 2012***	***June 2012***	***July 2012***	***Aug 2012***	***Sept 2012***	***Oct 2012***	***Nov 2012***	***Dec 2012***
Output 1:	**Increased awareness of SRH issues among women and men of reproductive age, and young people**											
1.1 Deliver SRH information												
1.2 Conduct market research												
1.3Develop IEC materials and service information												
1.4 Distribute IEC materials												
1.5Conduct advocacy workshops												
Output 2:	**FP counseling and services delivered at government health facilities, private clinics and via outreach**											
2.1 Deliver outreach clinical services												
2.2 Maintain referral system												
Output 3:	**Increased utilisation of SRH services**											
3.1 Expand into additional sub-districts		Erm/Bcu			Viq			Mnf/ Lau				
3.2 Conduct demand generation activities												
Output 4:	**Strengthened capacity of MSI Timor-Leste to provide a sustainable model of SRH service delivery complementing the Timor-Leste health system**											
4.1 Train outreach team members		EMOC	Induction	FP				Induction	Educators training		MEM	
4.2 Integrate activities into SISCA												
4.3 Conduct EoP EC (2009-2011) Evaluation												
4.4 Conduct clinical supervision												
4.5 Conduct QTA										QTA		
4.6 Conduct FCAT and ODA											FCAT/ ODA	

Annex 1: MISTL Risk Assessment Matrix 2012

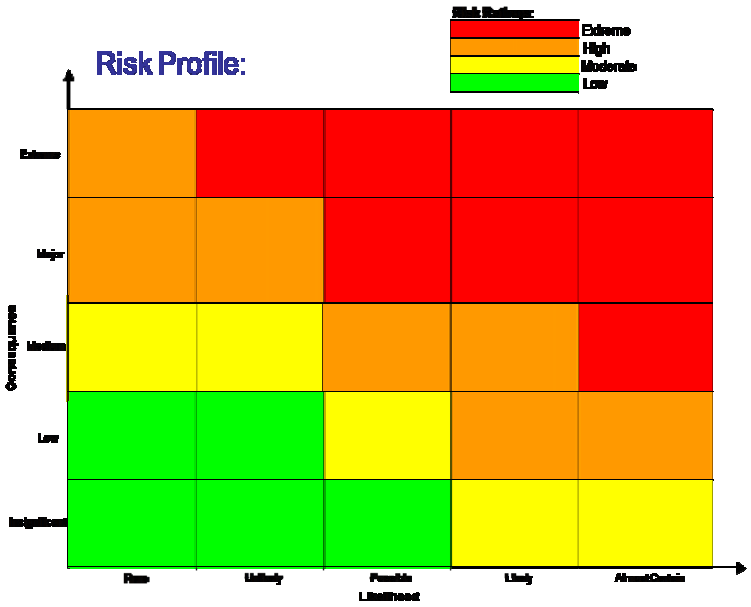
Highlighted below are the top risks associated with the implementation of MSITL's program in Timor-Leste. The matrix outlines proposed strategies to manage risks to ensure effective and sustainable aid outcomes, output delivery and efficiency and capability. The key is located at the bottom of the matrix.

Risk	L	C	R	Risk Management and Mitigation
Effective and Sustainable Aid Outcomes				
Risk of political, social and economic instability. Presidential and parliamentary elections will be held in 2012, increasing this risk.	P	M	H	• MSI has engaged (pro-bono) international security company, Control Risks, to provide strategic security advice. They visited the Timor-Leste office in 2006 and have since been actively involved with MSITL during periods of instability • MSITL regularly updates its risk assessment matrix to allow the organisation to quickly and strategically respond to changes in the country • MISTL to complete country specific security policy and SOPs in first quarter of 2012. • Continue attending INGO (JINGO) security meetings. Include security review as an item on SMT agenda. • Small mobile outreach teams are able to plan their work in safe areas, avoid unsafe locations and relocate easily and quickly if necessary
Government discontinues to address gender concerns, promotion of human rights, SRH and equal opportunities for women	R	M	L	• Continued reference to relevant international conventions such as the Convention to Eliminate all forms of Discrimination Against Women (CEDAW) and national policies where the government has made a commitment to SRH will be regularly highlighted through reports • Continued advocacy partnership with the Alola Foundation and ongoing involvement in sector working groups and other initiatives
MoH discontinues support for its public/private partnership with MSITL resulting in MSITL teams no longer being able to provide services through MoH facilities	U	Mj	M	• MSITL will develop work plans together with district health authorities to ensure that MSITL activities are an integrated part of DHS management strategies, thus fostering a sense of ownership and mutual responsibility is created
MoH discontinues providing SRH commodity supply to MSITL for SRH services provided outside of MSITL's RHC	P	M	M	• MSITL to ensure sufficient budget support is allocated to purchase back up SRH commodity supplies • MSITL to finalise all documentation required by MoH to import SRH commodities in case an emergency stock order is required • Identify various suppliers for SRH commodities • Register and import FemPlant (Sino Implant II)

