‘CHOICE’ PROJECT EVALUATION REPORT

Marie Stopes International Timor Leste

[“The human right of everyone to the enjoyment of the highest attainable standard of physical and mental health - The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.” United Nations Human Rights, Office of the High Commissioner for Human Rights]

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EXECUTIVE SUMMARY

Marie Stopes International Timor Leste's CHOICE program has delivered sexual and reproductive education, services and technical advice for three years (2009-2011) to Dili and remote areas across the country. They are only one of a few international NGOs that deliver health services directly to the people in partnership with the Ministry of Health. Together they have saved many maternal and infant lives, averted numerous unwanted pregnancies and helped to prevent unsafe abortions.

The project purpose and outputs included the following which have largely been met to a high standard.

Project Purpose – marginalised East Timorese women and young people will be able to access much needed sexual and reproductive health services and information through positive behaviour change and service delivery in eight districts of Timor-Leste.

Project Outputs

- Increased awareness of sexual and reproductive health issues among vulnerable and marginalised communities;
- Increased utilisation of sexual and reproductive health services and contraceptives;
- Strengthen the capacity of a non-state actor, MSITL, and the establishment of a sustainable model of service delivery;
- Contribute to the development of an enabling environment to promote high quality sexual and reproductive health information and services complementing the Timor-Leste health system.

This evaluation finds that there is increased awareness of sexual and reproductive health and an acceptance of modern methods of family planning by couples, as well as attendances at clinics for counselling and screening. By taking the messages to the people in the sub-districts Marie Stopes International Timor-Leste in affiliation with their partners Ministry of Health (MoH), Alola Foundation, the village leaders and community members have achieved a lot in difficult circumstances. During 2009 to 2010 there was an increase in the numbers of acceptors of a modern method of contraception and from 2010 to 2011 this levelled off. Stakeholders noted that as men play a vital role in family leadership they need to better understand sexual and reproductive health for their own sake and that of their wives and children.

As an organisation they have expanded quickly and they offer staff training and leadership opportunities. Internal processes are driven largely by international standards but are modified for Timor-Leste and are well developed. A significant number of documents were available to the evaluation team that showed careful

planning, monitoring and evaluation processes. Due to the quick expansion of the organisation there is an uneven standard of service and staff will continue to need training. Despite pressure to meet targets, opportunities for team-building and consolidation need to be found.. There are only 3 of 80 positions taken by foreigners and this bodes well for issues of sustainability.

The objectives of being able to work effectively and create an enabling environment presents more challenges to Marie Stopes Timor Leste. Timor-Leste is a country that has not been exposed to many of the sexual and reproductive debates that have occurred globally and is historically steeped in Catholicism. This means that the pace of change can seem overwhelming for some stakeholders who are grappling with the meaning of sexual and reproductive health and have fears of moral decay and loss of tradition. Furthermore, democratic governance processes are immature and this further complicates notions of partnership and shared agendas.

RECOMMENDATIONS

While these recommendations are largely for MSITL, they cannot achieve all of these by themselves and are thus also for their partners and stakeholders. A greater focus on advocacy and consolidation of the organisation is the main message for 2013-14.

General

MSITL education and services are highly valued and of good quality. Internal monitoring and evaluating processes are extremely high and there is no change recommended.

Advocacy

1. Provide broader sexual and reproductive health educational opportunities to various stakeholders. While the village level community education engagement is working well, people who hold responsible positions like politicians, government public servants and community leaders need exposure to a sexual and reproductive health agenda that is based on fact and explores values. By many accounts the Sexual and Reproductive Health Conference was successful. Similar advocacy activities and exposure outside of Timor-Leste may be helpful.
2. MSITL could invite Marie Stopes Philippines to Timor-Leste and share insights and developing strategies to work in a conservative Catholic environment which may be enlightening.
3. MSITL may wish to attend the upcoming conference 'Women Deliver' in Malaysia in May 2013. There are scholarships available. Other people outside of MSITL who work in maternal health or who need to understand the financing of health may also wish to attend.

4. Possible engagement with Rede Feto Timor-Leste and Secretariat of Office of Promotion for Equality to advocate women's sexual reproductive health rights in Timor-Leste. A suggestion is to have a workshop or seminar with women's organizations and Seretariat for Promotion of Equality (SEPI) in Timor-Leste.
5. MSITL could engage with regional and international advocacy networks such as APWLD or AWID and attend conferences or workshops held by these organizations, as well as support the attendance of Ministry of Health staff. To implement this there would need to be agreement with the Ministry of Health in terms of the follow-up and action to be done after the conference.

SRH supplies

6. Advocate for a secure supply of sexual and reproductive health medications/ supplies and high prioritisation on the Essential Drugs List, as they are life saving.
7. Clarify procurement and disbursement procedures with SAMES/ UNFPA and the Ministry of Health as there may be some minor misunderstandings.

Human Resources/Task shifting

8. Advocate for male nurses to attend training on insertion of sub-dermal contraceptive implants to increase accessibility of a popular method of family planning.
9. More team building, leadership training, facilitation skills for MSITL team leaders and team members across the districts to ensure sustainability.

Data collection

10. Reconsider data collection methods to better show new and reoccurring clients attending for contraceptive supplies or services.
11. Commission academic research when specific evidence for Timor-Leste is required – for example the quality, accessibility and acceptability of supplying long term contraceptive methods at SISCA outreach.

Working with key groups: men, young people, the church

12. Involve men in educational health promotion and provide them with learning opportunities as they need to understand their wives' health status and that of their children. Have activities in the evening and develop men's discussion groups.
13. More work/ education/ workshops/ training with youth and youth groups with skilled engaging facilitators. Timor's young population is hungry for information and at risk from avoidable sexual and reproductive issues. In some circumstance young unmarried people need to be supplied with contraceptives if they are at risk of mistimed pregnancy or sexually transmitted diseases.

14. Greater engagement with the church and church clinics. Have activities with the church to enable holistic information on both natural and modern family planning methods. Inclusion will help to educate the church on MSITL's activities and gain trust.

Increasing coverage

15. Future planning around coverage of delivery of services with consideration of underserved villages. Maybe a changing focus to other sub districts to enable greater coverage, however this needs to be balanced with consolidating current expansion. MSITL could extend the reproductive health services and work with existing community-based group in the districts such as Alola MCH groups. Alola has established many community groups in the districts which cover family planning, this could be used by MSITL as an opportunity to integrate their sexual reproductive health and do more work with men.

Marketing and communication

16. Better processes for communicating MSITL's mission and values as well as technical knowledge to external stakeholders.
17. Marketing - MSITL need to better promote MSI in Timor-Leste to raise the general public's understanding of MSI program and services. This would minimise some of the rumours about MSITL's work. One suggestion would be to produce a movie on MSI clinical and educational services for broadcast in TV and radio.
18. Activities or health promotion material need to be released and evaluated and information shared with CHC/ DHS/ Village Leaders on impact and effectiveness bearing in mind the cultural and health literacy gulf that can cause disaffection.

INTRODUCTION

This report examines the work of Marie Stopes International Timor Leste over a period of three years from 2009 to 2011. An evaluation was conducted in June 2012 of the Choice Program. The Choice Program's goal and four objectives were:

Goal - to contribute to the achievement of the Timor-Leste National Vision through innovative sexual and reproductive health interventions supporting the overall alleviation of poverty.

Project Purpose – marginalised East Timorese women and young people will be able to access much needed sexual and reproductive health services and information through positive behaviour change and service delivery in eight districts of Timor-Leste.

Project Outputs

- Increased awareness of sexual and reproductive health issues among vulnerable and marginalised communities;
- Increased utilisation of sexual and reproductive health services and contraceptives;
- Strengthen the capacity of a non-state actor, MSITL, and the establishment of a sustainable model of service delivery;
- Contribute to the development of an enabling environment to promote high quality sexual and reproductive health information and services complementing the Timor-Leste health system.

The project objectives were met through activities conducted at the MSITL Reproductive Health Centre located in Dili and via MSITL outreach services operating in 8 districts. These services include community based family health promotion; provision of counselling and family planning (FP) services, ANC, PNC and STI diagnosis and treatment delivered at community sites and static centres. Depending on the district these static centres included private clinics, government hospitals, Community Health Centres (CHC) and Health Posts.

