2014

Final Evaluation of Community Based Health and First Aid Program

Implemented in Manatuto and Manufahi districts of Timor Leste between 2009 and 2013

The document presents a detail account of the project activities and impact of the project in five crucial evaluation scales. It aims at capturing the good practices and anecdotal evidence in detail and also highlights the challenges and the areas of better programming in any future endeavor

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IFRC
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This report and the entire process is dedicated to

‘ERDIVA’

(a 13 year old girl from Cribas village in Manatuto, who was succumbed to death in April, 2013, due to dengue fever; our goal is to save lives of many Erdiva across the globe)

Acknowledgements

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Disclaimer: The views expressed in this report are those of the evaluator. They do not represent those of any of the institutions and people referred to in the report.

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Maps

Zooming in to Manatuto and Manufahi

is Bitirai in MANFAHI and Cribas in Manatuto

Contents

Executive Summary

The Task

The task was to undertake a thorough evaluation of the Community Based Health and First Aid (CBHFA) project in selected sites of Manatuto and Manufahi districts of Timor Leste between the period 2009 to 2013 by the Cruz Vermelha Timor Leste (CVTL) with multilateral support (I.e. through IFRC) from the Finnish Red Cross (FRCS). The purpose of the CBHFA final evaluation is both to account for the Finnish Red Cross support provided to CVTL as well as to draw lessons that will be useful in improvement of current and planned program implementation and sustainability strategies. The evaluation is expected to contribute to knowledge and recommendations on appropriateness and sustainability strategies of similar programs. The 8 key standards and criteria laid down under IFRC framework for evaluation have been followed and maintained[1]. Please refer to Annex for a full copy of the TOR with criteria for this evaluation.

Project Data

Originally, the CBHFA Pilot Project is planned to be implemented for 3 years, CHF 430,000 project (running from 2010 to 2012). Some funds (also from Finnish Red Cross) were put into preparatory work for the pilot in 2009. The Pilot Project is being implemented by CVTL Health Department, under the CBHFA Project Manager, who has responsibility for all CBHFA-related projects. The program goal is to prevent and manage injuries and common health problems in emergency and non-emergencies in vulnerable communities in two rural districts (Manufahi and Manatuto).

Overview of the report

The chapter on introduction explains the reason evaluation was done, the country and local context within which the CBHFA program was planned and implemented. The chapter details on the scope of work, methodology and recognises the limitations and key challenges. In subsequent headings various nuances are discussed under relevance, effectiveness, impact, efficiency and sustainability. The key findings are based on review of provided documents, field visits and interviews. Every section in the document discusses issues and provides some suggestions to improve on areas that can enhance service delivery by improving quality and contribute in creating a larger impact.

[1] IFRC framework for evaluation (www.ifrc.come/mande)

Major findings

The evaluation came up with a list of findings from the entire process, which included secondary data review, interaction with staffs and volunteers across levels and undertaking community level assessment with support from various community friendly, participatory tools and categorizing these findings under the relevance, effectiveness, efficiency, impact and sustainability. The below findings will provide summary of findings under each cluster without going into the depth of it, however the details can be found in the respective sectors –

1. Relevance: In both the sites it was found that the program has been well in line with the beneficiaries' expressed and immediate needs and participatory community processes were followed (especially in Cribas) to continuously update the needs of the community and adjusting the same in planning and services delivery, which made the program more dynamic and extremely community friendly. The CBHFA project was aligned with both CVTL mission and the overall IFRC global agenda of developing resilient and better prepared communities and in efforts of revitalise and mobilising the spirit of volunteerism to promote health and prevent common preventable health issues. The major findings under this category have been around –
    a. Site selection, which employed different methods for selection of sites in two different areas, however the selected villages and sub villages maintained the criteria of most vulnerable and despite targeting, different communities with different needs, the program remained viable
    b. The project in both the sites worked to complement the Govt. efforts and efforts of other stakeholders and development players in the field
    c. The project is able to create demand for health services in the communities and thus helped the public health system to respond better
2. Effectiveness: The program objectives have been fully met but the degree of achievements vary between sites (typically, Cribas shows more community participation and enthusiasm among the volunteers and general community members in taking up new activities and initiatives), branches (Manatuto as a branch is slightly more in tune with taking up an integrated health program, whereas Manufahi has a clear health capacity gap), sectors (overall the staffs and volunteers are more comfortable working in communicable diseases in general, which led to negligent implementation of Nutrition and like activities) and individuals (the branch health

officer at Manatuto is much equipped to deal with any new direction in health programming, whereas the health staffs in Manufahi need technical support and continuous mentoring).

a. The project has mostly maintained the timeline in Manatuto (started in 2009 and ended by the end of 2012), however in Manufahi the project started and ended late (started in the year 2010 and ended in 2013 with a year-long no cost extension period)
b. There are differential levels of support and supervision (in Manatuto the level of support was excellent; however in Manufahi the staffs' capacity and the geographical positioning of the site form the district headquarter made it difficult for the supervisory staff to provide adequate support)
c. The CBHFA PMER toolkit have been used in parts and not in totality. The Planning tools especially the Log frame and the M & E plans have been used by the delegation and CVTL NHQ staffs however the monitoring and reporting tools were not used at all. The Manufahi branch people could not show any reporting tools, which are used by the volunteers whereas Manatuto staffs did develop their own monitoring and record keeping tools, which are simple, user friendly and easily consolable. Copies of the same have been attached in the document (as Annex 05)
d. Volunteers selection (Bitirai model) – The Bitirai model of volunteering presents a grim picture and poor program planning (as this sub village of Fato Berloi has 99 household and around 31 trained volunteers in the village. A physical mapping (See Annex 4d) of the same by the community, unveiled a fact that the volunteers are not geographically, logically spread as there are village by lanes with 5 volunteers out of six households and no volunteer among 25 households. (detail of the same have been given in the relevant section)

3. Efficiency: The project has been efficient in developing volunteers' capacity across levels though the quality management and volunteer retention are two major challenges to be overcome for successful program delivery. Though, the NHQ team has actively supported the project in every way possible, however quick staff turnover slowed down the pace of implementation. Generally, the planned activities were well implemented within the stated time frames i.e. keeping to deadlines. However the overall program implementation in Manufahi has been delayed by a year, stretching the project to the end of 2013 through a one year no cost extension.

   As part of this analysis it is found that the Cost per beneficiary per year varied significantly between US$ 4 – 22 (in case of only direct beneficiary) and between US$ 2 – 11 (in case of

direct and indirect beneficiary). However the overall per beneficiary cost comes at US$ 16 over the 5 program years.

4. Impact: The Govt. official across levels acknowledged the work of RCRC and also gave the due credit for improved community demands which prompted them to have enhanced supply and health service and supplies by the Govt. Though quality of health services – is a major area of improvement both at the community and at the service delivery institution level

   At the NHQ and branch level the capacity of staffs have enhanced in many areas however there are scope of significant improvement in the technical areas especially in PMER capacity.

   There are local innovations in many places, the organization could capture and scale up/ diffuse these ideas and later market the same across the development sector and among Govt. institutions ; e.g. volunteers database by household – local innovation at Manatuto

5. Sustainability: The volunteers are from within the community which ensures the knowledge will stay in the community and the program interventions will sustain on its own (it has been observed in Ctribas, where the program has been concluded in Dec 2012).

   Behaviour change around Hygiene and sanitation are more likely to sustain as people are able to relate non-compliance with risk of disease and death (based on the focused group discussions).

6. Other significant findings:
   a. Nutrition: Though the program started with nutrition education and awareness building around diversified diet at the end the beneficiaries recalled only healthy cooking as part of Nutrition intervention and could not actually support the cases of malnutrition. It was also observed that the staffs and volunteers have poor capacity of implementing Nutrition program at the branch level and below, however capacity of nutrition programming was observed at the NHQ level but somehow, it did not percolate down.

      At the community level the dietary diversification is very poor (mostly Carbohydrate intake), which is leading to rampant Protein Energy Malnutrition (PEM), especially among young children. (See Annex 4c)
   b. Moderate capacity of the health service providers were observed in Fatu Barloi that provide services to Manufahi, whereas the Cribas health centre showed gross violation

of the universal precaution rules, which shows poor capacity and lack of basic orientation of the medical professionals

c. Though HIV is not a priority topic or area of intervention under this round of CBHFA programming'; but presence of risk factors like 1. Presence of high migration zones 2. Circularly mobility etc. pose enough reason to launch HIV prevention and management as an integrated part of the next round of programming.

Key recommendations

1. Quality of program has to improve, in relation to – capacity of staff (technical, program and financial management and PMER), logical volunteer selection (from village based to population based), introduction of proper pre and post-test methods (which is already in practice and need to include questions to assess, not only knowledge enhancement but improvement of skills, as well) and knowledge retention practices for staff and Volunteers' training and refresher; etc.,
2. Implementation model should be at a scale, with strong program management and M&E capacity and proper monitoring plan encompassing logical distribution of monitoring site; e.g. monitoring Bitirai from Same; is difficult and selection of sites needs more attention and clarity (especially Bitirai). However Bitirai is a very remote village without much resources but that should not be the only consideration; the selection of implementation site should be a result of a complex algorithm combining multiple factors, weighed as per the need of the community and capacity of the national society vis-à-vis resources available and allocated for undertaking activities in that site. (detail suggestive list of criterion has been given in the *'Relevance'* section)
3. The program needs to have public health lenses of programming (not disease focus; rather focus at the root causes); especially in WASH, Nutrition, regulating and reducing Alcohol and Tobacco use, dietary diversity and feeding practices, universal precautions, immunization etc. (See Annex 4a)
4. Newer and most relevant areas of programming need to be introduced especially in areas with high vulnerability and disease burden (e.g. more nutrition interventions to be launched in Cribas with a specific focus on children in need of clinical assessment and treatment; moreover a nutrition program for infant and children below the age group of 5 years, is never a very successful program unless it adheres the child care practices and linked with local food model, hence the revised nutrition program needs to have all the allied components that build a conducive environment for the program – and an integrated program approach can offer these

interventions in a more strategic manner, with possibility of better results) . This can be achieved by having more evidence based programming and using criteria oriented data and blinded selection of sites as per the community needs.

5. Documentation should be an integral part of programming and not as a stand-alone activity. The plan for documentation has to be drawn before the program is rolled out and the implementers across level should know the documentation requirement of the project and work accordingly.
6. Technical knowledge and skill sets are to be the most prominent deciding factors for selection of health staffs, across levels and not mere adjusting people with no idea of health program implementation.
7. The organization needs to have in-house research and M&E capacity, a talent acquisition/ retention policy for Staffs and volunteers and policies and execution of the same around protection and insurance of staffs in difficult situations are to be integral part of any project.
8. We need to weigh our volunteering model against the Govt. and other agencies and take steps to engage and motivate volunteers through innovative ways (by reward, recognition, district and national level felicitation etc.). Improved dialogues (may be through monthly or quarterly meetings) and better follow up mechanisms (once a month curtsy call from the supervisor etc.) with the volunteers, who are not actively engaged in any ongoing program, will also help retain them and keep the volunteers active at all time
9. Visibility of RCRC has to increase at the community level (which should not restrict to their wearing the emblem, T – shirt etc. but there should be visible wall painting or posters that enhance the visibility, manifold) and the volunteers and staffs need to have more and correct information about the movement as such (especially in Manufahi)
10. There are systemic and sectoral innovations in some of the places (e.g. the household listing by volunteers in Manatuto), which can be replicated across the projects and also tested and documented to make similar practices into organizational good practices
11. Launch and strengthen interventions and practices that focus on inclusive development (e.g. Gender, disability etc.) and let it cut across the technical and OD interventions
12. Have a sustainability plan (detail recommendations are given in the 'Sustainability section(from the beginning of program, rather make a practices to include a section on sustainability in the proposal. Also, initiate discussions around sustainability in the community and ensure that the community structures and the agencies in the community are able to take up the program interventions on their own – slowly shift to 'Community Based' to 'Community Led'

13. Need to have specific focus on research, monitoring & evaluation and documentation. The project outcomes and the significance of change could not be assessed as the baseline data was not available for most of the end-line indicators.

Conclusion

It was well understood, after the field visits and after interaction with staffs, volunteers and the community members across different levels; that this program, its elements and the practices in the community could not be assessed as stand-alone components rather it had to be analyzed and assessed in relation to the country context, capacity of volunteers, staffs and communities and overall health systems' situation in the country.

Though the nature of programming has been complex, the national society has been new and CBHFA as a concept was new to the CVTL; the national society did a good job of selecting the right communities, selecting the right programming issues and reached out to the right people, who are in utter need of services. The program at any level did not compromise on the vulnerability criteria, which has been acknowledged by the communities, Govt. officials and other stakeholders.

The program has been relevant, effective, moderately efficient and it has got strategies in place that might ensure sustainability. However, though the program was able to touch people's lives, deliver services with a human touch; it did not deliver result at a scale and the poor result measurement tools and the M&E capacity at the NS level further made it difficult to assess the actual degree of changes brought in by this project.

In case the program is being rolled out in the field in the next round the below elements are to be kept in mind –

1. The health program needs to be combined with other CVTL priority program areas for better relevance and sustainability
2. A modest mix of hardware (as we have seen in Cribas – WASH and Health mix) with the behaviour change component will have more result in the field (similar models have been tested and verified within the movement; Afghanistan CCBHI, Cambodia CBHFA programs etc. and outside)
3. A strong focus on program management, M & E with cross cutting technical support may lead to comprehensive, integrated risk reduction programs with significant components of health; towards achieving more health outcomes with less investment.

Introduction

Purpose of final external evaluation

The purpose of this External Evaluation is to assess and document the impact of the Community Based Health and First Aid (CBHFA) Program in selected communities of Manatuto and Manufahi districts of Timor Leste. The evaluation also identified the changes in knowledge, attitude and practices, highlighted the areas of improvement and provided recommendation on possible modifications. This is done through assessment of the relevance, efficiency, effectiveness, impact and sustainability of the program. The Evaluation also assesses the alignment with, and appropriateness of, policies and guidelines on the health program and determines the extent and depth of coordination and collaboration for partnerships. The findings from this Evaluation are also intended to inform future planning in same or similar programs.

Country Context

Timor-Leste is a small country in Southeast Asia and covers a total area of 14,919 square kilometers. It occupies primarily the eastern half of the island of Timor, with West Timor being part of the Republic of Indonesia. Timor-Leste is divided into 13 administrative districts, 65 sub-districts and 442 Sucos/villages and 2,225 aldeias/hamlets (DHS 2009/10). Dili is the capital and it is the largest city and the main port. The population is currently estimated at 1,066,582 (with male = 541,147 and female = 525,435) with an annual growth rate of 2.4 percent between the 2004 Census and the 2010 Census (NSD, 2010).