Risk of fraud, corruption, financial mismanagement.				MISTL has robust financial procedures in place that meet MSI Global Financial requirements. MSIA through the Regional Finance Manager and Project Support Manager provide support and monitor financial operations and capacity within MSITL. This is conducted on an ongoing basis as well as through specific TA inputs throughout the year. An external audit is carried out annually.
All premises leased by MSITL are on short term 1-2 yr) leases. Failure to negotiate ongoing lease agreements may result in disruption to work, loss of investment in property and significant additional expense to locate and renovate new premises.				Attempt to negotiate longer term lease agreements when multi-year funding obtained. When renovations to premises required, attempt to negotiate equivalent reduction in rent to minimize renovation/ rehabilitation costs incurred. Commence negotiations for renewal of lease agreements 6 months prior to expiry of lease period. Conduct regular meetings with Land and Property (relevant GOTL agency) to ensure that MSITL complies with current legal requirements.
MoH significantly changes MSITL's scope of work during the MoU renewal process	U	M-Mj	M-H	• MSITL has a good relationship with the MoH and continued communication and partnership in future will assist addressing this risk • MSITL's mission, current scope of work and impact to be reported to the MoH bi-annually
Output Delivery/Efficiency				
Community engagement: Community representatives do not sustain motivation and community based organisations are unwilling to work together on SRH issues	U	M	M	• Experience from MSITL's three years of work has shown that the community and leaders are very cooperative and due to the current lack of access to SRH information and services the community is highly unlikely to be unreceptive. • Priority given to recruiting district-based staff who are originally from that district. Local language as well as family and friendship ties in their work locations enable mobilisation and facilitate access to local communities
Local and religious leaders deny permission to conduct SRH information and services in their community	P	Mj	H	• Sensitive information is delivered in a respectful and culturally appropriate manner by local staff who are well trained to respond to potential opposition • MSITL currently involves local and religious leaders in SRH activities and they are specifically invited to an introductory workshop when MSITL commences work in new locations • MSITL will continue to build on this partnership with local authorities, church and community leaders, as well as youth leaders and youth groups • MSITL will engage FOSKA (Catholic Youth Movement) in its youth specific activities.
Activity Implementation: • Clients do not have equal access to information and services within program areas	U	M	M	• Weekly activity planning to ensure all program areas are equally served • Conduct evaluation of MSITL education program 2012. • Continued consultation with the MoH Health Promotion Department and FP Department to ensure consistency in education messages

• Education messages are not acceptable socially / culturally • Respondents are not confident to respond to M&E surveys honestly				• Participation in the FP, ARH and BCC Working Group meetings. • Use mystery clients, anonymous feedback, etc. as alternative M&E mechanisms to avoid issues of (dis)honesty. • Maintain strong positive relationships particularly with local authorities, church and community leadership, as well as youth leaders
Demand for SRH outreach services is overwhelming	P	M	H	• Use existing resources to their maximum potential. Ensure mobile services are in the field at least four days a week; the team of four enables them to break into two teams to cover different locations; team performance incentives to retain good service providers; regular monitoring of demand so planning can occur; weekend clinics will be considered if needed • Strengthen collaboration with other providers and referral pathways to enable the reduction of general health service delivery
High demand for FP/SRH services creates instability within the community / distrust of MSITL	P	Mj	H	• MSITL will ensure local leaders are fully engaged and informed of MSITL's presence and scope of work • Rights-based approach to SRH education focuses on the benefits of birth spacing and other key health messages rather than on limiting family size or population control • All service delivery activities are co-ordinated with the relevant CHC in the service delivery area • Client informed consent forms are signed before services provided • Clinical service delivery reports submitted to the relevant CHC as soon as possible after service provision (at least weekly)
Delays in delivery of SRH commodities and equipment	U	M	H	• Order a 6 month buffer stock of drugs & commodities each year; work closely with MoH and UNFPA to maintain supplies
Access difficult due to mountainous terrain and poor road infrastructure	A	L	H	• Recruit experienced drivers and purchase suitable 4WD vehicles to transport teams to rural areas • Ensure routine maintenance of vehicle fleet
Capacity				
Insufficient number of midwives apply for positions available	P	M	H	• Ensure all MSITL clinical staff have achieved competency to provide authorized FP services. • Implement a roster/rotation system for MSITL midwives to provide services across all Districts • Maintain appointment and referral systems at the District level for long acting methods for days when a midwife is not present • Explore establishment of midwifery scholarship program.
Retention of clinicians (midwives / nurses) with capacity and experience to provide quality SRH promotion, education and service delivery	P	M	H	• Provision will be made for ongoing professional development opportunities, support and incentives for team members • Maintain competitive salaries and positive work environment
Lack of appropriate applicants for senior	P	Mj	H	• Advertise internationally and within Timor-Leste

management positions				• Continue to build MSITL's good reputation within the health sector in Timor-Leste
Management capacity of MSITL limited	U	Mj	H	• MSI to continue supporting MSITL strategically, managerially and financially; provide management and systems training where necessary to build capacity
Unable to manage rapid expansion effectively, as well as retain high quality of services	U	Mj	H	• Recruit staff with the necessary skills and experience to manage the expansion • Ensure quality services are maintained by establishing strong M&E systems, quality control, audits etc.
Staff burnout	U	M	M	• Provide adequate training to new staff and regular refreshing trainings to existing staff • Support all teams with appropriate transport, per diems, holidays and other benefits



Likelihood	Consequence	Risk Rating
A= Almost Certain	E = Extreme	E = Extreme
L= Likely	Mj= Major	H = High
P= Possible	M = Medium	M = Medium
U= Unlikely	Lo= Low	L= Low
R= Rare	In= Insignificant	