This report will discuss the meaning and development of sexual and reproductive health, outline some of the salient features of sexual and reproductive health in Timor-Leste and note positive changes. The report will also present data and findings for each project objective and make recommendations.

SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health encompasses the wellbeing and function of human reproduction, both for men and women. The most commonly used definition came out of the International Conference on Population and Development in Cairo in 1994 and is endorsed by the World Health Organization:

> *Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (Palmer et al., 1999) p 1691*

The focus of reproductive health is not only the process of reproduction, but rather human sexuality in its broadest sense. Biology is only one part of reproductive health, as notions of happiness and freedom are also included. Reproductive health is a sensitive and sometimes taboo topic, interpreted widely across cultures and societies in different ways and at varying historical moments. This widely accepted definition describes a bio-psycho-social holistic model of health and alludes to the emotional aspects of sexuality. Pleasure and contentment are combined with elements of prevention and safety. The positive right of freedom to decide the number of children is also enshrined in this particular definition. While this definition is internationally endorsed, it does not mean that the right to this type of reproductive health is uncontested; in many cases it is completely flouted (Petchesky, 2003).

More recently, sexual and reproductive health has been seen to be a priority in the Millennium Development Goals (MDG). The Millennium Development Goals (MDGs) are eight development goals to be achieved by 2015 to respond to the world's main development challenges. The MDGs are contained in the Millennium Declaration which was the product of the UN Millennium Summit in 2000. Each goal has one or more targets with various indicators. They are primarily based on human development and are both enhanced and limited by the requirement for global consensus and partnership. Developing countries are responsible to reach the goals and developed countries have undertaken to help them. Periodic reports from the countries themselves and UN agencies give a picture of progress from 2000 to the end-date of 2015 (O'Donnell 2011).

Millennium Development Goals 4 (Child Mortality), 5 (Maternal Mortality and Universal Access to Reproductive Health Care) and 6 (HIV and Malaria) are of interest in this report. Timor-Leste gained independence in 2002, and began work towards the MDGs later than other countries. Despite this Timor-Leste is tracking well but much data is missing. Some progress has been made in poverty reduction, as well as improving maternal health. The non-government organisation Marie Stopes Timor Leste contributes to achieving MDGs 4, 5 and 6. Please see the appendices to view current MDG targets.

MDG 4 - Infant and child mortality is a tragic reality in Timor-Leste and is sensitive to maternal health, access to quality health services, as well as a hygienic and nourishing environment. Spacing pregnancies can assist with infant and child survival in several ways. Simply reducing the number of babies born will statistically reduce the infant mortality rate but more gratifyingly, infants who are born to mothers who can space their pregnancies are healthier and stronger. This also impacts on siblings who need not compete for family resources.

MDG 5 - Maternal mortality is poorly measured in Timor-Leste, however we know it is too high. Women's access to modern contraceptives is life-saving and should be high on the essential list of medications in the country. Women have a right to survive their pregnancies. Active family planning with modern contraceptives allows mothers to recover their health or in the case of very young women, delay their first pregnancy until they are mature.

5b Universal access to reproductive health care is also considered important. This means that young people and adults understand how their bodies function, how to protect themselves from STIs, how to delay sexual encounters and to consider how many children they can responsibly bring into their family. If we look at the unmet need for contraception as a proxy indicator, there remain a lot of couples who do not have access to reproductive health care.

MDG 6 – HIV appears uncontrolled and the conditions ripe for an epidemic. Urgent work needs to be done to raise awareness in the general population. Thailand is an example where frank and honest public health promotion managed to control a terrible epidemic. This means uncomfortable discussions about sexuality, prostitution, condoms and intravenous drug use; this may be difficult considering the cultural context of Timor-Leste but it is an issue that requires strong leadership and vision.

COUNTRY TIMOR-LESTE

Timor-Leste recently celebrated 10 years of independence and there is much to celebrate. Country-wide surveys confirm progress on several levels. Total fertility rates have dropped to 5.7 from 7.8 and acceptance of modern methods of contraception has jumped from 7% to 21% (Demographic and Health Surveys 2003/ 2010). All government and non-government organisations (and donors) who have over the decade put much work into health promotions and health education aiming to change behaviours need to be commended. Reducing the large number of children born to women not only lifts a burden on women and families but may also assist the economy and share out the scarce resources of schooling and health services.

One challenge faced by all in developing and rebuilding Timor-Leste is the lack of adequate infrastructure. Fragile conditions such as poor communications, deadly roads, sporadic electricity, feeble internet, and insufficient buildings make a difficult task almost impossible. Furthermore, the lack of human capacity can leave programmes floundering. There simply are not enough doctors, nurses, community health workers and managers. Timorese need skills and confidence to assist their country to flourish. Another issue is weak governance and fluctuating policy imperatives. A strong, legitimate democracy with transparent, ethical processes supports health projects to be successful. The Ministry of Health has signed a Memorandum of Understanding with Marie Stopes International Timor Leste and this is a promising collaboration.

The National Sexual and Reproductive Health Strategy (2004 -2015) is a document from which many aspects of human health can be addressed. It will shortly be due for renewal. The invitation to involve the Catholic Church in the development of this policy was inspired; however the dogma of the Church is detrimental to sexual and reproductive health in many ways if it prevents people learning how to protect themselves. Despite Timorese claims to Catholic faith they are embracing sexual and reproductive health knowledge and behaviours more suitable to the 21st Century. There are many countries which appear to be able to be faithful to the Catholic Church, as well as manage their fertility and health independently.

The CEDAW committee in 2009 was concerned with a number of elements of women's access to sexual and reproductive health. The committee noted high maternal and infant mortality, discrimination against women due to their sex and recommended that the State collect data to strengthen the knowledge base for effective policy on all aspects of women's health, especially regarding the monitoring of impact (Committee on the Elimination of Discrimination against Women, 2009). It would seem that Marie Stopes is assisting this directive.

EVALUATION PROCESS

Marie Stopes International Timor Leste gave the evaluation team access to scrutinise all internal documents, as well as talk with staff and stakeholders. Multiple documents were provided to the evaluation team and these are listed in the appendices. The documents included external, internal and global reports, Annual Reports (2009, 2010,2011), Team Satisfaction Survey Report (2011), Work Plans (2009, 2010, 2011, 2012), monitoring reports and statistical summaries, 'Reaching Out' (2009), outreach summary statistics (2009, 2010, 2011), Staff Performance Forms (2011), as well as Training Schedules (2011, 2012). The evaluation team also had access to all financial sheets. These documents were scrutinised for content, consistency and quality.

Interviews and focus groups were conducted with a variety of people who had direct experience over a number of years with Marie Stopes International Timor Leste. Please see the appendices for a list of discussants and the research tools used. Thirty people were interviewed in the first district, 27 in the second district and 19 in Dili. A total of 76 people inside and outside of MSITL gave their opinions and experiences. MSITL staff, government employees, non government staff, United Nation staff, and the recipients of services gave frank opinions. Interviews and focus groups were analysed using content and thematic analysis processes that related directly to the four objectives of MSITL.

KEY FINDINGS

Objective 1: Increased awareness of sexual and reproductive health issues among vulnerable and marginalised communities

It is not easy to discuss private matters and sexual and reproductive health are taboo topics. However the reports provided by MSITL show that large numbers of men and women have received education about sexual and reproductive health. Table 1 summarises the numbers of education contacts.

More women than men participated in health education promotion activities and as MSITL has expanded more districts have been included. Data collected by MSITL staff during the project found that the vast majority of clients are very satisfied with the services that they receive.

Table 1 Numbers of men and women receiving education services 2009 to 2011 through health promotion activities across the country

Districts	Male	Total	Female	Total				
	2009	2010	2011		2009	2010	2011	
Ainaro		758	1711			1,002	4,964	
Baucau		6,232	7158			8,934	13,480	
Bobonaro		3,082	864			7,417	4,808	
Dili		5,574	8251			8,152	17,790	
Ermera		2,638	2547			4,985	6,047	
Lautem		-	1025			-	2,059	
Manufahi		-	457			-	1,681	
Viqueque		1,527	3773			2,542	7,239	
Total	**7,862**	**19,811**	**25,786**	**53,459**	**11,454**	**33,032**	**58,068**	**102,554**

Source: MSITL Annual Reports and internal documents –note 2009 had no disaggregated data

Discussants also confirmed that they witnessed improvements in awareness in communities. A sample of the types of views and conversations that people are having is replicated here. These were all married women who had been mobilised through MSITL and Alola Foundation working together to raise awareness and provide information.