Timor Leste has a market economy that used to depend upon exports of a few commodities such as coffee, marble, oil, and sandalwood. Timor's Leste's economy grew by about 10% in 2011 and at a similar rate in 2012[2]. Timor now has revenue from offshore oil and gas reserves, but little of it has gone to develop villages, which still rely on subsistence farming. Nearly half the population lives in extreme poverty. The Timor-Leste Petroleum Fund was established in 2005, and by 2011 it had reached a worth

[2] de Brower, Gordon (2001), Hill, Hal; Saldanha, João M., eds., *East Timor: Development Challenges For The World's Newest Nation*, Canberra, Australia: Asia Pacific Press, pp. 39–51, ISBN 0-3339-8716-0. "Timor-Leste's Economy Remains Strong, Prospects for Private Sector Development Strengthened". Asian Development Bank.

of US$8.7 billion[3]. Timor Leste is labelled by the International Monetary Fund as the "most oil-dependent economy in the world". The Petroleum Fund pays for nearly all of the government's annual budget, which has increased from $70 million in 2004 to $1.3 billion in 2011, with a $1.8 billion proposal for 2012. [4]

The economy is dependent on government spending and, to a lesser extent, assistance from international donors. Private sector development has lagged due to human capital shortages, infrastructure weakness, an incomplete legal system, and an inefficient regulatory environment. After petroleum, the second largest export is coffee, which generates about $10 million a year. Starbucks is a major purchaser of Timorese coffee[5]. According to data gathered in the 2010 census, 87.7% of urban and 18.9% of rural households have electricity, for an overall average of 36.7%.[6]

The agriculture sector employs 80% of the active population. In 2009, about 67,000 households grew coffee in Timor Leste with a large proportion being poor. Currently, the gross margins are about $120 per hectare, with returns per labor-day of about $3.70. There are 11,000 household growing mungbeans as of 2009, most of them subsistence farmers[7]. [8]

Timor Leste's adult literacy rate in 2010 was 58.3 per cent, up from just 37.6% in 2001. Illiteracy is higher among women. Illiteracy was at 95 per cent at the end of Portuguese rule. In 2006, 10% to 30% of primary-school age children did not attend school. [9]

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[3] [b] "Observers divided over oil fund investment". IRIN Asia

[4] "Article IV Consultation with the Democratic Republic of Timor-Leste". IMF.

[5] [a] [b] [c] "U.S. Relations With Timor-Leste". U.S. Department of State. July 3, 2012

[6] "Highlights of the 2010 Census Main Results in Timor-Leste". Direcção Nacional de Estatística

[7] Doing Business in Timor-Leste". World Bank. Retrieved 13 February 2013.

[8] [a] [b] [c] [d] "Expanding Timor - Leste's Near - Term Non - Oil Exports". World Bank. August 2010. pp. iii.

[9] "National adult literacy rates (15+), youth literacy rates (15-24) and elderly literacy rates (65+)". UNESCO Institute for Statistics."Human Development Report 2009 – Timor-Leste". Hdrstats.undp.org. Retrieved March 28, 2010.

Roslyn Appleby (2010-08-30). *ELT, Gender and International Development: Myths of Progress in a Neocolonial World* Multilingual Matters. p. 92. ISBN 978-1-84769-303-7. [b] "Timor-Leste faces development challenges". Content.undp.org. January 12, 2006. Retrieved March 28, 2010. [b] [c] Robinson, G. *If you leave us here, we will die*, Princeton University Press 2 [b] "Table 5.7 - Profile Of Students That Attended The 2004/05 Academic Year By Rural And Urban Areas And By District". Direcção Nacional de Estatística

Context of Health Programme

Life expectancy at birth was at 60.7 in 2007. The fertility rate is at six births per woman. Healthy life expectancy at birth was at 55 years in 2007. Government expenditure on health was at US$150 (PPP) per person in 2006.[10] Many people in East Timor lack safe drinking water[11]. There were two hospitals and 14 village healthcare facilities in 1974. By 1994, there were 11 hospitals and 330 healthcare centers. [12]

The 2010 maternal mortality rate per 100,000 births for East Timor is 370. This is compared with 928.6 in 2008 and 1016.3 in 1990. The under-5 mortality rate per 1,000 births is 60 and the neonatal mortality rate per 1,000 live births is 27[13]. The number of midwives per 1,000 live births is 8 and the lifetime risk of death for pregnant women is 1 in 44[14].

By 2015, due to a Cuban–Timorese training program initiated in 2003, Timor Leste will have more doctors per capita than any other country in southeast Asia.[15]

According to the Global Hunger Index of 2013, Timor Leste has an GHI indicator value of 29.6 indicating that the nation has an 'Alarming Hunger Situation' earning the nation the distinction of being the hungriest country in the entire continent of Asia and the 4th hungriest nation in the world. [16]

CBHFA in Manatuto and Manufahi

Community Based Health and First Aid (CBHFA) approach was developed and implemented within the Red Cross Red Crescent movement to empower communities take control of their health and apply evidence based good practices along with behavior change to stay healthy. The CBHFA program was based on using simple tools adapted to local context to address priority needs. The CBHFA is an approach that seeks to create healthy, resilient communities worldwide thus playing a vital part in the International Federation of Red Cross and Red Crescent Societies´ (IFRC) Strategy, Strategic

[10] Human Development Report 2009 – Timor-Leste". Hdrstats.undp.org. Retrieved March 28, 2010.

[11] Timor-Leste faces development challenges". Content.undp.org. January 12, 2006. Retrieved March 28, 2010.

[12] Robinson, G. *If you leave us here, we will die*, Princeton University Press 2010, p. 72.

[13] Timor-Leste". United Nations Population Fund. Retrieved 2013-02-11.

[14] "The State Of The World's Midwifery". United Nations Population Fund. Retrieved August 2011.

[15] Hodal, Kate (June 25, 2012). "Cuban infusion remains the lifeblood of Timor-Leste's health service". London: guardian.co.uk.

[16] Welthungerhilfe, IFPRI, and Concern Worldwide: 2013 Global Hunger Index - The challenge of hunger: Building Resilience to Achieve Food and Nutrition Security. Bonn, Washington D. C., Dublin. October 2013.

Operational Framework (SOF) for Health 2015 and contributes to Millennium Development Goals 4, 5, 6 and 7.

CVTL is the National Society of the Red Cross in Timor-Leste and has been in operation since 2002. Since its foundation CVTL has worked to improve the quality of life for vulnerable people, operating primarily in the areas of disaster risk reduction (community preparedness, emergency response and livelihoods), health (water and sanitation, HIV/AIDS, community-based health and first aid, first aid training and emergency health), tracing and restoring family links, dissemination of the Red Cross values and principles and international humanitarian law. A relatively new youth Program aims to equip young leaders of tomorrow with skills and passion for humanitarian work.

In the past 5 years, CVTL has been implementing two important pilot projects – the CBHFA Pilot Project, and the CBDRR Pilot Project – which together will enable CVTL to develop its capacity to work effectively as a national organization providing protection for vulnerable people in priority local communities across the country, through the CVTL Branch in each District. CVTL's vision, in line with its new Strategic Plan, is to continue to strengthen its delivery of fully-integrated support and development assistance to vulnerable people and communities; after the pilots the next generation of projects are intended to merge Health and Disaster Risk Reduction work, to be part of "integrated community-based risk reduction" (iCBRR) as a CVTL core Program country-wide.

Originally, the CBHFA Pilot Project was planned to be implemented for 3 years, CHF 430,000 project (running from 2010 to 2012). Some funds (also from Finnish Red Cross) were put into preparatory work for the pilot in 2009. The Pilot Project was implemented by the CVTL branches of Manatutu and Manufahi, with support and monitoring provided by the CBHFA Project Manager at the NHQ, who has responsibility for all CBHFA-related projects.

The program goal is to prevent and manage injuries and common health problems in emergency and non-emergencies in vulnerable communities in two rural districts (Manufahi and Manatuto).

Program objectives include:

1. Enhanced capacity of CVTL to implement a standardized CBHFA *in Action* program nationally.
2. Enhanced capacity of CVTL branches (Manufahi & Manatuto) to respond to & support community needs with a focus on CBHFA *in Action.*

3. Improved knowledge and health practices in 4 target communities in two districts and demonstrated ability to respond to & support own health needs.

This program was implemented in two districts, Manatuto and Manufahi Districts. Addressing the challenge in target areas, aside of the software, the program was also provided support on provision of water system and sanitation facilities in the Manatuto and in the second district, Manufahi, the program provided wells and sanitation facilities.

The implementation of CBHFA Program was done in different time frame; from early 2009, in the first 2,5 years, program was only implemented in Manatuto District and finished by the end of 2012. The second district, Manufahi, started its implementation in July 2011 and was finished at the end of 2013. Due to the fact that some program activities which mainly was on water and sanitation infrastructure were not completed by the original timeline, IFRC Timor-Leste delegation requested for time frame extension to December 31, 2013 without additional budget. The total number of beneficiaries had covered by CBHFA program in two Districts were 6,989 people.

End line survey results

At the end of 2012, the results of the first two communities – Cribas and Au Beon from Manatuto district – had achieved exciting results including no new malaria cases reported. Meanwhile by end of 2013, the final two communities – Uma Berloik and Bitirai from Manufahi district – also documented no new malaria cases. The end-line survey that was conducted in December 2013 in Uma Berloik and Bitirai further revealed other improvements in health behaviour such as hand-washing with soap at critical times.

In September 2013, some of the project results and the work of the volunteers from Manufahi district were proudly recorded in a series of short videos that were played back to the communities as well as featured at the International Federation of Red Cross and Red Crescent Societies' (IFRC) statutory meetings held in November 2013.

The capacity built by CVTL in CBHFA through this Program will continue to be used, as CBHFA was implemented across all integrated community-based risk reduction program (ICBRR) Programs in the future as the tool to address health risks in communities (a methodology supported by all of CVTL partners). The lessons learnt from the CBHFA pilot project will be utilised to improve the implementation of the CBHFA component of CVTL's ICBRR Program.

Scope, Methodology & Constraints

Scope

Final evaluation of CBHFA program supported by Finish Red Cross in selected sites of Manatuto and Manaufahi districts of Timor Leste was conducted between 01 and 11 April 2014. The objective of the evaluation were to –

1. Review the effectiveness, efficiency and relevance of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.
2. Review how the CBHFA approach has been modified to local context and how the community-based approach has been implemented in the project communities?
3. Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

The program has been implemented in both the districts in 4 sites and was built upon on the existing WASH program, which was funded by the Australian Red

Table 1: (CBHFA program by FRC in Timor Leste)

District	Name of the Sub district	Name of the Village	No. of Volunteers
Manatuto	Manatuto	Cribas	22
	Aubeon	Aubeon	14
Manufahi	Fatuberliu	Clacuc	31
	Uma Berloik	Uma Berloik	29

Methodology

The methodology for data collection, collation and analysis included a combination of traditional and participatory tools guided by analysis of secondary data and information available in public domain, with the delegation and CVTL. More importantly, the evaluation followed a carefully drawn process which included, in a sequence –

- Collecting and gathering data about the program and reading through the secondary information sources, reports and programmatic documents
- Meeting with the County Delegation at Timor Leste on scope, methodology and the expected evaluation outcomes

- Meeting with number of CVTL staff members and collecting documents from them for reconstruction of the retrospective context
- Document analysis/review; a critical review of documented materials including all project related documents, MOU, IEC BCC materials, success stories, case studies, any other monitoring or evaluation report for the same project
- An assessment of the degree to which recommendations from the previous review recommendations have been implemented
- Project data consolidations – baseline data, mid line data, end line data, regular project monitoring data etc.
- Key informant Interviews with key stakeholders (staff and volunteers in the governance and management, authorities, other partners, Govt. media etc.) at national and branch levels
- Focus Groups Discussions with beneficiaries
- Field visits and beneficiary interviews using various tools including a number of PRA tools and verbal autopsy
    - Social Mapping
    - Caseload analysis
    - Problem identification
    - Root cause identification games etc.

The evaluation picked up one each site from each district (refer to table 02 for details) considering different criterion to understand implementation dynamics of the program across varied socio – demographic variables like –

1. Proximity of the site from a major urban hum (nearest and furthest)
2. Ethnicity of the population
3. Access to basic health services
4. Proximity with functional national highways
5. Population (dense and scattered); etc.

Table 2: (sites visited)

District	Sub district	Village	Sub village	No. of Vol	No. of HH	Pop	
						M	F
Manatuto	Manatuto	Cribas	Tuquete	22	295	303	251
			At-hoc			279	259
			Webani			305	279
			Ramak			253	258
			Caunua			260	266
Manufahi	Fatuberliu	Clacuc	Webica/ Bitirai	31	99	242	266

The evaluation team consisted of:

1. Gopal Mukherjee, Health Adviser (South Asia), IFRC SARD. (Evaluator)
2. Mr. Marcelino Albuquerque, CBHFA Manager, Cruz Vermelha Timor Leste (Support in translations and contextualization)

Limitations

1 The scale of the program is very small thus it is difficult to justify the area of evaluation as actual samples and rather the evaluation happened at a scale, which is difficult to justify scientifically

2 The changes happened in the field are not entirely because of the project interventions. There were other factors like strengthened public health system, introduction of SISCa, community engagement and ownership etc. However the project did not assess the contribution solely made by the project strategies and interventions and the changes made due to external factors. Due to this limitation, the exact impact of the project interventions could not be assessed

3 The baseline data was not presented, as no planned baseline was undertaken in the beginning of the project and the end line data was rather very elemental; so it is difficult to comment on the project impact and the contribution of the project into the public health systemic improvements in Timor Leste

4 Language: Since translation was important there were times when the translator would have to put effort in conveying and receiving the information. Since there was just one translator it got a bit tiresome to do the same work repeatedly. However the quality of translation was adequate.

5 Since the interviews with community members and volunteers were done in close proximity to the Red Cross teams (volunteers and staffs); the answers received may have been biased.

6 Sometimes the community members were found under influence of alcohol (in Bitirai), which might question the standard and quality of answer received from the community.

Major Findings

Major Findings

Relevance

In both the places, it was found that the CBHFA programs and all its components are in line with (rather complementing) the Ministry of Health sponsored programs at the lowest level. The CVTL staffs and volunteers share a good working relation with the health officials across levels and they support the SISCa program in treatment adherence and compliance.

In both the sites it was found that the program has been well in line with the beneficiaries' expressed and immediate needs and participatory community processes were followed (especially in Cribas) to continuously update the needs of the community and adjusting the same in planning and services delivery, which made the program more dynamic and extremely community friendly.

The Government of Timor-Leste through the Ministry of Health, is committed at the highest level to achieve the health for all Timorese people through its mission of ensuring availability, accessibility and affordable health services for all. It also calls for regulating the health sector and promoting community and broad-based stakeholder participation For the implementation activities using two approaches such as: Basic Service Packages through Community Health Centres, Health Posts, Mobile Clinics and SISCa and Hospital Services Packages through National and Referral Hospitals in all of territory. All the services are free for all. Tertiary care has been offered in collaboration with the neighboring countries such as Australia, Singapore and Indonesia.

Despite efforts by the Ministry of Health – the program communities, particularly in remote areas are still facing problems to access health care assistance due to various constraints. As a response to these issues of difficult geography and distance, the Ministry of Health explored possible solutions which could be applied in Timor-Leste. It was based on the notion that every Timorese citizen has the right to get assistance in the area of health promotion, prevention of diseases, treatment of sicknesses and rehabilitation, in order to achieve and maintain a healthy life. These solutions needed to be feasible, sustainable and appropriate for the unique context of this country and its people. Thus emerged the idea of a community-based integrated package of health assistance, called SISCa or Servico Integrado da Comunitaria.[17]

The CBHFA project was aligned with both CVTL mission and the overall IFRC global agenda of developing resilient and better prepared communities and in efforts of revitalise and mobilising the spirit of volunteerism to promote health and prevent common preventable health issues.