> *E: In our community we have many friends that don't want to use family planning method because they said that there are a lot of impacts, such as sickness, bleeding. Thus, many people said like this, it's fine to have many children rather than use family planning and get various illness.*
>
> *D: According to our religion they prohibit us to use family planning. This can make women fear to use the family planning. However, church allows using natural family planning.*

T: Some people have a good understanding but some people have limited understanding which can cause problems in the family, like when the women want to space the baby but the husband doesn't want to; they may have conflict in their family because women refuse to have children every year.

D: Birth spacing is good for women's health, so that women can have good health. So if she gets pregnant again she can stay healthy.

In this short snippet of conversation, several people discuss the complexity and diversity of views regarding the use of family planning methods. It is very positive to hear that thoughtful considered discussions are occurring in the villages of Timor-Leste.

There are many barriers faced by couples who wish to use modern methods of contraception. This is from the same focus group of married women as the conversation turns to difficulties in using modern methods of family planning.

E: First, probably their husband doesn't allow them to use family planning method. Secondly, parents in-law don't allow it because they expect the daughter in-law to have many children. That's what they want. They don't want them to use family planning to have only one or two children. Moreover, some women may be influenced by stories from friends about side effects which discourage them to use contraceptive methods.

D: The majority of the community, particularly those who live in the rural areas, they don't understand about family planning, so we need to keep continue provide information to them to raise their awareness on this issue.

E. People in the remote areas, there is no health center and lack of information, probably they receive information but they cannot access the services as the community center is far away from them. When they thought of visiting health facility for family planning, but then realize that they may pregnant already.

So we come to understand that families and friends influence their choices, and discussion education groups can assist to provoke fresh ideas where other resources are too distant.

And finally some last words about how the information is shared with communities.

E: I think they work very well because they go to visit community and deliver the information in the community place. MSI shows posters and pictures to audiences when they explain about types of diseases. They also show pictures of diseases that experienced by Timorese people. They show the facts which made people believe and understand easily about messages that being delivered. From my point of view, this is really good method to convince community to accept the information.

Many aspects of sexual and reproductive health are open to discussion and by using pictures or posters facts can be better understood.

We invited men to share their views and they said the following comments:

LC: Family planning can give opportunity to women to participate in other activities. Otherwise women cannot exercise their right. We hear this information

that women can have children but they need to prepare their health before getting pregnant again.

E: Gender, everyone has the same right. They [women] have ideas that they can contribute to the community and village. However, they have too many children to look after so they don't have time to participate in the community activities.

E: If a woman births every year, babies and mother can be malnourished and unhealthy.

M: Birth spacing is good (3 years) so mother can recover and baby is healthy.

LC: There is a need to conduct socialization with men. Men are interested to learn. Women are often the ones who receive this information about family planning. Men need to understand this information because the man is the one who makes decisions in the family.

ML: More information and training needs to be provided to the men.

LC: We should plan. If you have too many children you can't control them and there may be problem and conflict if we abandon them and they cannot go to school.

L: If you have too many children the garden and coffee plantation may not be enough to share.

M: If you are in a better financial position you can have more children (6-7) otherwise 4 is enough.

M: When women are young they can go to any places they want to. But when they start having family, it restricts their movement, they cannot travel, or visit family in other districts due to having a child every year.

LC: It is important to space the birth so mother could be free to work or doing business, so both parent have responsibility to protect their children, but if women have too many children they can only stay at home.

LC: Husband and wife should make an agreement based on the women's will to avoid problem in the family.

Suggestions:

LC: Marie Stopes should not stop here. It is difficult to access information here. They need to conduct socialization on birth spacing to all communities because there are some hamlets that are far away from here and they cannot access the information.

The men covered a wide range of aspects of sexual and reproductive health for women and children. They were able to make links to women's rights to participate in community life, travel and to be healthy. They also alluded to the difficulties some families bear. As men held positions of responsibility in the family, they particularly thought that all men should have good sexual and reproductive health information.

In the past Timorese have been intimidated by colonising family planning programmes. Indonesia's *Keluarga Berencana* was delivered without quality or concern for human rights. The Catholic Church rightly challenged it at the time (Richards, 2012). However this current data demonstrates that there is a broad and considered debate and information sharing process occurring across Timor-Leste. When MSITL solicited feedback regarding their health education 35 people responded in 2010. The majority had learned about 'Reproductive Health', 'Family Planning' and 'STIs' in MISTLeducation sessions. Ninety to ninety-five per cent of all respondents found the education sessions to be interesting and easy to understand, and believed that family planning was important. Sixty per cent of respondents classified the education sessions (information session time, place of information distribution, member and participant feeling) as 'good', and 25% as 'very good'. Forty per cent of respondents suggested MSITL visit more frequently. This is very good feedback.

Objective 2: Increased utilisation of sexual and reproductive health services and contraceptives

The reports provided by MSITL show that this objective has been met. The uptake of sexual and reproductive health services by clients is very good. The following tables summarise the program's successes.

Table 2 Numbers of clients receiving services in Dili and 8 districts

Service Summary RHC Dili and 8 Districts Client Profile	2009	2010	2011	Total
Female	8,680	30,848	35,415	74,943
Male	1,297	2,625	4,534	8,456
Youth (15 – 24 yrs)	1,323	8,649	10,947	20,919
Family Planning Clients	5,014	18,805	18,425	42,244
Non Family Planning Clients	4,963	14,668	21,524	41,155
Total	**9,977**	**33,473**	**39,949**	**83,399**

Source: MSITL Annual Reports and internal documents

MSITL has seen increasing numbers of men and women over the three years. MSITL counts the number of times clients visit the service. This means that if a woman attends four times a year for a contraceptive injection she is counted four times. This next table shows the types of family planning provided by MSITL in Dili and the 8 districts.

Table 3 Numbers of types of services provided from 2009 to 2011

Service Summary RHC Dili and 8 Districts Family planning services	2009	2010	2011	Total
Tubal Ligation	7	4	1	12
IUD	522	813	853	2,188
Injection – 1 month	252	228	238	718
Injection – 3 months	2,723	12,378	11,579	26,680
Pill	952	8,436	7,754	17,142
Male condoms	139,443	71,425	35,428	246,296
Female condoms	8	2	2	12
Emergency Contraception	17	28	48	93
3 year implant insertion	251	237	2	490
5 year implant insertion	138	1,545	2,008	3,691
Natural FP	16	19	76	111
Total	**144,347**	**95,133**	**57,998**	**297,478**

Source: MSITL Annual Reports and internal documents

Some of the levelling of numbers here is to do with time taken out of service provision to train staff or women finding a method that suits them. Injections and implants are popular. Very few Timorese are choosing permanent modern methods of family planning, most are using reversible methods. Also this table suggests that there were many couples ready to take up family planning and new efforts need to be made to boost awareness and behaviour changes.

The next table shows the numbers of types of services offered by MSITL, which include Safe Motherhood, STI/HIV services and post abortion care in the districts and in Dili.

Table 4 Numbers of sexual and reproductive health services 2009 to 2011

Sexual health services	2009	2010	2011
Safe Motherhood	988	3,979	4,472
Pregnancy test	372	1,064	4,168
STI/HIV services	1,589	2,419	2,687
Other sexual health	891	1,435	1,423
Post abortion care	18	18	9
Total	**3,858**	**8,915**	**12,759**

Source: MSITL Annual Reports and monthly Service Statistics

This table shows the breadth of services offered to clients including maternal health and sexual health and reproductive health services. Abortions are not offered to clients because the legislative requirements are very restrictive. Belton (2009) has written on this:

…Law 19/2009 was passed, with 13 amendments to Article 141, which are highly restrictive. They say women must be facing imminent death and have no other medical option other than to terminate the pregnancy. The woman must consent in writing and her spouse or another person also sought to give consent. Three doctors need to agree to the procedure and sign a certificate. A fourth doctor, not one of the original three, should perform the abortion and one of the doctors should be trained in obstetrics and gynaecology. There should be a delay where possible of two days between gaining consent and performing the procedure. Furthermore, medical practitioners may conscientiously object to performing an elective abortion but must refer the woman to another colleague. Thirty-four parliamentarians out of 65 voted for the amendments, eight abstained and one requested the expert advice of a doctor, as he felt he was not well informed enough in obstetrics.

These amendments shocked women's health advocates in Timor-Leste. In a letter to the President, calling on him not to sign the amendments into law, they pointed out that it was not possible, particularly in rural areas, to have access to four doctors in Timor-Leste, let alone with knowledge of abortion or specialism in gynaecology and obstetrics. (Belton et al., 2009, Pages 56-57)

If women present requesting a termination of pregnancy they are offered counselling to keep the pregnancy. If a woman presents with early spontaneous pregnancy loss or an infection from a self-performed abortion, she is provided with emergency obstetric care (post abortion care) to save her life.

The next table is an estimated calculation of the couple years of protection from pregnancy if men and women continue to use their chosen method of family planning. MSITL estimate that currently there is a value of 34,579 couple years of contraception coverage. The value of Couple Years Protection means the time a couple will be protected against an unwanted pregnancy based on the contraceptive method used, so the more time a method is used, the possibility of time protection is greater. This is an international measure where a family planning method is given a standard value from the Guttmacher Institute (Darroch and Singh, 2011) and also Maries Stopes International "Impact 2-Marie Stopes International, 2012". (For more information contact: **research@mariestopes.org** Developed by: Michelle Weinberger, Francisco Pozo-Martin (LSHTM), and Kristen Hopkins)

Table 5 Couple protection years and estimated impact of services

Couple Years of Protection (CYP)	2009	2010	2011
Total CYPs (FP only)	5,430	14,241	14,906

Source: MSITL Annual Reports and monthly Service Statistics

The table below (Table 6) is also an estimated model which shows the numbers of averted unintended pregnancies, live births averted and abortions avoided. By providing couples with family planning information and services, unwanted babies and abortions are diminished.

Table 6 Estimated demographic impacts of family planning[1]

Demographic impacts	Calculated model	2009	2010	2011
Unintended pregnancies averted				
	Total	2,012	5,967	6,378
Abortions averted				
	Total	593	1,609	1720

Furthermore 27 maternal deaths and almost 2,500 unsafe abortions have been averted.

While these tables show dramatic numerical impacts on many aspects of sexual and reproductive health, the impact on people's lives at the individual level is also interesting. As we interviewed staff, clients and colleagues many stories emerged. This story of an unwanted pregnancy was recounted by MSITL staff.

> *There was a young university student who got pregnant. She was feeling sick and she was four months already. She asked for an abortion and I referred her to hospital for a termination but she did not want to go. She said she would kill her herself and she had written a goodbye letter to her mother. I gave her my phone number – I'm not supposed to do that. She sent me a text message at 4am and told me that she was suiciding in the sea. I went to find her. My wife wondered what I was doing. I called the police to come and help me. We got her out of the sea and I counselled her until the early morning. I asked Fokupers (Timorese NGO) to help her. I contacted the family and her mother wanted her to die but I said that the family just had to accept this situation. I said that the family must talk with her and I arranged a family reunion. Now she is married to that father and she has her baby.*

MSITL works to prevent unsafe abortion. This young woman was at risk of unsafe abortion and death.

Another story of saving a woman's life by a different member of MSITL staff:

> *In a remote district with no telephones and no transportation there was a pregnant woman with 13 children. Early in her pregnancy she became weak and started to bleed. It was very serious. Her husband lifted her into a wheelbarrow and pushed her for one and half hours to the CHC. There wasn't a government midwife there at the time but the MSI midwife was there. She immediately saw the woman's life was in danger. The woman was in clinical shock if she didn't respond soon the woman would die. The midwife started an infusion, cleaned her*

[1] Caculated using MSI Impact2 calculator (2012) available at www.mariestopes.org/impact-2

womb and the woman began to recover consciousness. As the woman began to wake up she demanded an IUD so she wouldn't get pregnant again.

This is emergency maternity obstetric care provided by MSITL staff in a remote setting. It is the same procedure that is used to perform a termination of pregnancy called Manual Vacuum Aspiration; the procedure can be used to save lives.

Some women understand the need for their contraception and go to great lengths to get it. MSITL staff told of one of their client's who overcame many barriers.

> *A woman in a remote district was using Depo injections and she knew it had expired and she needed a fresh injection. So she walked to meet the health post, but the health post was closed as she came too early. She continued and walked 3 hours to a community health centre but when she got there the Depo had run out. So she started to take the long walk home without any supply*
>
> *Luckily it was the MSI day to visit the health post to deliver services. We were working in the community all day. It was very hard work. We had no lunch that day and were exhausted. We packed our things ready to leave and the car was already on the road. As we were driving away we saw this woman run toward us. She had walked the long distance back again as she had heard from her neighbour that we provided family planning there. She begged us to stop and ask to give her implant, as she wants to use the method which could last longer. Of course we did. So you see we deal with the vulnerable people, the young, the marginalised, women who have unwanted pregnancies and those with low education and health literacy.*

MSITL has provided numerous couples with sexual and reproductive health services in the Choice program. When MSITL solicited feedback from their clients in 2010, 42 people responded. Everyone indicated that information was kept confidential, that they wanted other services and that family planning is important. Seventy-six per cent of respondents indicated that MSITL services were 'good' and 21% stated 'very good'. A further 62% responded 'good' to the information being easy to understand; 16% responded 'very good'. This is very positive feedback.

Objective 3: Strengthen the capacity of a non-state actor, MSITL, and the establishment of a sustainable model of service delivery

MSITL is viewed as a reliable recipient of donor monies. The donor suggested that MSITL were timely in their reporting and that the standard of reporting was professional. They stated that if they needed more information MSITL were always willing to provide it. The only donor of substance at present is AusAID but USAID, the European Commission and some private donors have in the past also funded this program.

Discussions with staff found that the organisation is a globalised NGO with international standards. MSI produces guidelines and procedures to be used across its international programmes. These are modified for Timor-Leste and they function to a high standard. There are perceived differences between procedures and standards set by MSITL and the Ministry of Health. For example, the supplying of long term

contraceptive methods (IUCDs and implants) at mobile locations. MSI has many years experience in supplying remote communities in 26 other countries and are experts in providing this type of mobile service (Marie Stopes International, No date). However, despite originally supporting this initiative, recently the MoH prefers that these methods are not supplied at SISCa outreach clinics. This means that valuable cars and time are used to transport women across the land to community health centres to receive health services. This also means that women will not be able to access long term methods of contraception because they do not have the time or home support to travel for hours. This will reduce women's ability to choose a long term method with the predicable outcomes of unwanted pregnancy and higher maternal mortality. We also found that some districts demand this service for their population. MoH states that it is a better quality of service to provide long term methods in static clinics and not at SISCa, however there is no substantive evidence to support this.

MSITL has expanded rapidly and now employs 81 staff on yearly contracts who work across 8 districts. Staff work in areas of management, human resources, marketing, finances, logistics, clinical services, health education and transport. There are only 3 positions that are currently occupied by foreigners: the Country Director, the Program Manager and the Operations Manager. Staff commented on the progressive nature of MSITL's genuine actions to employ and promote Timorese into positions of management. Staff are aware of their job descriptions and are able to access specialised training to be able to complete their work. Staff are reviewed regularly in job performance processes. Some staff are given opportunities to train in other countries using the MSI international network. Staff commented on the barrier to recruit clinical staff to MSITL and they believe this is due to a general lack of trained health professionals in Timor-Leste, as well as only being able to offer them a 1 year contract. However there is also a shortage of all health professionals in Timor-Leste (Dawson et al., 2011) which may also impact on recruitment.

During discussions with staff they noted that due to the rapid expansion of services there was tension between building a sustainable model of high quality service delivery and meeting targets. According to the Strategic Plan, developed by the teams in 2010, MSITL will expand up to a national level by 2015. However, it may be time for Marie Stopes to consolidate their successes and slow the targets in order for internal and external stabilisation. This should be further assessed internally. The next section will discuss the external environment.

Objective 4: Contribute to the development of an enabling environment to promote high quality sexual and reproductive health information and services complementing the Timor-Leste health system.