[17] http://www.moh.gov.tl/?q=node/82

Though the target communities have been identified through two different set of processes. The Bitirai selection process is completely unbiased and not influenced by any internal or external factors, except the needs and context of the situation. The process evidenced collection of data around the health vulnerability indicators and selecting Bitirai among all the other sub villages of Fatu Berliu. However the effectiveness indicators (especially in relation to economic feasibility of programming and impact at a scale) were not taken under consideration and thus the program interventions in Bitirai despite being, extremely meaningful (as this is a truly vulnerable and extremely difficult to reach community) carry the burden of very high per beneficiary cost of implementation.

On the other hand, despite having lack of clarity of Cribas's selection process as an intervention site the evaluator personally feels that Cribas has been one of the best selections. Based on the below factors –

- Cribas is close to city (demonstrability)
- Value for money (significant population)
- Problem areas (many and still existing)
- A good site for experimenting new ideas
- Buy in of the village head (an ex RCV and an active stakeholder of the program)
- Active RCV and the distribution of their working areas are meaningfully distributed
- Strong branch team (especially Health)

Other than the above points, if the site has some more features like a strong vulnerability angle (no health facility, away from high road, prone to disaster, significant population of marginalized section etc.), geographic remoteness, disaster prone, lack of institution (school, health facility etc.) etc.

The beneficiaries found the services are comprehensive and in response to their actual needs. However, they also have needs of higher priorities (like Nutrition, WASH, Alcohol and Tobacco prevention etc.) and the project needs to focus on the root causes and not only immediate diseases management and prevention.

The project in both the sites worked to complement the Govt. efforts and efforts of other stakeholders and development players in the field. The newly proposed Integrated Community Based Risk Reduction Program (ICBRR) even has presence of different NGOs in a place as one of the exclusion criteria, which helps RC reach out to the most vulnerable people

Local health departments in both the places clearly expressed CVTL value addition in dealing with the overall health problems. They further asked CVTL to scale up the programs, geographically and cater to the needs of people in the community level in a more integrated manner.

The program also worked in collaboration with other national society and integrated cross organizational resources to fulfil CBHFA priorities. Additional funds were contributed to the project by New Zealand Red Cross for covering national headquarters costs and for the first nutrition training. CVTL's community-based water and sanitation projects funded by Australian Red Cross and Austrian Red Cross use methodology and materials developed by the CBHFA pilot for hygiene promotion and other health promotion.

Organizational development is also supported by New Zealand Red Cross, Norwegian Red Cross and Japanese Red Cross Society, specifically targets strengthening organisational structures such as branch infrastructure, support services, volunteer and member management and policy development and skill development for staff, which together increased the relevance of the program at the district and community levels.[18]

Effectiveness

To initiate, it is to state that the CBHFA program has been successful in entering the community and establishing a cadre of volunteers and undertaking assessments involving communities which was relevant and effective in gaining the confidence of communities. However it will not be worthwhile to discuss about the major findings in this chapter without closely relooking into the CBHFA program review findings, which were undertaken in July 2011.

CBHFA Program Review[19]

A review of the CBHFA program was carried out over a period of 2 weeks in July 2011, as an in-house task by the CVTL Health staff working on the CBHFA Pilot and related projects, with the IFRC Health Delegate. The participatory process was assisted by an outside facilitator. The aim of the Review was two-fold: to develop an efficient method for CVTL project staff to carry out progress reviews of projects as part of their routine PMER procedures; and to review the CBHFA Pilot Project.

The Review was carried out in 3 steps:

[18] Gist from pledge based reports submitted by CVTL through IFRC

[19] **CVTL Community Based Health and First Aid Pilot Program Midline Review, July 2011**

1. RESULTS and EXPENDITURE achieved: The Log Frame used by CBHFA staff was reviewed and Outputs developed for each Outcome. CBHFA staff made a table summarizing the RESULTS achieved under each part of the Project Plan, from the Project start in 2009 until now, mid-2011. Budget of EXPENDITURE was also recorded.
2. ANALYSIS of progress so far: workshop discussion was used to analyze and comment on the results achieved. Participants discussed Project Strengths (which parts of the Pilot Project had gone well, had been completed or had produced important results); and Weaknesses (areas of concern, slow progress towards the Outcomes).
3. LESSONS: A number of Lessons were drawn from the analysis. These are points that can be used by the CBHFA Project, other CBHFA and Health Projects, other parts of CVTL Management, and by IFRC, donors and other partners, to strengthen future work.

Results and Analysis

These are the main lessons that have been drawn from the CBHFA Pilot Project Review. They form a set of decisions by the Pilot Project Manager and staff, which they will implement directly or pass as recommendations to senior management and partners.

Lesson 1 – CBHFA Programming

All CBHFA work by CVTL (currently 2-3 projects) should be managed, monitored and learned from together as a single Program. This is especially important at this pilot stage. Staff needs to form one team and not be working on just one project. There should be just one set of tools.

Lesson 2 – PMER Improvement

Project Planning, Monitoring, recording and information management, evaluation and reporting should be tightened up. This should include strengthening budgeting and expenditure management on each Outcome and Output.

The CBHFA team should be provided with training in all aspects of PMER, and this should be used to strengthen the Project's PMER processes.

Lesson 3 – Integration of Community-based work

It is important to start now to integrate Community-Based work by CVTL; i.e. the integration of CB Health (CBHFA) and CB Disaster Risk Reduction (CBDRR) (and Water & sanitation; plus Livelihoods) to form a single iCBRR Program.

It will be useful to organize a broad evaluation of all CVTL's CBHFA pilot work together so that it can inform the development of the proposed iCBRR program.

Lesson 4 – Capacity development, management and support of CVTL staff and volunteers

The CBHFA Pilot Project (and other projects) is an important opportunity to develop the capacity of each staff member; an adequate capacity building plan should be made for each CBHFA staff member.

More people should be trained to be national master facilitators of CBHFA.

Branch (staff and) volunteers are important members of the CBHFA team and need to be treated properly by management, with better recognition, support and development.

Lesson 5 – Integration of Program/Project management and Organizational Development

The OD components of the CBHFA Pilot Projects (mainly under Outcomes 4 and 5) need to be managed and implemented more closely with the other (Health) parts of the Project. Health and OD need to do this together.

Lesson 6 – Community selection and Project commitment

Community selection and entry are critical steps and must be done carefully and transparently. Cribas should be maintained as one of the 4 communities participating in the CBHFA Pilot Project. The funding provided by ARC for the water supply should be treated as 'complementary' to the CBHFA Pilot and should not be regarded or managed separately.

Findings

The program objectives have been fully met but the degree of achievements vary between sites (typically, Cribas shows more community participation and enthusiasm among the volunteers and general community members in taking up new activities and initiatives), branches (Manatuto as a branch is slightly more in tune with taking up an integrated health program, whereas Manufahi has aq clear health capacity gap), sectors (overall the staffs and volunteers are more compfortable working in communicable diseases in general, which led to negligent implementation of Nutrition and like activities) and individuals (the branch healtj officer at Manatuto is much equipped to deal with any new direction in health programming, whereas the health staffs in Manufahi need technical support and continuous mentoring).

The project has mostly maintained the timeline in Manatuto (started in 2009 and ended by the end of 2012), however in Manufahi the project started and ended late (started in the year 2010 and ended in 2013 with a year-long no cost extension period)

The monitoring and supportive supervision were found to be strong in Manatuto, whereas the same is significantly weak in Manufahi. The capacity of staff and the quality and design of capacity building in these aspects also brought down the scale majorly.

Quality of programming was assessed in both the places and found to be almost at the same level. There was no quality standard defined in the project activities. Hence, there are significant scope of improvements in the areas of

- Nutrition programming (which will make CVTL as one of the most effective agencies in Timor Leste, as the problem of Nutrition is rampant and severe in the country; it would also increase relevance and acceptability of the organization at the community level, as the community also identifies Malnutrition as one of their priority areas of intervention)
- Volunteers selection (Bitirai model) – The Bitirai model of volunteering presents a grim picture and poor program planning (as this sub village of Fato Berloi has 99 household and around 31 trained volunteers in the village. A physical mapping (See Annex 4d) of the same by the community, unveiled a fact that the volunteers are not geographically, logically spread as there are village by lanes with 5 volunteers out of six households and no volunteer among 25 households. This scenario needs to change
- Quality of training (across levels) – the quality of training and capacity building efforts put in across levels are to be monitored, reviewed and standardized. The interview of the branch volunteers and the staffs members, in both the places revealed that the RCV and staffs require technical refresher and skill building on 'programming'.
- M&E capacity of the organization (across levels) – poor connection between baseline and end-line planning and poor use of data for mid-course program corrections. There is no M&E point person at CVTL and the same situation remains at the delegation, which needs to improve by investing into the issue.
- Scale of implementation (which will establish CVTL as a credible partner to the MoH, TL and the actual implementation capacity can be demonstrated to the larger development sector in general)
- Per beneficiary cost (which needs to be brought down to stay in competition with other active players in the fields of Timor Leste)

Rampant alcoholism, tobacco use and very limited dietary diversification, leading to Protein Energy Malnutrition (PEM) and making the community more prone to the vicious cycle of disease and disability. Mode of programming in many places are quite event centric and does not have many long term programming ideas

Gender equity and disability inclusiveness are not the immediate focus areas (example – Toilets, which are not PWD accessible/ domestic violence as a direct result of alcohol consumption etc.). Gender and Diversity mainstreaming was not very well addressed in the CBHFA program. The evaluation could not ascertain information on how different issues for different groups were considered, discussed and innovatively resolved. There is a large representation of women among non-paid staff i.e. Branch and community volunteers and village RCVs. However, no women are at any decision making levels in the key program structure (especially at the branch level).

After discussing with project staffs across levels, it was realized that the project did not use all the CBHFA PMER tools, for different reasons as quoted by the staffs and volunteers across different levels. The planning tools namely proposal format, log frame and M & E plan had been either fully or partially used. The monitoring tools and the reporting format, including important tools like Indicator Tracking Sheet have not been utilized and maintained for understanding the direction of the program and also to get a sense of the movement of the program in optimum direction or not! All the other monitoring tools like the household visit tool, volunteers record book etc. have not been utilized.

Upon questioning the people at the village level (RCV) expressed that they never came across with the tools. However the branch staffs and branch level volunteers told us that they had seen the tools before but due to complex nature of the tools they were not very willing to use the same and they devised their own tools for maintaining database and reporting at the field levels (see annex 4d). This good practices was found in Manatuto and Cribas village, whereas the RCV and staffs at Manufahi and sub village Bitirai were not able to demonstrate any usage of the any PMER tool (either self-devised or the CBHFA – PMER toolkit)

In totality the finding was, somehow the PMER toolkit has been used at the country delegation and the the CVTL headquarters, however due to the complex nature of the tools (especially for monitoring and reporting) especially at the level of execution, the same were not rolled out across the branches and community. Branches with trained health staff with adequate capacity (like Manatuto) created their own tools, which are context specific, simple and easy to execute and collected, collated and disseminated

data across levels; whereas in places like Manufahi there were absence of some of the monitoring tools (e.g. household wise volunteers' list etc.).

Efficiency

The project has been efficient in developing volunteers' capacity across levels though the quality management and volunteer retention are two major challenges to be overcome for successful program delivery. Though, the NHQ team has actively supported the project in every way possible, however quick staff turnover slowed down the pace of implementation. Generally, the planned activities were well implemented within the stated time frames i.e. keeping to deadlines. However the overall program implementation in Manufahi has been delayed by a year, stretching the project to the end of 2013 through a one year no cost extension. The financial support from FRC and IFRC has been efficient as reported by the program team. Allegedly the program accounts were submitted timely from the field to the NHQ on a monthly basis.

The total budget for the programme was approximately 432,000 CHF. Matrix below has disaggregated the CVTL costs by year and number of direct and indirect beneficiaries. As part of this analysis it is found that the Cost per beneficiary per year varied significantly between US$ 4 – 22 (in case of only direct beneficiary) and between US$ 2 – 11 (in case of direct and indirect beneficiary). However the overall per beneficiary cost comes at US$ 16 over the 5 program years.

Year	Total Activity budget (CVTL)	Total expenditure (CVTL)	Expenditure in activities only	Direct Beneficiary	Indirect beneficiary	Cost per direct beneficiary	Cost per beneficiary (Direct + Indirect)
Year	Total Activity budget (CVTL)	Total expenditure (CVTL)	Expenditure in activities only	Direct Beneficiary	Indirect beneficiary	Cost per direct beneficiary	Cost per beneficiary (Direct + Indirect)
2009	102388	30347	20025	2056	2706	11	6
2010	61961	8401	8238	2108	2706	4	2
2011	64344	77801	67560	3126	4177	22	11
2012	75846	84194	72047	3564	5864	20	9
2013	49093	59031	49593	2937	5864	17	7
Total	353632	259774	217462	13791	21317	16	7

When this cost is juxtaposed with the beneficiary number, it is evident that the project beneficiary remain the same people without many changes and thus the actual cost comes to somewhere close to US$ 70 per beneficiary. Below there are figures from other health programs across the globe which gives a sense that the CBHFA program could have been more cost efficient, in terms of expenditure per beneficiary. However this evaluation did not take under consideration any other program run by other agencies in Timor Leste with similar program and geographical coverage. The global figure suggests an approximate average expenditure of US$ 4.00 per beneficiary/ per year in CBHFA but considering the difficult program terrain in Timor Leste, high turn-over of staffs and volunteers and high cost of living, it is considered to be one of the costlier set up for running CBHFA program. However some more research need to be undertaken about per beneficiary cost in other health programs run in Timor Leste by other CSO bodies and efforts to be made, for bringing the per unit cost.

- *CARE RACHNA (India) – 13 years, US$500 million, reaching out to 6 million P/L women and children bellow 2 years – cost per beneficiary US$ 6.41 BMGF funded Avahan program (India, Nepal, Bangladesh - cost per beneficiary US$ 0.91*
- *GFATM global standard allocation – cost per beneficiary US$ 168.00 (for HIV with treatment)/ US$ 0.3 (for HIV without treatment) – similar trend for TB and Malaria*
- *Swaziland CBH program (Govt. and MSI) - cost per beneficiary US$ 7.00 (with treatment)*
- *NHS cost per beneficiary US$ 16.00 (all inclusive)*

Impact

The program was able to generate improved demand for basic health services e.g. for Malaria, Diarrhoea etc.. Whereas the community is trying to dig dipper into the root causes and envisioning at solving the problems from the genesis. The community will require a lot of support in this process, and thus well capacitated staffs with understanding of participatory planning and capacity building process will be required here.

The Govt. official across levels acknowledged the work of RCRC and also gave the due credit for improved community demands which prompted them to have enhanced supply and health service and supplies by the Govt. Though quality of health services – is a major area of improvement both at the community and at the service delivery institution level

At the NHQ and branch level the capacity of staffs have enhanced in many areas however there are scope of significant improvement in the technical areas especially in PMER capacity.