Advocacy is a method of creating an enabling environment and MSITL has participated in the National Family Planning Working Group, a group chaired by the MOH and involving non-government (NGO and UN) partners working in this area. The FP Working Group met four times in 2010 and another four times in 2011. MSI also participated in the Adolescent Reproductive Health Group but this group did not meet regularly. The Maternal and Child Health Group, which was also not very active in

2011, largely attributed to changes in MOH personnel in the MCH Department. The feedback on the National Conference on Reproductive Health, Family Planning and Sex Education held in 2010 suggests that it was successful. A broad representation from Timor-Leste society participated in discussion and debate about evidence based sexual and reproductive health. Many issues were raised concerning the state of health and the best ways to improve health. The conference produced recommendations for different sectors and specifically civil society. The conference delegates recommended that civil society should:

- provide training on Family Planning with NGOs assisting to take training initiatives to the grassroots level;
- work together with the government to make available the full range of Family Planning methods;
- MSITL should continue to provide regular training and education at village level on Family Planning;
- Fundasaun Alola must provide health education to women in rural areas;
- establish or expand peer counselling programs for youth on family planning and HIV issues at community level;
- provide a program to educate and improve men's own reproductive health;
- strengthen involvement of males/ fathers in childbirth programs;
- provide sexual and reproductive health education to youth in the community
- provide parenting education at the community level.

MSTL is implementing many of these recommendations.

Another area of work that MSITL has pursued is that of task shifting. Task shifting means training different levels of health staff to perform certain duties. This increases the number of health professionals who can provide a direct service to the client. For example, in the past only female midwives were trained to insert implants, now with MSITL's advocacy and training, female nurses can also perform this task. Since opening in 2006, MSITL has seen an annual increase in interest in long acting contraceptive methods such as implants. Five-year implants are a very popular method of contraception administered by the MSITL team. In 2009, MSITL's six midwives provided 17% of all implants in Timor-Leste. The following year, demand for long acting methods had increased significantly and MSITL's ten midwives provided approximately 70% of all implants in Timor-Leste[2].

In 2011 MSITL, with the National Institute of Health Sciences and the Ministry of Health, organised the first national training on long term methods for family planning in Timor-Leste that allowed female nurses to undertake practical implant training. Seven female nurses completed the training, five of whom were from MSITL. There still remains a lack of appropriately qualified health staff in this field. Extra clinical training is required to elevate team members to a standard MSI level to provide the best quality of services to the community.

Furthermore, all formal training for health workers must be conducted through the National Institute of Health Sciences. However MSITL provides capacity building by modelling good practice in client-focused SRH service delivery, as well as through providing informal support to district and sub-district health staff in counselling and service provision. MSI also conducts information sessions for health volunteers on MSI's work in Timor-Leste including an overview of SRH and family planning.

[2] Estimates calculated using MSI Impact2 tool.

The majority of MSITL's daily activities such as awareness raising, health promotion and clinical service delivery, were not delivered by MSITL teams alone but in collaboration with Community Health Centre/ Health Post staff and/ other NGO teams. Activities were always, where possible, coordinated with health staff, local authorities, community leaders and/or health volunteers (PSFs).

MSITL has a mixed reputation amongst partners and stakeholders in Timor-Leste. Every external stakeholder interviewed commented on the need for sexual and reproductive health education and services delivered by MSITL; they stated that it was a professional and good organisation.

One discussant acknowledged the high quality work of MSITL and their impact on the national sexual and reproductive health of Timor-Leste. However she was very concerned with the Church's opinion on health matters and was worried about the Emergency Contraceptive Pill's inclusion in service provision as she did not understand that the Emergency Pill prevents, not causes, abortion. The issues raised are around the politics of sexual and reproductive health, not so much substantive issues.

One external stakeholder shared their opinion:

> *MSITL does good work; I am contented with their work. They are responsible for family planning and distributing it to remote districts. They have helped to reduce the total fertility rate from 7.8 to 5.7. We now work better together than before. However, I have to say that MSITL doesn't seem to follow the political situation and they don't follow the National Reproductive Health Strategy. For example the Emergency Contraceptive Pill is not included in our policy, MSITL are not in line with our policy. The Church thinks it is an abortion pill! We would prefer they think about quality over quantity. The Church thinks that door to door health promotion is too pushy. The Church allows choice and information to be given in the community but not services. The Church would like to stop MSITLs work but I say no! As MSITL is our partner so we are the one who should deal with them about issues that emerge due to MSITL's services.*

Another senior stakeholder was not very familiar with MSITL's maternal health work and was also very concerned that the Church would perceive health promotion activity as promoting a loss of morality in Timor-Leste:.

> *Family planning helps to reduce the MMR but we need more ANC with skilled midwives and post natal care and Emergency Maternal and Obstetric Care. We need help to increase midwife skills. Birth spacing can mean healthier mothers by giving them time to recover. Also it allows time for the girls to grow up. It is important to provide information for the young people so they can make choices. But if you give condoms to the youth this will promote free sex and the Church don't agree with this.*

On reflection there is no evidence available to the evaluation team to show that MSITL has gone beyond the intention and meaning of the Sexual and Reproductive Health Strategy policy document. MSITL has an agreement with the Ministry of Health to provide Emergency Contraception and MSITL provides Safe Motherhood services directly and indirectly to Timorese women.

There was no mention of the threat of HIV, except for the UNFPA stakeholder who recognised this as a significant potential sexual health problem.

All external stakeholders interviewed wished for better communication and collaboration with MSITL.

MSITL produces detailed work plans for each district which are distributed to stakeholders. Work plans include a monthly schedule of specific dates, times and locations of outreach.

However many stakeholders lamented that they were unaware of MSITL's scope of work, work plans, and methods of working. Government departments and services particularly felt they were not included in MSITL's plans. Many interviewees commented on this perception and to a lesser degree in the districts than in Dili. Some interviews noted that MSITL were capable and responsive partners, however in order to better work together toward the establishment of a stronger health system they wanted a more trusting relationship and greater transparency. Often this was because sexual and reproductive health is known to be topic that is inevitably confronting and they wanted to be prepared to deal with the challenges. This seems to be a very important issue that MSITL needs to reflect on.

As Timor's health system is still developing and under resourced, many stakeholders appreciated sharing MSITLs resources such as cars for transportation. They also appreciated that their staff and the technical advice was of a good quality. One issue that seems to cause confusion is that of procurement and distribution of pharmaceutical supplies. This seems to need further clarification between MoH, UNFPA and MSITL.

Many stakeholders wished that MSITL could expand into other rural and remote areas. When MSITL solicited feedback from community leaders 18 people responded in 2010. Over 90% of respondents 'agreed' or 'agreed a lot' that MSITL staff were well organised and professional. Eighty-eight per cent (88%) 'agreed' or 'agreed a lot' that MSITL should continue to work in the community and that MSI has good relationships with local community leaders and the community itself. Over 70% of respondents 'strongly agreed' that MSI's work is important in the community and 'agreed' that there was change in the community. This is excellent feedback.

LESSONS LEARNED

- *Need for greater advocacy and learning experiences in sexual and reproductive health for leaders and change agents*

Sexual and reproductive health is not well understood in Timor-Leste. Even the most senior people interviewed were often unable to articulate the meaning and content. Very few people outside of MSITL were able to understand the priorities of sexual and reproductive health at a national level; those articulated in MDG 4 and 5 and 6 regarding infant mortality, maternal mortality, universal access to health services and HIV/AIDS control. Stakeholders in senior positions talked of pornography and 'free sex' (sex outside of marriage) as being their top concerns regarding sexual and reproductive health. This is disappointing. There appears to be a lot of energy spent on morality rather than substantive health issues in some areas. Morals are clearly important but when they obscure the facts of women becoming ill and dying, infants not surviving, children being neglected, teenagers having unwanted pregnancies, couples not understanding how to space their babies, and people becoming infected with avoidable diseases, this seems unreasonable.

The slippage between government policy and Catholic doctrine should not surprise those who know Timor-Leste. Richards (2012) has written on the influence of the Catholic Church, which is not dissimilar to the Philippines. Despite rhetoric of democracy, independence and constitutional processes, the Catholic Church is a political player. However, in the Health Seeking Behaviour Study (Zwi et al., 2009), research shows that the reasons for not spacing births had little to do with religious faith. As illustrated below this came ninth for men and did not even rate in women's considerations.

Table 5 - Reasons for not birth spacing (HCSBS sample)

Reason	Women n (%)	Men n (%)
Heard of other's bad experience	43 (36.4)	33 (26.8)
Like babies	38 (32.2)	47 (38.2)
Afraid of side effects	10 (8.5)	8 (6.5)
Against spouse's wishes	6 (5.1)	4 (3.3)
Own previous bad experience	4 (3.4)	3 (2.4)
Against traditional beliefs/ancestors	4 (3.4)	3 (2.4)
Community opinion/reputation	3 (2.5)	0 (0.0)
Against own family's wishes	1 (0.9)	3 (2.4)
Against religious beliefs - God	0 (0.0)	6 (4.9)
Need to populate country	0 (0.0)	1 (0.8)
Can't afford to buy	0 (0.0)	1 (0.8)
Other	9 (7.6)	14 (11.4)
Total	**118 (100.0)**	**123 (100.0)**

ource: Timor-Leste Healthcare Seeking Behaviour Study (2009)

'Free sex' especially in youth is feared by many stakeholders and this inhibits them from considering providing candid information to young people. Sex before marriage appears to not be common in Timor-Leste. In a study of HIV/AIDS knowledge, a survey of 900 university students showed the 'free sex' phenomenon to be a myth. This table taken from that report shows very few young educated people indulging their passion. However, some young men are visiting sex workers and need to know about condoms

(Pisani and Dili Survey Team, 2004). On the matter of HIV/AIDS where messages are difficult to deliver and the consequences for a nation so dire if ignored.

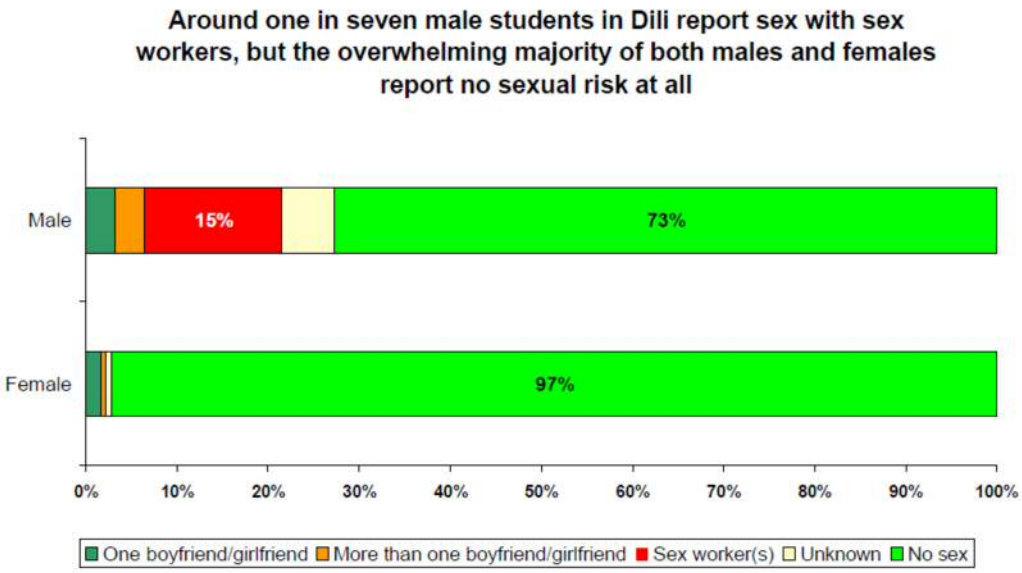

Figure 1: Percent of university students in Dili who have had sex with different partner types in the last year.

Source: HIV, STIs and Risk Behaviour in East Timor: a historic opportunity for effective action report (2004).

➢ *Need to focus on youth*

A number of young women in Timor-Leste who marry early in villages go on to conceive in their teens years. The Health and Demographic Survey (2009-2010) found that seven percent of women age 15-19 have already had a birth or are pregnant with their first child. The percentage of women who have begun childbearing increases rapidly with age, from 1 percent among women aged 15 to 20 percent among women aged 19. Rural women are more than twice as likely as urban women to have begun childbearing early. Adolescent childbearing is lowest in Dili (2 percent) and highest in Oecussi (16 percent). Teenage pregnancy is also markedly higher among women with little or no education (13 to 16 percent) than among mothers with secondary or higher levels of education. The percentage of teenagers in the lowest three wealth quintiles who have begun childbearing is also relatively higher , as compared with those in the highest two wealth quintiles. Early child bearing by women who marry at young ages is concerning.

➢ *Need for trusting partnerships and resource sharing*

Further challenges include the rugged terrain and lack of infrastructure in which to deliver health services. Districts are not fully resourced with health staff, logistics, pharmaceuticals, guidelines on how to implement their own policies (Soares, 2012). According to Soares (2012) remoteness and under development increase the complexity of meeting targets, or even being able to communicate effectively with all stakeholders.

Recent research conducted on health governance in Timor-Leste indicates weak governance structures (Soares 2012). This is an important point. MSITL faces the challenge of trying to partner with a maturing democratic government. Issues such as

responsiveness, transparency, professional ethics, accountability, implemented strategies and guidelines, and monitoring are still developing. This affects cooperation and participation at the district and headquarters levels and goes some way to explaining the disengagement that MSITL have to work with, such as unsigned MOUs.

In order to to deliver sexual and reproductive health programs at a national level, governments need to invest in education; create legal and policy that articulates social justice objectives; invest in and have human resources; and improve standards of management, as well as be mature enough to take risks to help the poor, the vulnerable and youth. Timor-Leste has some way to go on these elements.

➢ *Need to consolidate, advocate and build on strengths*

MSITL is a catalyst organisation. A catalyst, according to the Oxford Dictionary is 'a substance that increases the rate of a chemical reaction without itself undergoing any permanent chemical change'. MSITL's vision of sexual and reproductive health is often challenging to others, they test new ideas in Timor-Leste; and for this they are often criticized. MSTL pushes the boundary of what is acceptable but this is not necessarily a negative thing. Modern democracies are based on divergent views and MSITL is encouraging a range of people to consider new ideas based in sound public health evidence. To provide high quality sexual and reproductive health information and services to a population is highly beneficial. MSITL needs to continue doing what it is highly specialized in, which is clinical and public health approaches to sexual and reproductive health. Individuals may choose to do what they will with these new ideas according to their own conscience, based in their faith and the grounded awareness of their own situation.

APPENDICES

Appendix A List of internal documents viewed by the evaluation team

Marie Stopes International and Marie Stopes International Timor Leste. (2008). REACHING OUT: Extending the reach of comprehensive SEXUAL AND REPRODUCTIVE HEALTHcare to vulnerable communities in rural Timor Leste *Project Proposal to Europe Aid/ European Commission*.

Marie Stopes International and Marie Stopes International Timor Leste. (2010). REACHING OUT: Extending the reach of comprehensive SEXUAL AND REPRODUCTIVE HEALTHcare to vulnerable communities in rural Timor Leste *Interim Narrative Report Europe Aid/ European Commission*.

Marie Stopes International Timor Leste. (2009a). Annual Report. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2009b). Outreach Services Statistics. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2009c). Outreach Services Statistics Dili. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2009d). Reaching Out Monitoring Report. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2009e). Reaching Out Project Synopsis. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2009f). Workplan MSITL. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2009-2011). Workplan MSITL. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010a). Annual Report. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010b). Baseline Report for Reaching Out. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010c). CHOICE Client Questionnaire Analysis. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010d). CHOICE Education Questionnaire Analysis. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010e). CHOICE Leaders Questionnaire Analysis. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010f). Formtu Avaliasaun be Membru Ekipa. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010g). Outreach Services Statistics. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010h). Relatorio Focus Group Discussion. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010i). Revised Logical Framework. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010j). Statistical Report by District. Dili: Marie Stopes International Timor Leste, .

Marie Stopes International Timor Leste. (2010k). Workplan MSITL. Dili: Marie Stopes International Timor Leste.

Marie Stopes International Timor Leste. (2010- 2011a). Monitoring and Evaluation - Clients. Dili: Marie Stopes International Timor Leste,.

Marie Stopes International Timor Leste. (2010- 2011b). Monitoring and Evaluation - Education. Dili: Marie Stopes International Timor Leste,.