There are local innovations in many places, the organization needs to capture and scale up/ diffuse these ideas and later market the same across the development sector and among Govt. institutions ; e.g. volunteers database by household – local innovation at Manatuto

Sustainability

The volunteers are from within the community which ensures the knowledge will stay in the community and the program interventions will sustain on its own (it has been observed in Ctribas, where the program has been concluded in Dec 2012).

Behaviour change around Hygiene and sanitation are more likely to sustain as people are able to relate non-compliance with risk of disease and death.

No community structure established or strengthened upon – which would have been a better mechanism to sustain the activities however an integrated approach of programming has been launched and thus the program districts will have better chances of sustainability of this program's components, as well

The evaluation findings suggest that the sustainability is likely since the programme has been successful in increasing knowledge source in villages which has a potential to sustain may activities. Also, except trainings and some material support, the work of RC volunteers has not been based on any funds. The project was able to tap synergies from existing RC structures at the NHQ and district branch levels. It has successfully trained local people as RC volunteers and the reciprocity of health and WASH programs highly raised the significance of this project in villages.

The project has developed links with local health system and its staff at health centres and has been well regarded for the added value brought by RC trained volunteers. This can be one reason for support from the MoH. Also, district health HR officer is the chairperson in RC at Manatuto at district level so collaboration with MOH has been strong and well supported in this kind of scenario.

Other significant findings

Nutrition programming

Nutrition component did not work very well as we promoted only healthy cooking as part of Nutrition intervention and could not actually support the cases if malnutrition. It was also observed that we have poor capacity of implementing Nutrition program at the branch level and below, however capacity of nutrition programming was observed at the NHQ level but somehow, it did not percolate down.

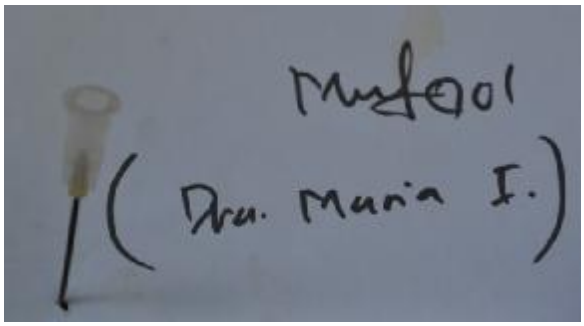
At the community level the dietary diversification is very poor (mostly Carbohydrate intake), which is leading to rampant Protein Energy Malnutrition (PEM), especially among young children.

There are other faulty child care practices, which is putting the communities at risk of malnutrition, like -

- Mixing water and other liquids (with breast milk) during the first 6 months of child birth is one of the major factors of child malnutrition
- Exposure to multiple infections is a major issues for bringing up the malnourished children to normal category
- Too many– too early child birth (many children within a short span of time); leading to weak mother and weak children (generally it is a norm to have 5 – 6 children in the rural areas; however there are women who gave birth to 10 – 11 children in a span of 12 – 13 years; as more children signify more prosperity)
- Ready to Use Treated Food (RUTF) is available at the health centre level but RC volunteers do not have understanding of those, hence there is no community based integrated nutrition programming by the RCV

Capacity of Health Service Provider

Poor capacity of the health service provider across levels leading to poor health service delivery. In many places the principles of Universal precaution is not maintained at all; e.g. in Manatuto – the Heath centre is running from a hut by the side of the new health centre is standing idol – dispute between Govt. and the construction company also the notice about the doctor's absence outside the makeshift health post was pinned with used needles, which is a gross misappropriation of the universal precaution practices.



HIV programming

Though HIV is not a priority topic or area of intervention under this round of CBHFA programming'; but presence of risk factors like 1. Presence of high migration zones 2. Circularly mobility etc. pose enough reason to launch HIV prevention and management as an integrated part of the next round of programming.

There are probable cases of HIV in the communities (there are cases of death by unknown disease (or a disease that progressed very fast). The reporting system for HIV is not strong in Timor Leste, which may lead to unreported cases even in the interiors of the country, putting the general population at risk of HIV infection.

This situation is further complicated with presence of the below factors –

- No testing facility at the sub centres
- Rampant stigma and discrimination
- No ANC testing facility at the sub centre

Recommendations

Recommendations

The recommendation section is divided into five segments, each one is having thematic recommendations for improvement of future programming. These recommendations are not specifically linked to any of the topics of evaluation rather adhering by these recommendations will have impact on more than one evaluation criteria. However for better readability the areas of major impact are quoted in bracked by the side of the recommendations, in this section. Below the recommendations are delivered in a simple to understand language and in easy formats –

Recommendations for improving the quality of interventions

It was observed that the quality of intervention is a major area of improvement and hence the recommendations for improvement in this section are –

- Quality of program has to improve, in relation to – capacity of staff (technical, program and financial management and PMER), logical volunteer selection (from village based to population based), introduction of proper pre and post-test methods (which is already in practice and need to include questions to assess, not only knowledge enhancement but improvement of skills, as well) and knowledge retention practices for staff and Volunteers' training and refresher; etc., (Effectiveness / Impact/ Sustainability)
- Implementation model should be at a scale, with strong program management and M&E capacity and proper monitoring plan encompassing logical distribution of monitoring site; e.g. monitoring Bitirai from same; is difficult and selection of sites needs more attention and clarity (especially Bitirai). However Bitirai is a very remote village without much resources but that should not be the only consideration; the selection of of implementation site should be a result of a complex algorithm combining multiple factors, weighed as per the need of the community and capacity of the national society vis-à-vis resources available and allocated for undertaking activities in that site. (detail suggestive list of criterion has been given in the *'Relevance'* section) (Relevance/ Effectiveness/ Efficiency)

Recommendations for strengthening technical areas of interventions

Technical areas of intervention is the backbone of any program hence technically sound program generate more logical and community owned outcomes. In the future rounds the below points are to be kept in mind for improving the technical content and concept –

- The program needs to have public health lenses of programming (not disease focus; rather focus at the root causes); especially in WASH, Nutrition, regulating and reducing Alcohol and

Tobacco use, dietary diversity and feeding practices, universal precautions, immunization etc. (Relevance/ Effectiveness)

- Newer and most relevant areas of programming need to be introduced especially in areas with high vulnerability and disease burden (e.g. more nutrition interventions to be launched in Cribas with a specific focus on children in need of clinical assessment and treatment; moreover a nutrition program for infant and children below the age group of 5 years, is never a very successful program unless it adheres the child care practices and linked with local food model, hence the revised nutrition program needs to have all the allied components that build a conducive environment for the program – and an integrated program approach can offer these interventions in a more strategic manner, with possibility of better results) . This can be achieved by having more evidence based programming and using criteria oriented data and blinded selection of sites as per the community needs. (Efficiency)
- Technical areas of interventions should include but not restrict to - (Relevance/ Effectiveness)
    a. Strong focus on nutrition (which includes nutrition of adolescent, pregnant and lactating mothers and children below 5 years of age. It also includes having am integrated program on nutrition covering all the aspects of it namely availability of food, accessibility of food, food quality, applicability or utilization of food; mainlky around hygiene promotion and treatment of severe and acute malnutrition at the cilinical and community levels)
    b. Focus on local food model (it was observed; despite having a lots of locally grown vegetables; especially beans and leafy vegetables; the community in Timor Leste prefer to sell those in the market and prefer to by food out of that money, which are less nutritive and full of carbohydrates; focused intervention in this area can help the community slowly change their eating practices towards healthy diet)
    c. Focus on child care and feeding practices (in many places it was reported that the mothers tend to mix water with breast milk during the first six months of child's life, which in a way make the child less immune to infection and thus more prone to malnutrition)
    d. Promote the concept of FADU (Frequency, Amount, Density and Utilization); for improvement of nutritional status of children[20]

[20] 'Essential Nutrition' the gold standard for nutrition in children by Dr. Tina Sanghvi, 2005

- Focus more on HIV programming; mainly around community level awareness raising and working with the community systems for more awareness around voluntary testing and usage of condom for triple protection – 1. From unwanted pregnancy; 2. From Sexually Transmitted Infections and 3. From HIV and AIDS (it has a long term impact for the country) (Relevance/ Effectiveness)
- Focus on rather a multi – sectoral approach (ICBRR is perfect in that sense). CVTL may also think about having cross sectoral linkages with programs of other organizations (example – in Cribas Timor aid is running a program on Alcohol and Substance Abuse prevention - as per the evaluation these issues were also identified by the community as one of the major risk factors for health, which also lead to domestic violence. A cross sectoral linkage with Timor aid in Cribas may help the program come up with better outcome, without directly covering all the priority areas highlighted by the community. (Relevance/ Effectiveness/ Efficiency/ Impact/ Sustainability)
- Focus more on working in consortium with Govt. departments, UN bodies and other national and international NGOs and learn from each other – this will also give advantage in Resource Mobilization, in case CDTL wishes to go for competitive projects/ bidding. Joint monitoring with WHO and GoTL, will provide opportunity for marketing the good practices. (Relevance/ Effectiveness/ Efficiency/ Impact/ Sustainability)
- Documentation should be an integral part of programming and not as a stand-alone activity. The plan for documentation has to be drawn before the program is rolled out and the implementers across level should know the documentation requirement of the project and work accordingly. (Effectiveness)

Recommendations for structural or organizational modifications

This is a critical area of improvement, as this will lead to long term impact in programming and will have defused outcome across the program areas of CVTL. The recommendations are –

- Technical knowledge and skill sets are to be the most prominent deciding factors for selection of health staffs, across levels and not mere adjusting people with limited understanding of health program implementation. (Relevance/ Efficiency)
- We may try and build program implementation model based on the need, not what existing capacity we have (we can always enhance capacity in the process or outsource some of them) (Relevance/ Efficiency)

- The organization needs to have in-house research and M&E capacity, a talent acquisition/ retention policy for Staffs and volunteers and policies and execution of the same around protection and insurance of staffs in difficult situations (Efficiency/ Impact)

Recommendations for modifications at the Community level interventions

The impact of any program is visible at the community level and hence it is pivotal that the structures and strategies at the community level deliver optimum outcome in limited resources. Below are the recommendations for improving the models at the community level -

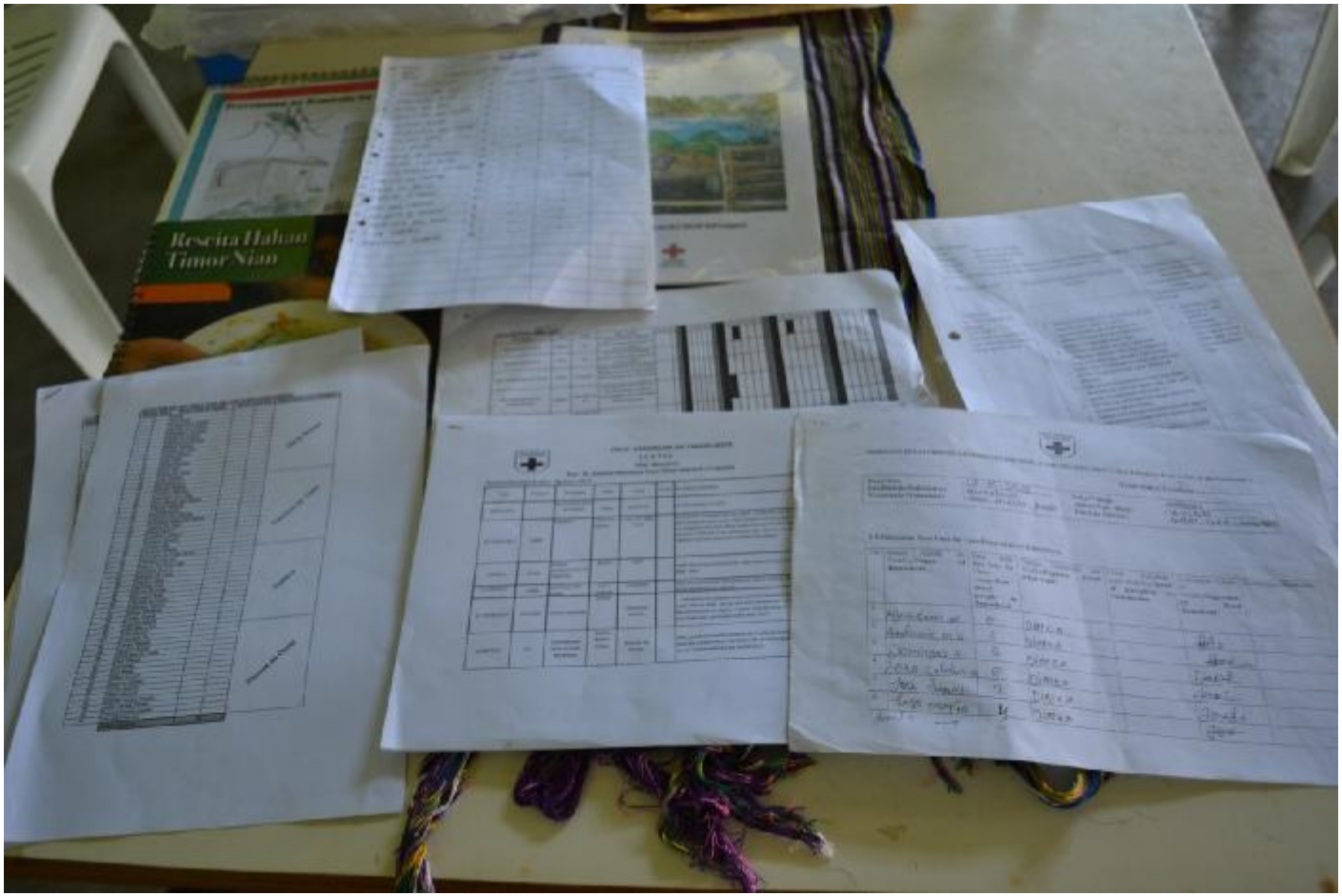
- We should be more analytical in terms of capturing program nuances and giving direction to the program based on those findings (see Annex 4b – Erdiva case and Annex 4a – root cause of the diseases). This will help the program in devising and executing strategies that cut across the disease components and deliver outcome level results; it will also consider strengthening of the social and the environmental factors by presenting the right facts and giving examples from the local circumstances, which will have more contextual value at the community. The collateral advantage of this strategy would be innovative presentation and more anecdotal evidences, which will help in better dissemination and mobilization of resources for a cause. (Like – the verbal autopsy of Erdiva's story could have been an excellent piece of article in the Dengue Global Advocacy Report) (Relevance/ Impact)
- We need to weigh our volunteering model against the Govt. and other agencies and take steps to engage and motivate volunteers through innovative ways (by reward, recognition, district and national level felicitation etc.). Improved dialogues (may be through monthly or quarterly meetings) and better follow up mechanisms (once a month curtsy call from the supervisor etc.) with the volunteers, who are not actively engaged in any ongoing program, will also help retain them and keep the volunteers active at all time (Relevance/ Effectiveness/ Sustainability)
- Visibility of RCRC has to increase at the community level (which should not restrict to their wearing the emblem, T – shirt etc. but there should be visible wall painting or posters that enhance the visibility, manifold) and the volunteers and staffs need to have more and correct information about the movement as such (especially in Manufahi) (Relevance/ Impact)
- There are systemic and sectoral innovations in some of the places (e.g. the household listing by volunteers in Manatuto), which can be replicated across the projects and also tested and documented to make similar practices into organizational good practices (Effectiveness/ Efficiency)