Marie Stopes International Timor Leste. (2010- 2011c). Monitoring and Evaluation - Leaders. Dili: Marie Stopes International Timor Leste,.
Marie Stopes International Timor Leste. (2011a). CHOICE Client Questionnaire Analysis. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011b). CHOICE Education Questionnaire Analysis. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011c). CHOICE Leaders Questionnaire Analysis. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011d). Clinical Supervision Tool. Dili: Marie Stopes International Timor Leste, .
Marie Stopes International Timor Leste. (2011e). Hili Los, Salva Moris Strategic Plan 2011-2014. Dili: Marie Stopes International Timor Leste,.
Marie Stopes International Timor Leste. (2011f). Memorandum of Understanding. Dili.
Marie Stopes International Timor Leste. (2011g). Monitoring and Evaluation Framework - Reaching Out Choice Dili: Marie Stopes International Timor Leste,.
Marie Stopes International Timor Leste. (2011h). Observation Tool. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011i). Outreach Services Statistics. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011j). Relatorio Focus Group Discussion. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011k). Satisfikasaun Kliente - monthly data 2010 to 2011. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011l). Staff Performance Scan (English). In Form (Ed.). Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011m). Standar Servisu ba MSITL ekipa baze. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011n). Summary Statistics Sites. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011o). Team Satisfaction Survey Report 2011 *Right Choices SAves Lives - Hili Los, Salva Moris*. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2011p). Training Schedule. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (2012). Training Schedule. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (Unknown-a). Case Studies - Ainaro, Bobonaro, Dili, Ermera, . Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (Unknown-b). Manager Performance Plus Form. Dili: Marie Stopes International Timor Leste,.
Marie Stopes International Timor Leste. (Unknown-c). Methods of data colection. Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (Unknown-d). QTA - Client Focussed. In Form (Ed.). Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (Unknown-e). QTA Programme Clinical Goverance. In Form (Ed.). Dili: Marie Stopes International Timor Leste.
Marie Stopes International Timor Leste. (Unknown-f). Team Member Perfomance Review Form. In Form (Ed.): Marie Stopes International Timor Leste, .
Michelson, J. (2011). QTA Checklist. Dili: Marie Stopes International Timor Leste.

Appendix B Interview Schedule – MSI Staff

Focusing on Objective 3 (Strengthen capacity of MSITL, and establishment of a sustainable model of SRH service delivery).

Indicators	Questions
Numbers of recruited and trained staff	How long have you worked for MSITL? How did you come to work for MSITL? Tell me how you were recruited? Did you need to travel, leave your village/district to work with MSITL? ("where possible staff will be employed from local district") Tell me about the training/induction you received when you started? Do you work in a team or by yourself? Do you know how many people are employed by MSITL?
Case study	Do you have a story about MSITL where you think it has made a big impact in someone's life?
No. of staff trained for leadership roles	If you wanted to be a manager or have a leadership role in MSI how could you do that? Do you feel supported/ encouraged to take on responsibility or leadership? Have you done any leadership training and what? Would you like to do any leadership training?
Production of policy, job descriptions, manuals, procurement procedures	If someone came in and you didn't know what to do – how would you manage that? What would you do, who would you ask? Are there any procedure manuals that explain what you should do and how you should do it? Where are they? Please show me. Have you ever needed to use these? Are there any checklists? Self-evaluation systems? Lists of what you are responsible for? Have you received any training in infection prevention? Can you show me a policy about this? Have you ever had someone complain about the MSI service? What do you do if that happens? Do you use client feedback forms for everyone? Can I have a look at one? Are you clear about your role and what is required for you to do? Is there any aspect of your job that you are not sure about or would like to know better? Tell me about what your work plans to achieve. How do you procure/order the medicines that you need? Who monitors the drug stores (inventory) and how often does this happen? Have you ever run out? What happened? Do you usually have all the medicines that you need? Where do the procurement orders come from? Do you ever need to refer clients to another clinic/ hospital/ services? How do you refer? Can you explain to me what you would do? Tell me about this process: is this an easy process to do, do you get feedback from the place you have referred to? How often would you need to do this? Tell me about a situation where you have had to refer someone. Which other services do you work closely with? What are the relationships with these other services like?

Training or scholarship activities/opportunities for specific staff, students, midwives (skills development programs)	Can you tell me about any training opportunities that have been made available to you? Are you aware of any MSI scholarship opportunities or know of anyone who has been given a MSI scholarship? Can you give me any information about scholarships for midwives in Dili?
In country management training and of ongoing capacity building of staff	How many team meetings, MSI meetings do you have? Where do these occur? Dili or outreach areas? What do you talk about? What training or workshops does MSI TL provide for to further skill development? What, how often? Has this training been helpful, applicable to your daily work, helped you to manage you work better or more efficiently, better quality, increased knowledge? How has this actually helped? Have you had any training in IT, computer skills, information management, evaluation, planning (non-clinical areas to build organisational capacity of staff)? How are the needs of MSI TL staff assessed? Is any ongoing supervision provided for staff? How is this provided?
Monitoring and Evaluation systems and processes	How do you provide feedback or input about your work or what is happening? Are you asked for your feedback often or do you feel comfortable to provide this? If an incident or emergency happens do you record this/ how/ where/ what do you do? Can I see the incident reporting form? What happens afterwards? Tell me about a time when you had to write an incident report and what the process was. Managers: Are you able to describe your monitoring and evaluation framework? How is this developed? How does it take into account national strategies, targets and developments? Is there any document you can show which includes plans and actions/ roles and responsibilities for the project team? Is this available and known to all staff? How do you measure the impacts of the M&E plan? What evaluation methods are used? Can you show me any work plans or reports provided by staff? How often does that happen? Are you able to show any internal audits or evaluation process documents?
Review and update of admin and financial systems; trained personnel	What administration or recording of information is required in your job? Can you explain to me what you need to do? Have you received any training about administration and financial management? Have the recording, software or administration systems you work with changed in the time you have been working with MSI? If so, what happened and how did you learn the new system?
Findings of evaluations and review disseminated	Do you know of any previous evaluations or research that has been done on MSIs work? Did you find out about the work done and what the findings were? How? Are you aware of any changes that have come about from the evaluations? Describe How are findings provided to stakeholders?

Appendix C Focus Group Tools

Villager Evaluation Guide

A focus group is a guided conversation on a topic held amongst people who hold similar characteristics. There are 2 groups – young married women and married men

Activity 1 Sexual and Reproductive Health Game

This is game for adults only and you will need to bring some prizes for people to win – examples include condoms, music tapes, and food snacks.

Introduce yourself and explain that you are assessing the quality of work that MSI provides to village people and you welcome people's comments and opinions. (External evaluator, confidentiality and participants consent)

Invite up to 10 people (men and women) from 1 village to play a game – divide them into 2 groups of 5 people. The aim of the game is to answer the questions and get the highest score. The group with the highest score wins the prizes. We will start with some easy questions but they will get harder…. Maximum points possible = 28

As you ask the questions start with the easy ones and encourage people to talk about that topic. Ask both teams for answers – it doesn't matter if other people watching join in too.

MSI	Pregnancy	Family Planning	STI/ HIV
How many times does MSI visit your village in a month? 1 point	How can you tell if a woman is pregnant? Periods stop or tummy gets bigger or breast bigger for 1 point	Name 1 natural family planning method Breast feeding or withdrawal or counting days of woman's cycle for 1 point	What is a sexually transmitted disease? Something that you catch from other people through having sexual contact for 1 point
How often does MSI come to visit your village? 2 points	When and how often should a woman go to the clinic for pregnancy checks? She should go in the first 3 months of pregnancy and have at least 4 checks for 2 points	Name 1 contraceptive method used by a man Vasectomy or condoms for 2 points	Which contraceptive protects you from nearly all sexually transmitted diseases (and stops babies too!) Condoms for 2 points
What services can you get from MSI? Must mention 3 or 4 things to get 4 points	What checks does the midwife do for a woman and baby to keep them healthy and strong? BP and tummy check and blood check and urine check for 4 points	Name 3 contraceptive methods used by a woman Must mention 3 to get all 4 points	What are the symptoms of STI? Sometimes no symptoms! Women – abdominal pain, vaginal discharge, Men – painful urine, discharge from penis

Activity 2 Focus groups - Then please ask some people to remain for a quiet conversation. Ask the following questions depending on the group (don't have mixed groups!).