Recommendations for improving the other misc. factors for better program outcomes -

There are recommendations which are equally important but do not fall under any of the above areas. Those recommendations are clubbed together below under the other recommendations section –

- Launch and strengthen interventions and practices that focus on inclusive development (e.g. Gender, disability etc.) and let it cut across your technical and OD interventions (Relevance)
- Gender and Diversity mainstreaming must be addressed at all levels in the programme within the framework of organisational development for any project that is rolled out. Donors must include this as a prerequisite for fund availability and implementation. It is important in any community based programme to identify issues specific to groups of men and women of different age and social backgrounds during community assessments, action plans and to analyse outcomes. This will help to improve effectiveness. (Relevance)
- Partnership with civil societies that are working on gender related themes and issue should be explored for a collaborative way of working in the communities. (Impact/ Sustainability)
- Programmes should include gender analysis and ways to address its issues as a part of capacity building trainings for the project staff. They should ensure that the analysis is done at the assessment stage and planning phase. (Relevance)
- It is important to ensure representation of different groups of men and women at meetings and forums where all can be involved for decision making. The messages and other information through IEC or in sessions must be made gender sensitive. (Relevance/ Impact)
- Have a sustainability plan from the beginning of program, rather make a practices to include a section on sustainability in the proposal. Also, initiate discussions around sustainability in the community and ensure that the community structures and the agencies in the community are able to take up the program interventions on their own – slowly shift to 'Community Based' to 'Community Led' (Sustainability)
- Need to have specific focus on research, monitoring & evaluation and documentation. The project outcomes and the significance of change could not be assessed as the baseline data was not available for most of the end-line indicators. (Effectiveness / Impact)

Annexes



Finnish Red Cross

Terms of Reference

Evaluation of Community Based Health and First Aid Program in East Timor

1. Summary

1.1 Purpose: The purpose of the CBHFA final evaluation is both to account for the Finnish Red Cross support provided to CVTL as well as to draw lessons that will be useful in improvement of current and planned program implementation and sustainability strategies. The evaluation is expected to contribute to knowledge and recommendations on appropriateness and sustainability strategies of similar programs.

1.2 Audience: The evaluation will be used by the FRC, CVTL and other ongoing CBHFA programs. Any NS that implements CBHFA project as part of the RCRC movement will be benefitted from the good practices, challenges and the recommendations of this evaluation

1.3 Commissioners[21]: This external evaluation is commissioned by the Finnish Red Cross in compliance with the FRC evaluation and learning framework.

1.4 Duration of evaluation: The overall evaluation process takes about 25 – 30 days of time, which includes one week of secondary information collection and study, 2 weeks of in country evaluation including debriefing etc. and approximately one week time for development, circulation, feed back collection and finalization of the report

1.5 Time frame: last week of March 2014 through end of 3rd week of April 2014

1.6 Location: locations of the desk study will be mostly in Delhi; however some field data can be read and analyzed at Dili. The field visits will be mostly carried out in two districts of East Timor namely field visits Manatuto and Manufahi.

[21] Commissioner organises, finances, selects and contracts the evaluation team.

2. Background

CVTL is the National Society of the Red Cross in Timor-Leste and has been in operation since 2002. Since its foundation CVTL has worked to improve the quality of life for vulnerable people, operating primarily in the areas of disaster risk reduction (community preparedness, emergency response and livelihoods), health (water and sanitation, HIV/AIDS, community-based health and first aid, first aid training and emergency health), tracing and restoring family links, dissemination of the Red Cross values and principles and international humanitarian law. A relatively new youth Program aims to equip young leaders of tomorrow with skills and passion for humanitarian work.

In the past 5 years, CVTL has been implementing two important pilot projects – the CBHFA Pilot Project, and the CBDRR Pilot Project – which together will enable CVTL to develop its capacity to work effectively as a national organization providing protection for vulnerable people in priority local communities across the country, through the CVTL Branch in each District. CVTL's vision, in line with its new Strategic Plan, is to continue to strengthen its delivery of fully-integrated support and development assistance to vulnerable people and communities; after the pilots the next generation of projects are intended to merge Health and Disaster Risk Reduction work, to be part of "integrated community-based risk reduction" (iCBRR) as a CVTL core Program country-wide.

The CBHFA Pilot Project was planned to be implemented for 3 years, CHF 430,000 project (running from 2010 to 2012). Some funds (also from Finnish Red Cross) were put into preparatory work for the pilot in 2009. The Pilot Project was being implemented by CVTL Health Department, under the CBHFA Project Manager, who had responsibility for all CBHFA-related projects.

The project goal was to prevent and manage injuries and common health problems in emergency and non-emergencies in vulnerable communities in two rural districts (Manufahi and Manatuto).

Project objectives included:

4. **Enhanced capacity of CVTL to implement a standardized CBHFA *in Action* program nationally.**
5. **Enhanced capacity of CVTL branches (Manufahi & Manatuto) to respond to & support community needs with a focus on CBHFA *in Action.***
6. **Improved knowledge and health practices in 4 target communities in two districts and demonstrated ability to respond to & support health needs.**

This project was implemented in two districts, Manatuto and Manufahi Districts. The project provided provision of water system and sanitation facilities in Manatuto and wells and sanitation facilities in Manufahi and health and hygiene promotion in both.

The implementation of project was done in different time frame in each location. For the first 2,5 years project was only implemented in Manatuto District and it finished by the end of 2012. The second district, Manufahi, started the implementation in July 2011 and was finished by the end of 2013.

Working in Partnership

Additional funds were contributed to the project by New Zealand Red Cross for national headquarters costs and for the first nutrition training. CVTL's community-based water and sanitation projects funded by Australian Red Cross and Austrian Red Cross use methodology and materials developed by the CBHFA pilot for hygiene promotion and other health promotion.

Organizational development is supported by New Zealand Red Cross, Norwegian Red Cross and Japanese Red Cross Society, and targets strengthening organisational structures such as branch infrastructure, support services, volunteer and member management and policy development and skill development for staff.

Project impact

The CBHFA pilot Project Review[22] was carried out over a period of 2 weeks in July 2011, as an in-house task by the CVTL Health staff working on the CBHFA Pilot and related projects, with the IFRC Health Delegate. The participatory process was assisted by an outside facilitator. The aim of the Review was two-fold: to develop an efficient method for CVTL project staff to carry out progress reviews of projects as part of their routine PMER procedures; and to review the CBHFA Pilot Project.

The endline surveys from 2012 and December 2013 revealed improvements in health behaviour such as hand-washing with soap at critical times. Malaria cases were not reported after project implementation. In September 2013, some of the project results and the work of the volunteers from Manufahi district were proudly recorded in a series of short videos that were played back to the communities as well as featured at the International Federation of Red Cross and Red Crescent Societies' (IFRC) statutory meetings held in November 2013.

[22] **CVTL Community Based Health and First Aid Pilot Program Midline Review, July 2011**

The capacity built by CVTL in CBHFA through this project will continue to be used, as CBHFA is implemented across all integrated community-based risk reduction program (ICBRR) programmes in the future as the tool to address health risks in communities (a methodology supported by all of CVTL partners). The lessons learnt from the CBHFA pilot project will be utilised to improve the implementation of the CBHFA component of CVTL's ICBRR programme.

The total number of beneficiaries had covered by CBHFA project in two Districts were 6,989 people.

3. Purpose and Scope of the Evaluation

The purpose of the CBHFA final evaluation is both to account for the Finnish Red Cross support provided to CVTL as well as to draw lessons that will be useful in improvement of current and planned program implementation and sustainability strategies. The evaluation is expected to contribute to knowledge and recommendations on appropriateness and sustainability strategies of similar programs.

The Finnish RC is committed to a rigorous evaluation of this program that is both independent and open-minded. The Finnish Red Cross principal concern is to determine:

- **Project relevance**
- **Project effectiveness and impact**
- **Project efficiency**
- **Partnership**
- **Project Management**
- **Project sustainability**

This evaluation should also provide the Finnish RC as well as the IFRC leadership with an assessment of the degree to which the program contributed to the strategic priority areas described above in the background section.

Results of this final evaluation will be used to make recommendations regarding the implementation of similar program approach in future.

4. Evaluation Objectives and Criteria

4.1. Objectives

- **Review the effectiveness, efficiency and relevance of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.**
- **Review how the CBHFA approach has been modified to local context and how the community-based approach has been implemented in the project communities?**
- **Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.**

4.2. Evaluation criteria and specific evaluation questions

- **Relevance**
- **How relevant is the project regarding the beneficiary requirements, local context and needs?**
- **How well was the target groups identified?**
- **How do beneficiaries view the comprehensiveness of package of services – training, information spreading, household visits, and awareness raising campaigns, IEC materials – offered to or directed towards them?**
- **How does the project compliment intervention of other actors, most importantly relevant Government departments?**
  (How has the project contributed to the CVTL strategic plans and aims?)

- **Effectiveness**
- **Were objectives achieved on time?**
- **Were the activities conducted in a planned and timely manner throughout the project?**
- **Were the supervision and management mechanisms on all levels sufficient in relation to project needs and expectations?**
- **Were qualities standards defined, and are activities achieving high levels of quality in implementation?**
- **How satisfied with the project are project beneficiaries? What is the stakeholders' viewpoint related to the performance of the project? What are the main issues raised regarding satisfactions with the project?**
- **How satisfied is CVTL – including local branches – with the project? What are the main issues raised regarding satisfactions with the project?**

- **Efficiency**
- **How well were the inputs (funds, people, materials and time) used to produce results?**
- **Has the scale of benefits been consistent with the cost? Cost-efficiency: (a)to what extend has the funding been utilised to directly assist beneficiaries b)Has the project support and operational costs been reasonable (%) compared to entire budget and beneficiary assistance**

- **Impact of intervention**
- **Did the project address the needs of all intended beneficiaries in a consistent manner as per project design?**
- **Did the project achieve its intended impact?**
- **Has there been any unforeseen or indirect positive or negative impact (to the communities, volunteers, NS)?**

- **Sustainability**
- **Is there sufficient community ownership regarding the project?**
- **How well has the phase out been planned and managed?**
- **What are the main factors affecting, either positively or negatively, the sustainability of project outcomes?**
- **Do lessons from implementation of this project indicate any changes in design in the future to ensure better sustainability?**

In addition, this evaluation should examine the level of gender and diversity mainstreaming i.e. how issues specific to groups of men and women of different age and social backgrounds should be taken into account in future, to ensure proper needs assessment and improved effectiveness.

5. Evaluation Methodology

The evaluation will use the following <u>data sources</u>:

- **partners' agreements**
- **previous mid-term review report, evaluations of previous project phases, monitoring reports**
- **all project related documentation provided by the CVTL and TL CD (plans, budgets, financial and narrative reports, guidance documents, etc.)**
- **baseline data, previous evaluations**
- **other reports including publications, Govt. programs and policies**
- **monitoring formats**
- **monitoring data compilation**
- **project reports**
- **IEC and BCC materials developed by the project**
- **Media coverage (if any)**

<u>Reference documents:</u>

- **Federation strategy 2020, policies, guidelines**
- **CBHFA framework**
- **CBHFA modules**
- **CBHFA PMER toolkit**

<u>Methodology</u>

- **Briefing the CD at TL**
- **Briefing at partner NS Headquarters**
- **Document analysis/review; a critical review of documented materials including all project related documents, MOU, IEC BCC materials, success stories, case studies, any other monitoring or evaluation report for the same project**
- **An assessment of the degree to which recommendations from the previous review recommendations have been implemented**
- **Project data consolidations – baseline data, mid line data, end line data, regular project monitoring data etc.**

- **Key informant Interviews with key stakeholders (staff and volunteers in the governance and management, authorities, other partners, Govt. media etc.) at national and branch levels**
- **Focus Groups interviews with beneficiaries**
- **Field visits and beneficiary interviews**
- **Using PRA tools to get more in depth information**
- **Photography**
- **Case studies collection**

All findings should be evidence based and methodology used explained in the final evaluation report.

6. Deliverables

The evaluation team will provide:

- A debriefing on findings - in country to the CVTL management and project staff at the end of the mission to discuss the initial findings, conclusions and recommendations.
- A draft final evaluation report – after returning from the field visit. The draft will be shared with the FRC, CVTL and other relevant stakeholders for comments.
- A final (corrected) evaluation report - The report will have a maximum length of 30 pages, including an Executive Summary. Approval for the report from the FRC and CVTL.
- **A presentation of the evaluation findings.**

7. Proposed Timeline (or Schedule). *Summarizes the timing of key evaluation events, i.e. desk review, briefing, data collection and analysis, presentations, draft and final reports, etc*

- **Desk review: 25 – 31 March 2014**
- **In country evaluation: 01 Apr – 11 Apr 2014**
- **Report writing and delivery of deliverables: 15 Apr – 20 Apr 2014**

The in-country evaluation will follow the below schedule (may be adjusted later as per the field situation)

Day/ Date	Activities	Person(s) required	Place
Day 01	• **Reach Dili in the afternoon** • **Receive security briefing** • **Meeting with the CD on the evaluation, make presentation of the plan, seek feedback and adjust the plan accordingly**	**IFRC staffs**	**Dili**

Day/ Date	Activities	Person(s) required	Place
Day 02	• Secondary literature study • Meeting with the CVTL program, management and support people • Meeting with volunteers • Meeting with relevant Govt. stakeholders • Finalization on field visit and tools to be used for evaluation	NS staffs And Govt. officials	Dili
Day 03	• Travel to Manatuto • Meeting with the branch people • Secondary literature review • Meeting with the volunteers • Meeting with local health officials • Finalizing the field plan with the project staff and branch volunteers	Branch secretary Volunteers, Govt. officials CBHFA project staffs	Dili Manatuto
Day 04	• Field visit to Manatuto • Meeting with the local volunteers • Meeting the community Stakeholders • Meeting with the Community using semi structured questionnaire and PRA tools • Meeting with the service providers	Local volunteers Translators Community members	Manatuto
Day 05	• Debriefing to the branch officials • Travel back to Dili	Branch secretary	Manatuto Dili
Day 06	• Weekend		DIli
Day 07	• Travel to Manufahi • Meeting with the branch officials and project staffs • Finalization of a field visit plan	Branch secretary Volunteers, CBHFA project staffs	Dili Manufahi
Day 08	• Field visit to Manafuhi • Meeting with the local volunteers • Meeting the community Stakeholders • Meeting with the Com munity using semi structured questionnaire and PRA tools • Meeting with the service providers	Local volunteers Translators Community members	Manufahi
Day 10	• Meeting with the Govt. officials at Manufahi • Debriefing to the project team at Manufahi • Travel back to Dili	Govt. officials	Manufahi DIli

Day/ Date	Activities	Person(s) required	Place
Day 11	• First half: Writing the draft recommendations • Second half: Debriefing with he CD and NS	Second half – debriefing all relevant	Dili

8. Evaluation Quality and Ethical Standards.

The evaluators should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards of the IFRC.

The IFRC Evaluation Standards are:

1. ***Utility: Evaluations must be useful and used.***

2. ***Feasibility: Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.***

3. ***Ethics & Legality: Evaluations must be conducted in an ethical and legal manner, with***

particular regard for the welfare of those involved in and affected by the evaluation.

4. ***Impartiality & Independence; Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.***

5. ***Transparency: Evaluation activities should reflect an attitude of openness and transparency.***

6. ***Accuracy: Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be***

determined.

7. ***Participation: Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.***

8. ***Collaboration: Collaboration between key operating partners in the evaluation process***

improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at: www.ifrc.org/what/values/principles/index.asp

9. Evaluation Team and Qualifications. ***Summarizes the composition and technical qualifications of the evaluation team. Please consult the FRC Learning and Evaluation System***

The team will consist of 3 members comprising of –

- **A consultant/ third party reviewer (leading the team) to be nominated by FRC**
- **One participant nominated by each East Timor CD of IFRC and CVTL Health department**

The evaluation team shall jointly have: e.g.

- **University degree/s at the post-graduate level in relevant field of study (e.g. health, water and sanitation, disaster management, social sciences).**
- **Experience with technical knowledge of relevant program delivery using community based and participatory methods in developing countries.**
- **Solid knowledge and experience of project monitoring and evaluation methods and approaches.**
- **Proven experience in evaluating development co-operation programs or projects, incl. analyzing development impacts and cross cutting objectives. Preferably at least 2-3 reference projects, each reference being at least 20 days long. Experience from working as a Team Leader is an asset.**
- **Excellent analytical, writing and presentation skills.**
- **Sound knowledge of the Red Cross and Red Crescent Movement and it works preferred.**
- **Good knowledge of written and spoken English; people with Portuguese, Bahasa or Totun will be an asset**

The team leader will be responsible for the coherence of the evaluation report.

The evaluation team will report to the Evaluation Manager NN at the FRC.

10. Application Procedures. Clearly states the specific procedures, materials, and deadlines for potential applicants to submit their application.

Aapplications invited with updated CV by 15 Mar to 20 Mar 2014

Selection of consultant by NS and FRC by 20 Mar 2014

TOR prepared by : Dewindra Widiamurthi

Date and signature : 13/03/2014

3. EVALUATION CRITERIA IFRC Framework for Evaluation ANNEX 1

The following eight evaluation criteria endorsed by the IFRC Secretariat guide *what* we evaluate in our work. They are key measures used to determine the factors for success in our work. They differ from the evaluation standards and process (discussed in Sections 4 and 5) in that the criteria inform *what* we evaluate, (the focus of inquiry), whereas the standards and process guide *how* we conduct the evaluation. The evaluation criteria are complementary, and together they seek to provide a comprehensive evaluation of IFRC's work. Acknowledging the broad geographic and thematic scope of IFRC's work, all of the criteria may not be relevant in its evaluation. Therefore, if a particular criterion is not applicable to an evaluation context, this should be explained in the evaluation report, as can be any additional criteria applied.

The criteria are based on internationally recognized practices, largely adopted from the OECD/DAC criteria,6 include the Fundamental Principles and Code of Conduct of the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGO) in Disaster Relief, and are informed by and reflect the priorities of additional IFRC Secretariat policies and guidelines, as well as other international standards and guidelines adopted by IFRC, i.e. the Sphere Standards.

3.1 The Red Cross and Red Crescent Fundamental Principles, Code of Conduct, IFRC's Strategy 2020

IFRC work should uphold IFRC policies and guidelines. Foremost, this includes the (1) Fundamental Principles of the Red Cross and Red Crescent Movement, the (2) Code of Conduct for International Red Cross and Red Crescent Movement and NGOs in Disaster Relief, and (3) the IFRC Strategy 2020 adopted in November 2009 by the 17th Session of the General Assembly.7

3.2 Relevance & Appropriateness

Relevance and appropriateness are complementary criteria used to evaluate an intervention's objectives and wider goal. *Relevance* focuses on the extent to which an intervention is suited to the priorities of the target group, (i.e. local population and donor). It also considers other approaches that may have been better suited to address the identified needs. The *validity of design* is an important element of relevance. This refers to the logic and coherence of the design of the intervention, (i.e. project or Program), and that its planned (or modified) objectives remain valid and appropriate to the overall goal/s.

***Appropriateness* focuses on the extent to which an intervention is tailored to local needs and context, and compliments other interventions from other actors. It includes how well the intervention takes into account the economic, social, political and environmental context, thus contributing to ownership, accountability, and cost-effectiveness. When applicable, it is particularly important that the evaluation function**

supports a community's own problem-solving and effective decision-making to address local needs, and build community capacity to do so in the future.

3.3 Efficiency

Efficiency measures the extent to which results have been delivered in the least costly manner possible. It is directly related to *cost-effectiveness* – how well inputs, (i.e. funds, people, material, and time), are used to undertake activities and are converted to results. It is typically based upon an intervention's stated objectives and the processes by which they were pursued, analyzing the outputs in relation to the inputs and their respective indicators. It includes whether the results or benefits justify the cost, and can compare

6 OECD/DAC (1999) supplemented their standard five evaluation criteria of efficiency, effectiveness, impact, sustainability and relevance with the two additional criteria of coverage and coherence to better evaluate humanitarian assistance provided in complex emergencies. The IFRC criteria are adopted from these criteria, and informed by the ALNAP (2006) guide for using the OECD-DAC criteria.

7 Complete citations of these two documents can be found Annex 1: Resources, as well as the IFRC webpage for Principles and Values

(http://www.ifrc.org/what/values/index.asp?navid=04_02), which provides additional resources and links.

alternative approaches to achieving the same results to determine whether the most efficient processes have been adopted. It is closely related to effectiveness and the measurement of performance.

3.4 Effectiveness

Effectiveness measures the extent to which an intervention has or is likely to achieve its intended, immediate results. It is based upon an intervention's objectives and related indicators, typically stated in a logical framework. However, the assessment of effectiveness should not be limited to whether an intervention has achieved its objectives, but also to identify the major reasons and key lessons to inform further implementation or future interventions. When relevant, this should include a comparison with alternative approaches to achieving the same results. Key elements of effectiveness include:

- ***Timeliness***. Evaluations should assess to what extent services and items were delivered in a timely manner, and to what degree service provision was adequately supported to achieve objectives on schedule.
- ***Coordination***. This refers to how well various parts of an intervention, often involving multiple actors, were managed in a cohesive and effective manner. This is particularly relevant in the work of IFRC, where disaster response or longer-term development initiatives often involve multiple National Societies, local and national governments and institutions, and other partners.
- ***Trade-offs***. Evaluations should assess the effect of decisions made during the intervention that may alter the goals or priorities in acknowledged or unacknowledged ways.
- ***Stakeholder perspectives***. The viewpoint of stakeholders can help identify factors related to the performance of an intervention, such as who participated and why, and the influence of the local context.

3.5 Coverage

Coverage refers to the extent population groups are included in or excluded from an intervention, and the differential impact on these groups. Evaluation of coverage involves determining who was supported by humanitarian action, and why. It is a particularly important criterion for emergency response, where there is an imperative to reach major population groups facing life-threatening risk wherever they are. Coverage is linked closely to effectiveness (discussed above), but it has been included here as a separate criterion as it is especially relevant for the work of IFRC and its commitment to provide aid on the basis of need alone (see Box 1). Key elements of coverage include:

- ***Proportionality*. Evaluations should examine whether aid has been provided proportionate to need, and includes key questions of equity and the degree of inclusion and exclusion bias. *Inclusion bias* is the extent that certain groups receive support that should not, and *exclusion bias* is the extent that certain groups that should receive support do not.**
- ***Demographical analysis*. The assessment of coverage typically requires a breakdown of demographic data (disaggregation) by geographic location and relevant socioeconomic categories, such as gender, age, race, religion, ability, socioeconomic status, and marginalized populations (i.e. internally displaced persons - IDPs).**

- ***Levels of coverage*. Coverage can usually be assessed on three levels: 1) International, to determine whether and why support provided in one intervention, or response, is adequate in comparison to another; 2) National or regional, to determine whether and why support was provided according to need in different areas; and 3) Local or community, to determine who received support and why.**
- ***Cultural/political factors*. Coverage is often culturally determined. What constitutes "need," and therefore who is assisted, often requires an analysis of socio-political and economic factors and related power structures.**

Box 1: Red Cross/Red Crescent Code of Conduct and Coverage

Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone. Wherever possible, we will base the provision of relief aid upon a thorough assessment of the needs of the disaster victims and the local capacities already in place to meet those needs. Within the entirety of our Programs, we will reflect considerations of proportionality. Human suffering must be alleviated whenever it is found; life is as precious in one part of a country as another. Thus, our provision of aid will reflect the degree of

suffering it seeks to alleviate. **(Principles 2 of the Code of Conduct for International Red Cross and Red Crescent Movement and NGOs in Disaster Relief)**

3.6 Impact

Impact examines the positive and negative changes from an intervention, directly or indirectly, intended or unintended. It attempts to measure how much difference we make. Whereas effectiveness focuses on whether immediate results have been achieved according to the intervention design, the assessment of impact expands the focus to the longer-term and wider-reaching consequences of achieving or not achieving intended objectives. Its scope includes the wider effects of an intervention, including the social, economic, technical, and environmental effect on individuals, groups, communities, and institutions. Key elements of impact include:

- ***Attribution*. A critical aspect in assessing impact is the degree to which observed changes are due to the evaluated intervention versus some other factor. In other words, how much credit (or blame) can the measured changes be attributed to the intervention? Two broad approaches are used to determine attribution. Comparative approaches attempt to establish what would have happened without a particular intervention, and theory-based methods examine a particular case in depth to explain how an intervention could be responsible for specific changes. Both these approaches may involve the use of qualitative and quantitative methods and tools, and are often used in combination. What is most important is that the approach and method fits the specific circumstances of an impact assessment – its purpose, the nature of the intervention being assessed, questions, indicators, level of existing knowledge, and resources available.**
- ***Methodological constraints*. The measurement of impact has considerable methodological constraints and is widely debated. Of the evaluation criteria, it is typically the most difficult and costly to measure, due to the level of sophistication needed. As its focuses on longer-term changes, it may take months or years for such changes to become apparent. Thus, *a comprehensive assessment of impact is not always possible or practical* for an evaluation. This is especially true for evaluations carried out during or immediately after an intervention. The reliable and credible assessment of impact may require a longitudinal approach and a level of resources and specialized skills that is not feasible.**

3.7 Coherence

Coherence refers to policy coherence, ensuring that relevant policies (i.e. humanitarian, security, trade, military, and development) are consistent, and take adequate account of humanitarian and human-rights considerations. While it is closely related to coordination, coherence focuses on the extent to which policies of different concerned actors in the intervention context were complementary or contradictory, whereas coordination focuses more on operational issues. Given that IFRC

interventions are often implemented through various partnerships with governments, other international organizations and agencies, and within the Movement itself, coherence is an important criterion to consider separately, especially for upholding the Fundamental Principles of Impartiality, Neutrality, Independence, and Unity. Key considerations in the assessment of coherence include:

- ***Multiple actors*. Evaluating coherence is of particular importance when there are multiple actors involved in an intervention with conflicting mandates and interests, such as military and civilian actors in a conflict setting, or multiple agencies during an emergency response to a disaster.**
- ***Political repercussions*. The assessment and reporting of coherence can have political**

  consequences, given its focus on wider policy issues. Therefore, careful consideration should be given to the objective credibility in measurement, and the manner in which findings are reported.
- ***Methodologically challenging*. Similar to impact, coherence is measured in relation to higher level, longer-term objectives, and can be difficult for the evaluator/s, depending on their capacity and resources to conduct policy analysis.**

3.8 Sustainability & Connectedness

Sustainability is concerned whether the benefits of an intervention are likely to continue once donor input has been withdrawn. It includes environmental, institutional, and financial sustainability. It is especially appropriate for longer-term interventions that seek to build local capacity and ownership so management can continue without donor funding, i.e. livelihoods Programs. However, with interventions that respond to complex emergencies or natural disasters, acute and immediate needs take precedence over longer-term objectives. Thus, connectedness has been adapted from sustainability for these situations. *Connectedness refers to the need to ensure that activities of a short-term emergency are implemented in a way that takes longer-term and interconnected factors into account.* It focuses on intermediate objectives that assist longer-term objectives, such as the establishment of key linkages between the relief and recovery (i.e. a sound exit strategy handing over responsibilities to appropriate stakeholders, allocating adequate resources for post-response, etc.).

2. Evaluation work schedule with visit timetable

Agenda CBHFA Final Evaluation Supported by Finnish Red Cross
April 1-11, 2013

Day/Date	Activities	Person(s) required	Place
Tue, Apr 1	• Reach Dili in the afternoon • Receive security briefing • Meeting with the CD on the evaluation, make presentation of the plan, seek feedback and adjust the plan accordingly	IFRC staffs	Dili
Wed, Apr 2	• Secondary literature study • Meeting with the CVTL program, management and support people • Meeting with volunteers • Meeting with relevant Govt. stakeholders • Finalization on field visit and tools to be used for evaluation	NS staffs And Govt. officials	Dili
Thu, Apr 3	• Travel to Manatuto • Meeting with the branch people • Secondary literature review • Meeting with the volunteers • Meeting with local health officials • Finalizing the field plan with the project staff and branch volunteers	Branch secretary Volunteers, Govt. officials CBHFA project staffs	Dili Manatuto
Fri, Apr 4	• Field visit to Cribas • Meeting with the local volunteers • Meeting the community Stakeholders • Meeting with the Community using semi structured questionnaire and PRA tools • Meeting with the service providers	Local volunteers Translators Community members	Manatuto
Sat, Apr 5	• Debriefing to the branch officials • Travel back to Dili	Branch secretary	Manatuto Dili
Sun, Apr 6	• Weekend		DIli
Mon, Apr 7	• Travel to Manufahi • Meeting with the branch officials and project staffs • Finalization of a field visit plan	Branch secretary Volunteers, CBHFA project staffs	Dili Manufahi
Tue, Apr 8	• Field visit to Bitirai • Meeting with the local volunteers • Meeting the community Stakeholders • Meeting with the Community using semi structured questionnaire and PRA tools • Meeting with the service providers	Local volunteers Translators Community members	Manufahi
Wed, Apr 9	• Meeting with the Govt. officials at Manufahi • Debriefing to the project team at Manufahi • Travel back to Dili	Govt. officials	Manufahi DIli
Thu, Apr 10	• Intensive sessions with CVTL and IFRC Health teams • Meeting with other health projects within CVTL • Working on the draft recommendations (jotting down the observations against the	CVTL health teams and IFRC Health focal person	Dili