Young married women - 8 only	Men - 8 only
Family Planning: How many children is a good number for a family? What do people in your village say about family planning and spacing babies? Why is it good to put some space between the babies? What difficulties do women face when trying to use contraception?	Family Planning: How many children is a good number for a family? What do people in your village say about family planning and spacing babies? Why is it good to put some space between the babies? How can men help women to use family planning well?
MSI: Please tell us about your experience with the MSI staff Do you feel that MSI program has benefited you and your community? What do you think about the MSI outreach services in your community? (quality, acceptability, accessibility, and affordability)	MSI: Please tell us about your experience with the MSI staff Do you feel that MSI program has benefited you and your community? What do you think about the MSI outreach services in your community? (quality, acceptability, accessibility, and affordability)

Thank the people for their time.

Appendix D Interview Tools

• **Monthly meetings with MoH or local health authorities** MSI perceptions - Please outline the strengths and weaknesses in MSITL's relationship with MoH.	**MoH Representatives** What is the content of the LOU? What is your understanding of the MSI program and services? How does MSI contribute to meeting MDG 4 and 5? Have there been any advantages in partnering with this program? Have there been any obstacles in partnering with this program? What has MSI contributed to family planning, and BCC working group?
• **Monthly meetings with MoH or local health authorities** MSI perceptions - Please outline the strengths and weaknesses in the relationships with the local health authorities?	**Local Health Authorities** Can you explain why SRH is important in your area? What is your understanding of the MSI program and services? Have there been any obstacles in partnering with this program?
• **Outreach and Sisca 3 locations monthly** **MSI perceptions-** Have you been able to deliver outreach services and participate in Sisca in 3 locations monthly? Is this enough to cover the districts that you offer services in? What does it achieve? What is the content of the discussions? How many people go on to accept family planning methods?	**Sisca staff/manager/community health centre** Can you explain why SRH is important in your area? What is your understanding of the MSI program and services? Have there been any obstacles in partnering with this program? What is your perception of community opinion on birth spacing? What has been your experience delivering family planning to communities? What has been your experience in working with this program?

Are there stockouts?	
• **Alola Foundation monthly discussion meeting in community** MSI how do you receive information about these monthly meetings? Has it increased knowledge and acceptance of family planning?	**Alola representative** What is the content of the LOU? Has Alola Foundation been able to deliver the monthly discussion groups to communities? What does it achieve? What is the content of the discussions? How many people go on to accept family planning methods? Do you know if their knowledge increases?
• **National Family Planning Working Group x 2 year** MSI perception - Can you tell me about this forum? What has it achieved?	
• **MoH, local and international NGOs demonstrate increased understanding of SRH services and information**	How does MSITL do this? How is the impact measured or assessed? Ask NGOs this directly
• **Annual SRH seminar** MSI manager - Has this occurred each year? What was the content? Who participated? What was achieved?	
• **Relationship with the Catholic Church** MSI perception - Have you a working	**Church representative** How is sexual and reproductive health important to your

relationship with the Church? What are the strengths and weaknesses of contact with the Church? What is your strategy to manage the Church's influence?	community? What is the community opinion on family planning? What is your opinion about MSI services and program?

Appendix E Table 1 Data on Millennium Development Goals 4, 5 and 6

MDG	Indicator	Timor Leste			
MDG 4. Reduce Child Mortality	**4A – Reduce by two thirds, between 1990 and 2015, the under-five mortality rate**	**Male**	**Female**	**Total**	**Source Year**
	4.1 Under five mortality rate (per 1000 live births)	85	76	64	(2009-2010)
	4.2 Infant mortality rate (per 1000 births)	59	53	45	(2009-2010)
	4.3 Proportion of 1 year old children immunised against measles				
MDG 5. Improve Maternal Health	**5A – Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio**				
	5.1 Maternal mortality ratio		No data	557	(2009-2010)
	5.2 Percentage of births attended by skilled health personnel		22.3	29.9%	(2009-2010)
	5B – Achieve, by 2015, universal access to reproductive health				
	5.3 Contraceptive prevalence ratio			Na	(2009-2010)
	5.4 Adolescent birth rate		51	Na	(2009-2010)
	5.5 Antenatal care coverage (at least one visit and at least four visits)		87.5		
	5.6 Unmet need for family planning			Na	(2009-2010)
			55.1	Na	(2009-2010)
			30.8		
MDG 6. Combat HIV/AIDS, malaria and other disease	HIV/AIDS - no reliable data but stable at this stage. Projection trend to be baseline epidemics by 2025 [2]	HIV/AIDS – regressing [1, 2]			
	Malaria – likely to achieve by 2015 but did not show decreasing trend in 2009 [2]	Malaria 2006-2010*, % households owning at least one ITN			42
		Malaria 2006-2010*, % under-fives sleeping under ITNs			42
		Malaria 2006-2010*, % under-fives with fever receiving anti-malarial drugs			6
	TBC – on track [4]	TBC – early achiever			

Sources: MDG website and National Health Demographic Surveys

Appendix F List of discussants

Interviews or Focus Groups	District 1	District 2	Dili
MSITL staff	1 Team Leader 1 Midwife	1 Team Leader 1 Educator	1 Program Manager 1 Country Director 6 Staff
Government health staff	1 DHS Deputy 1 DPHO MCH 1 DPHO Health Promotion 1 Head of CHC 1 CHC Midwife 1 CHC – Nurse SISCa responsible 1 Health Post Manager 1 PSF Family Health Promoter	1 DHS MCH 1 DHS Health Promotion 1 DHS Head 1 CHC Chief 1 Health Post Midwife 1 PSF Family Health Promoter	1 MoH FP 1 MoH Adolescent Reproductive Health Officer 1 MoH Quality Control 2 MoH Health Promotion 1 MoH Community Health
Volunteer or Driver	0	1	1
Government education staff	1	1 Village Secretary	0
Villagers and MSI Clients	3 Focus groups with married women 1	2 Focus groups with men and married women	0
Men	0	5	0
Women	18	11	0
Church	0	1	0
Australian Embassy	0	0	2
United Nations	0	0	2
Alola Foundation	1 Field Officer	0	1 Advocacy Manager
Total	**30**	**27**	**19**

REFERENCES

BELTON, S., WHITTAKER, A., FONSECA, Z., WELLS-BROWN, T. & PAIS, P. 2009. Attitudes towards the legal context of unsafe abortion in Timor-Leste. *Reproductive Health Matters,* 17**,** 55-65.

COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN 2009. Concluding observations of the Committee on the Elimination of Discrimination against Women Timor Leste. New York: United Nations, .

DARROCH, J. E. & SINGH, S. 2011. *Estimating Unintended Pregnancies Averted from Couple-Years of Protection (CYP)* [Online]. Guttmacher Institute. Available: http://www.guttmacher.org/pubs/2011/01/24/Guttmacher-CYP-Memo.pdf [Accessed 18 June 2011].

DAWSON, A., HOWES, T., GRAY, N. & KENNEDY, E. 2011. Human resources for health in maternal, neonatal, and reproductive health at community level: A profile of Timor-Leste. Sydney: Human Resources for Health Knowledge Hub and Burnet Institute.

MARIE STOPES INTERNATIONAL No date. Increasing family planning access and choice - Key lessons from Marie Stopes International clinical outreach programmes. London.

PALMER, C. A., LUSH, L. & ZWI, A. B. 1999. The emerging international policy agenda for reproductive health services in conflict settings. *Social Science and Medicine,* 49**,** 1689-1703.

PETCHESKY, R. P. 2003. *Global Prescriptions - Gendering Health and Human Rights,* London and New York, Zed Books and United Nations Research Institute for Social Development.

PISANI, E. & DILI SURVEY TEAM 2004. HIV, STIs and Risk Behaviour in East Timor: an history opportunity for effective action. USAID, Family Health International.

RICHARDS, E. 2012 'Not with fear': understanding the role of the Catholic Church in reproductive healthcare in Timor-Leste. *In:* LEACH, M., MENDES, N. C., SILVA, A. B. D., XIMENES, A. D. C. & BOUGHTON, B. (eds.) *Hatene (Understanding) Timor Leste.* Dili: Timor Lest Studies Association, Swinburne Press.

SOARES, A. I. 2012. *Development and Implementation of Timor-Leste Health Policy Framework 2002: A Governance Analysis.* Charles Darwin University.

ZWI, A. B., BLIGNAULT, I., GLAZEBROOK, D., CORREIA, V., BATEMAN STEEL, C. R., FERREIRA, E. & PINTO, B. M. 2009. Timor-Leste Health Care Seeking Behaviour Study. Sydney: University of New South Wales.