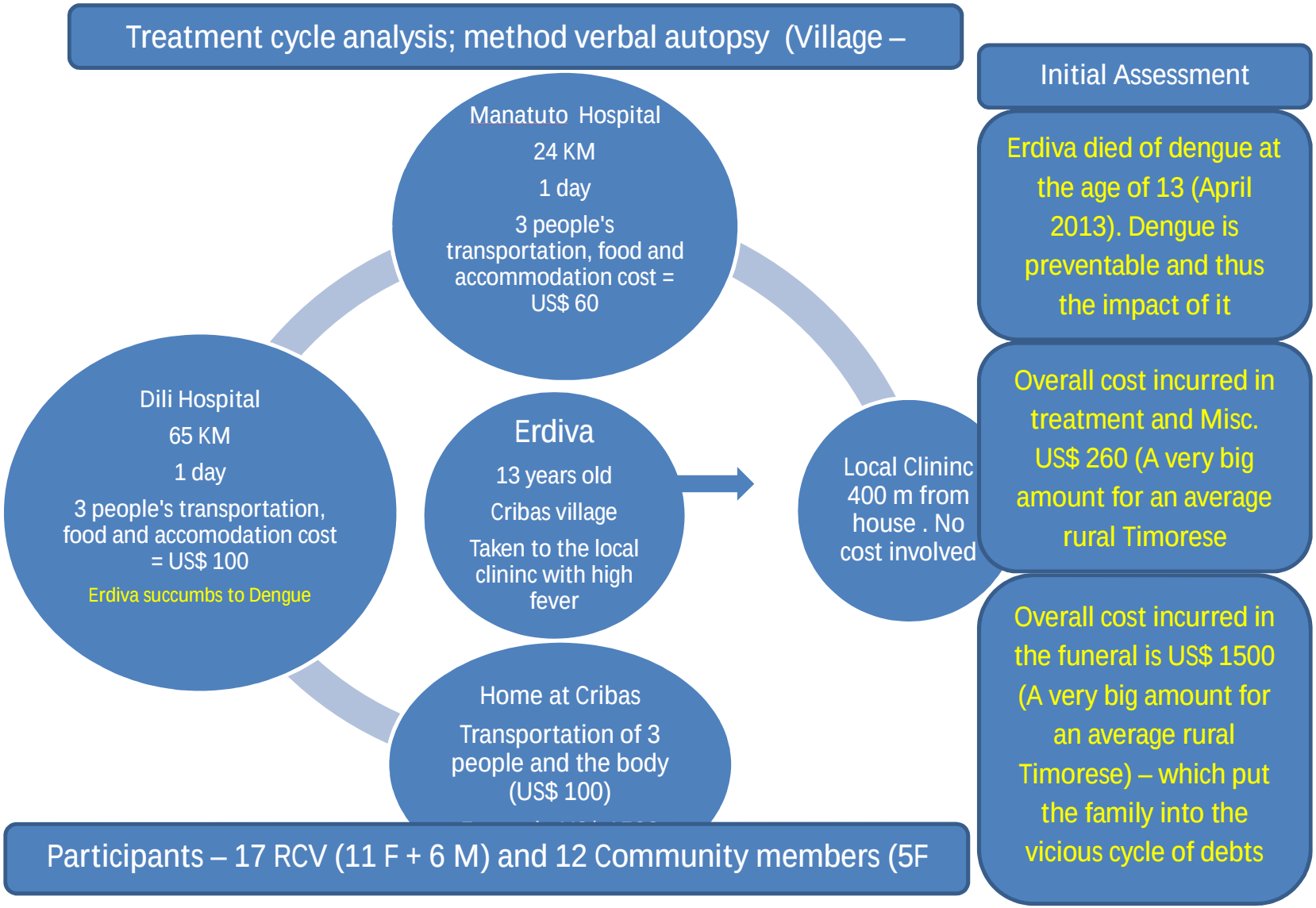
Day/Date	Activities	Person(s) required	Place
	evaluation criterion)		
Fri, Apr 11	• **First half: Developing a presentation on the findings and draft recommendations** • **Second half: Debriefing with the CD and NS**	**Second half – debriefing all relevant stakeholders**	**Dili**

3. List of people interviewed

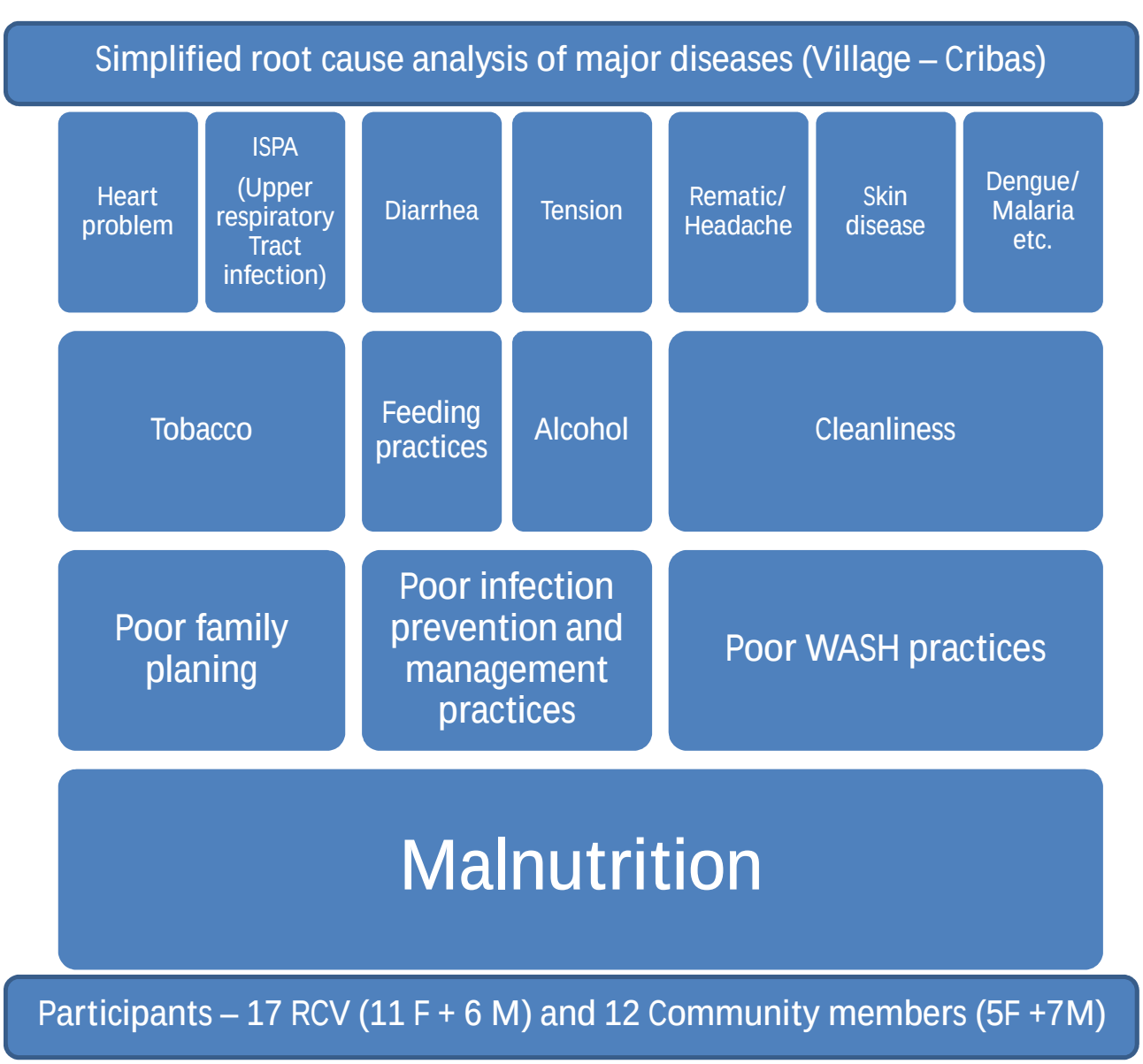
Name	Designation
At the national headquarter	
Kathryn Clarkson	Head of country delegation IFRC in Timor Leste
Dr Dewindra Widiamurti	Health and DRR Delegate IFRC Timor Leste Delegation
Mr. Stuart Bryan	Water and Sanitation Delegate, Australian Red Cross
Mr. Januario Ximenes	Secretary General CVTL
Mr. John Nunes Lomes, Ximenes	Acting Coordinator, Logistics, CVTL
Mr. Marcelino Albuquerque	CBHFA Manager, Cruz Vermelha Timor Leste (CVTL)
Mr. Joao Pinto	Health Coordinator, CVTL
Mr. Hermenegildo Cardoso Rente	Disaster Management Coordinator at CVTL
Mr. Agapito da Silva	Organizational Development Coordinator – CVTL
Mr. Estanislau Guterres	Communication Coordinator – CVTL
Mr. Apolinario Gusmao	Finance Manager – CVTL
Ms. Dulce De Almeida	Finance Officer, CVTL
Mr. Mariano de Jesus	Commercial First Aid Manager – CVTL
Mr. Erculano Cunha	Health in Emergency Manager – CVTL
Ms. Maria Pascoela Da Cruz	Livelihood Manager, CVTL
Mr. Cornelio Dedeus Gomes	Former Health Coordinator CVTL, Presently working with CVTL
At the Branch level	
Mr. Adelino Caldeva	Branch Coordinator, Manufahi
Julino Da Coasta	Out Reach Worker, Manufahi
Anjelino Meria Perera	DM and Health Officer, Manufahi
Vicento Do Santoz	Disseminator, Manufahi
Mario DC Moriz	Branch Coordinator, Manatuto
Egidiio C Oliveira	Chairman, Manatuto
Orlando De Carevalho	Health Officer, CVTL Manatuto
Community level	
Manatuto	17 RCV and 12 community members + 4 households
Manufahi	19 RCV and 7 community members + 3 households
Fatu Berloi	3 Health staffs at the local health centre

4. Annexes of the PRA tools exercised in the field

a. Treatment cycle analysis; method verbal autopsy (Village – Cribas)



b. Simplified root cause analysis of major diseases (Village – Cribas)



Initial Assessment

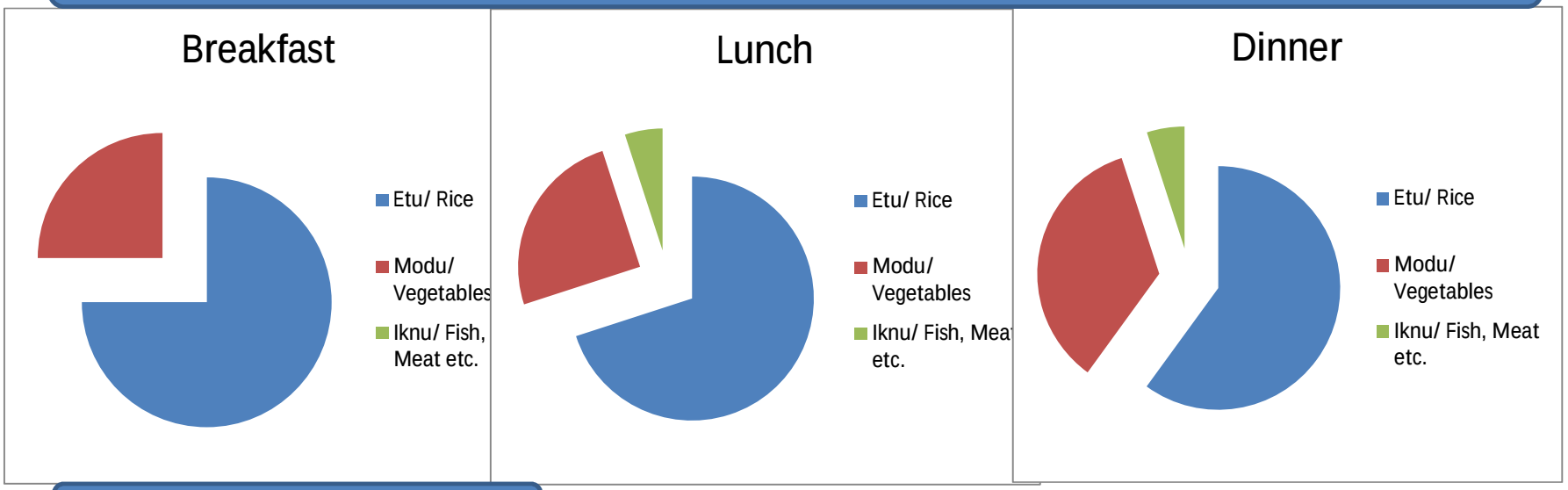
The initial assessment refers to the diseases, which are known to the community and they often see it happening in and around their communities

Upon probing they started thinking about the practices and factors that attribute to the risks these diseases and concluded to the risk factors, which are written across two different levels in the diagram

At the end of the participatory assessment almost all of them attributed their problems to Malnutrition with differential opinions about poor WASH practices as one of the major root cause

c. Analysis of eating pattern and root causes of Protein Energy Malnutrition (Participatory)

Analysis of eating pattern and root causes of Protein Energy Malnutrition (Participatory)



Initial Assessment

The initial assessment suggest that the community despite eating a lot of carbohydrate in the form of Rice, the villagers eat some vegetables and Meat. But upon probing further – it came out that the villagers eat instant noodles, banana (mostly fried) and Potato and consider these as vegetables. The fact remains that they eat very less amount of vegetables and Iknu (fish, meat, egg) – is not a regular phenomenon, they eat it occasionally and the milk and milk product consumption capacity and intention both are very low. In totality the community people tend to eat a lots of carbohydrate rich food in different forms and the rampant PEM cases in the village is a direct outcome of that.

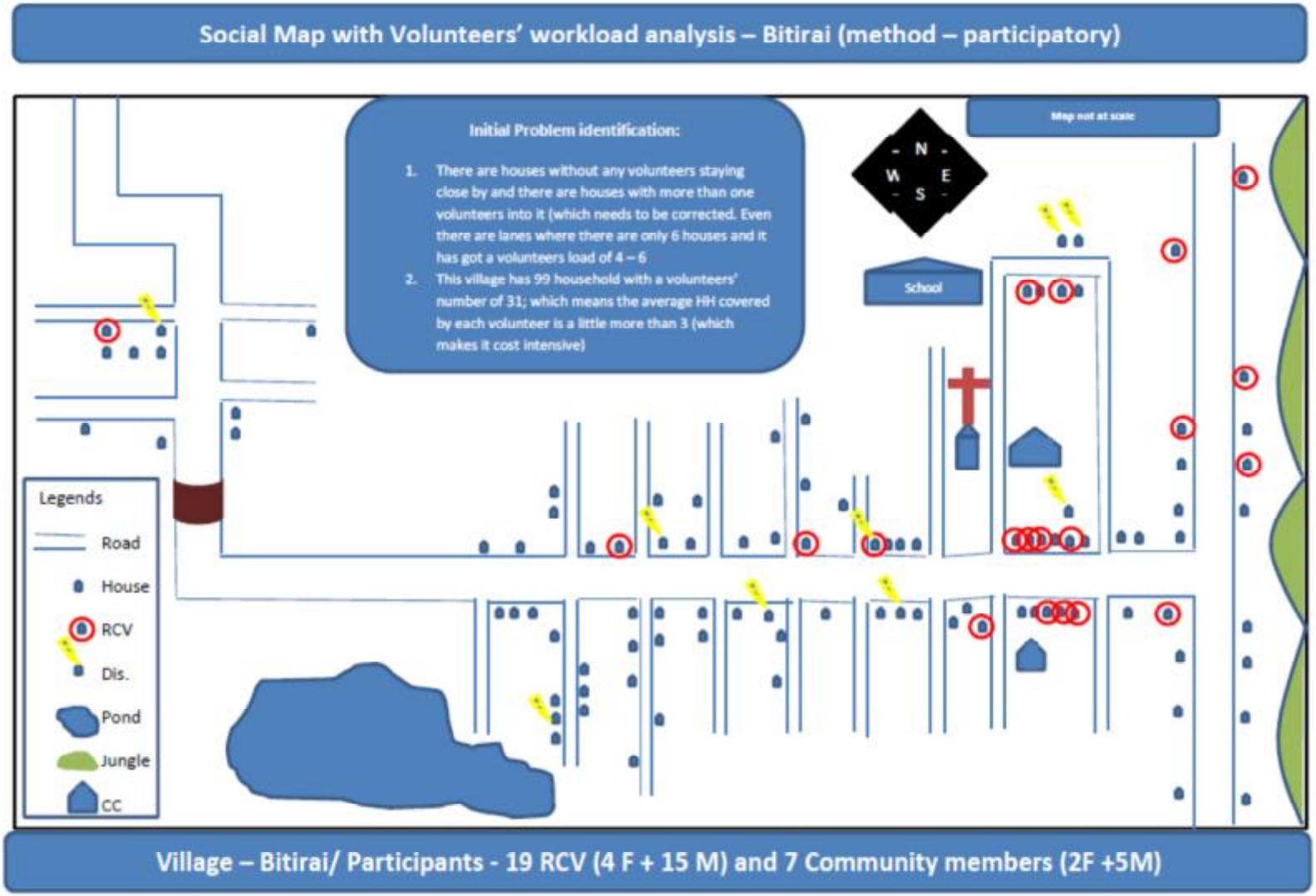
Etu is mainly Rice, white bread and sometimes Casava

Modu is mainly Instant noodles, Banana (fried) and Potato (they grow a lot of green leafy vegetables and Beans but they do not eat it, rather they sell it

Iknu is mainly – Fish, Meat, Chicken and Eggs

Village – Bitirai/ Participants - 19 RCV (4 F + 15 M) and 7 Community members (2F +5M)

d. Social Map with Volunteers' workload analysis – Bitirai (method – participatory)



5. Volunteer database by household (local innovation)

ATU HATENE HAU NIA FAMILIA KADA UMA KAIN ALDEIA TUQUETI & ATHOK (CRIBAS)

Numero Uma	Naran Chefe da Familia	Numeru Uma kain	Responsalve husi Voluntario Suku
1	Andreas Salu	1	Urbano dos Reis
2	Abilio da Cunha	2	
3	Abel Alves	1	
4	Fernando Leki Mauk	3	
5	Mateus da Costa	3	
6	Agostu Soares	1	
7	Luis Soares	1	
8	Afonso Soares	1	
9	Arcanjo Morais	3	
10	Joao Makon	3	
11	Romana Bui Kiak	3	
12	Domingos Pinto	1	Muijes Sousa
13	Filomeno M. Soares	1	
14	Jose Raimundo	1	
15	Boaventura Malaluk	1	
16	Carlos Soares Pires	1	
17	Cazamiro Bere Lorok	3	
18	Jose Soares	1	
19	Isabel Soares	1	
20	Gaspar Soares	2	
21	Cleremina Bibais	2	
22	Agustinho Soares	1	
23	Baltazar Soares	2	Carolina Lopo
24	Alcino Soares	4	
25	Juliao Marubi	?	
26	Jacinto Soares	1	
27	Luis Lemos Soares	1	
28	Jose M. Soares	3	
29	Celestino Leki Hunuk	2	
30	Hendrique Soares	1	
31	Martinho Alves	4	
32	Hermenezildo Maliban	2	
33	Antonio Esan	1	
34	Manuel Ximenes	2	Anjelina Alves
35	Antonio Julio Soares	2	
36	Januario Soares	1	
37	Crispin Bere Nahak	3	
38	Alcino Morais	3	
39	Francisco Buik Soares	2	
40	Mateus Alves	2	
41	Mario Soares	1	
42	Manuel dos Reis	2	
43	Antonio Here Loi	2	
44	Cristovao Pinto	1	
45	Clementino dos Reis	1	Afonso Soares
46	Jose Carlos Soares	1	
47	Januario Alves	3	
48	Julio Alves	1	
49	Alberto Malarak	1	
50	Guilerme dos Reis	2	
51	Lorenso Leki Hunuk	2	
52	Filomino M. Soares	1	
53	Domingos Lino	2	
54	Alexandre da Silva	1	
55	Thomas Soares	1	

56	Roberto Soares	2	Romao de Oliveira
57	Armindo de Oliveira	2	
58	Daniel dos Reis	3	
59	Domingos Lo`ok	1	
60	Cornelio da Costa	2	
61	Antonio Rui	1	
62	Domingas Soares	5	
63	Cornelio M. Soares	3	
64	Victor Hornai	3	
65	Luis Lemos	1	
66	Saltorio Soares	1	
67	Romao Mali Kolik	1	Cornelio da Costa
68	Paulina Soares	2	
69	Sebastiao dos Reis	1	
70	Sebastiana Bicolo	2	
71	Antonio Julio Soares	3	
72	Geraldo dos Reis	2	
73	Mateus da Costa	1	
74	Abel de Jesus Soares	1	
75	Mario da Costa	2	
76	Barba de Oliveira	1	
77	Felix de Oliveira	1	
78	Afonso Marubi Soares	3	Isabel Soares
79	Jeronimo dos Reis	2	
80	Alosius Suri	1	
81	Hermenegildo Monis	2	
82	Lorenco Morais	2	
83	Rui dos Reis	2	
84	Martinho Soares	1	
85	Alexandre dos Santos	1	
86	Mariano Ximenes	1	
87	Andre Ximenes	2	
88	Francisco Alves	2	
89	Belarmino Soares	2	Antonia dos Santos
90	Gaspar de Jesus	2	
91	Pedro dos Reis	2	
92	Elsa Soares	1	
93	Domingoa Miu Lai	2	
94	Luis dos Reis	2	
95	Sebastiana Soares	1	
96	Maria dos Reis	1	
97	Peregrino X. Martins	2	
98	Antonio Teti Soares	3	
99	Pinto Alves	2	
100	Matias dos Reis	2	Francisco dos Anjos
101	Jeronimo Soares	1	
102	Francisco L. dos Santos	1	
103	Hilario da Cruz	1	
104	Rodolfo dos Santos	1	
105	Eugenio Soares	2	
106	Jose das Neves	2	
107	Saturnino das Neves	1	
108	Salvador Bere Haek	2	
109	Euriko Alves	2	
110	Domingos Laku	1	
111	Daniel Malaku	2	

112	Jose Soares Bara	2	Andre dos Reis
113	Martins Soares	2	
114	Bibui Soares	1	
115	Hilario dos Santos	1	
116	Ana Rosa Alves	2	
117	Bernardo Alves	2	
118	Agosto dos Santos	1	
119	Jacinto M. Alves	2	
120	Cristovao Soares	2	
121	Jose Carlos Alves	2	
122	Placido Soares	3	
123	Jose Raul das Neves	1	
124	Domingas dos Reis	2	Saturmino das Neves
125	Tomas Alves	1	
126	Agustinho Martins	1	
127	Alberto Loi Olok	2	
128	Raimundo dos Reis	1	
	Total Familia	221	

ATU HATENE HAU NIA FAMILIA KADA UMA KAIN ALDEIA KAUNUA (CRIBAS)

Numero Uma	Naran Chefo da Familia	Numeru Uma kain	Responsalve husi Voluntario
1	Duarte	1	Maria Nunes
2	Jose Alves	1	
3	Teodozio Dos Santos	1	
4	Heminio Dos Santos	1	
5	Sebastiaon Henrique	1	
6	Adolfo de Oliveira	2	
7	Florindo Doa Santos	3	
8	Mateus Soares	1	
9	Ernesto da Costa	1	
10	Juliaon Mabere	1	
11	Jose Pires	1	
12	Daniel Siqueira	1	
13	Maria Nae	3	
14	Raimundo Alves	1	
15	Jose Gomes	3	
16	Domingos D.D	2	Francisca da Costa
17	Vicente Soares	1	
18	Teodoro Miranda	3	
19	Domingos da Costa	1	
20	Jose Manuel dos Santos	1	
21	Vicente Miranda	2	
22	Luis Sarmento	2	
23	Candidos Dos Santos	1	
24	Domingos Maria dos Santos	2	
25	Jacinto dos Reis	2	
26	Albino Ramos	2	
27	Agustinha Soares	1	
28	Rozalina Bisosek	1	
29	Antonio Julio	1	
30	Fernando Makehi	1	
31	Domingos da Costa Nunes	1	Sejaltina
32	Francisco Manuel	1	
33	Antonio dos Reis Laka	1	
34	Fernando Maano	2	
35	Eduardo da Costa	1	
36	Gaspar Lopes	2	
37	Aleixo da Cruz	2	
38	Afonso da Costa	1	
39	Domingos Badi	2	
40	Thomas da Costa	3	
41	Francisco Ramos	2	
42	Serzio Sarmento	1	
43	Carlos Amaral	2	
44	Laurind Amaral	2	
45	Joao Mau Lirun	3	
46	Lisis Mamali	3	Thomas da Costa
47	Francisco Hiri	1	
48	Cansio Maleuk	1	
49	Agripino Xavier	1	
50	Domingos da Costa	1	
51	Paul Soares	1	
52	Sebastiao	1	
53	Ana Maria	2	
54	Diogo Amaral	1	
55	Maturun Soares	1	
56	Carlito Ramos	2	
57	Hilario Mahadi	1	
58	Antonio Carlos (ranak)	1	
59	Julito Cairala (ranak)	2	
60	Antonia Soares (ranak)	1	
61	Izak Raul (ranak)	1	
	Total Familia	92	

Field visit report

Naran : Orlando de Carvalho

Posisaun : Branch health officer

Data visita : 10-12/06/2012

Objective : Hamutuk ho voluntario sucoA ubeon halao demostrasaun tein ba inan sira promosaun kona ba mal nutrisaun, saude higine no encontro ho voluntario suco

Prosesu nebe atinji	Iha mudansa ruma durante ita boot sira nia reporting ?	Iha problema particular ruma, nebe halo ita la atinji actividade no recomendasaun ruma nebe presiza.
10/06/2012 Sai husi manatuto ba aubeon		Problema udan no dalan nebe kuak.
11/11/2012 Hamutuk ho voluntario suco halo demostrasaun iha programa sisca.	➢ Iha Sisca fulan ida ne'e pessoal saude sira hanesan bain- bain fo nafatin oportunudade mai staff saude no voluntario suco sira atu implementa programa demostrasaun tein ➢ Iha fulan ida ne'e tuir lista nebe mak voluntario sira halo iha meja 1 katak mal nutrisaun iha fulan ida ne'e menus husi fulan uluk 15 pessoas no fulan ida ne'e tun ba iha 13 pessoas husi total labara 58 pessoas. ➢ Inan sira mos kontente no interese tebes atu rona no halo tuir saida mak mak staff saude no voluntario sira hato'o ➢ Iha fula ida ne'e demostrasaun tein kona ba sasora kahur lakeru. ➢ Labarik sira mos gosta tebes atu han sasoro nebe prepara maske hetan kanuru isin ida – ida.	▪ Iha Aubeon la iha aihan local nebe sufsiente ▪ Iha aubeon komunidade sira mos htan desastre tanba udan bo'ot no halo rai dodok tebes.
12/06/2012 Encontro ho voluntario no fila husi aubeon ba Manatuto	➢ Halao encontro ho voluntario sira koalia kona ba : o Actividade door to door o No atu hato'o nafatin informasaun ba com tamba . tempo udan. o Halo mos plano ba fulan oin hamutuk ho voluntario sira. o Labele uja atribut CVTL hodi ba halao actividade pribadi. Tamba agra iha tempo kampanha nia laran.	

CRUZ VERMELHA DE TIMOR LESTE

(C V T L)

Filial Manatuto

Rua : St. Antonio Manatuto Suco Aiteas Hp(+670)77365286

Branch Monthly Report Agustus 2013

Data	Program	Actividade	Fatin	Target	Distan	Resultado Actividade	Benefisio		total	Problema	Remaks
							M	F			
29/07/2013		sai husi Manatuto ba Aubeon	Dalan	Staff CVTL		to'o iha Aubeon Ho diak	2	3	5		dia 1/8/2013 fila husi Aubeon - Manatuto
30-31/07/2013	ICBRR	encontro	cede Suco Aubeon	Com, VV, Lider local		hare fila fali resultdao VCA iha 2010 , no iha soru mutuk ne hetan duni mudansa balun nebe maka persija CVTL atu implementa fali nia programa iha area refere, maka hanesan Saude (Diarea) Desatre livelihood no ba sanitasaun nian. Ba hare mos fatin nebe mak be'e sai hodi afeta komunidade iha Aubeon.	35	27	62		
2/8/2013	Saude	prepara equipamentos no Hadia file	Branch	Staff		hadia fali no tau hamutuk file nebe mak iha branch iha nia fatin idak - idak.					
5-7/08/2013	ICBRR	promosaun iha escola	E.P.F Hohorai	estudante		halo ona promosaun iha escola ho topico malaria, Diarea, no oinsa fase liman ho sabaun.	30	25	53		
12-14/08/2013	HIV/AIDS	treinho HIV/AIDS	Branch	voluntario Branch		voluntario sira hatene no komprende ona kona ba diverente entre HIV no AIDS, no vol sira mos komprende saida mak discriminasaun no stigma, orgaun reproductiva no iha biban ida ne'e hodi mos vol sira ba vizita fatin VCCT.	14	6	20		
15/08/2013	F.A	Coordensaun kona ba mini Workshop	Ensino Basico Cribas	Director da Escola		halo coordenasaun ho Director da Escola atu hodi halo mini work shop iha escola refere, iha biban ida ne'e husi parte escola hatan no sei implementa iha dia 16/08/2013	1				

16/08/2013	F.A	mini Work shop	Ensino Basico Cribas	estudante		topico nebe maka hato'o iha sorumutk ida ne maka : primeiro sokoros, prinsipiu asaun emergensia, moras fratura, moras espesifico no iha biban ida ne halo mos pratika kona ba primeiro sokkoros. Husi paarte escola haksolok tebes tamba actividade refere fo benefisio ba estudante sira atu oinsa halo primeiro sokoros ba iha sira nia a'an no mos ba sira nai maluk seluk nebe maka krik hetan asidente	2	13	15		
16/08/2013	CBHFA	kordnasaun	CHC Laclo	programa SISCA		ba CHC laclo hasoru malu ho pescal saude nebe maka resposabilisa ba programa sisca husu kona ba data implementasaun sisca iha Suco Hohorai, halo ona koordensaun no konfirma kona ba data Sisca no sei halo iha dia 16 /09/2013		1			
20/08/2013	CBHFA	sai husi Branch	dalan			To'o Hohorai ho diak halo mos konfirmasaun ho team lider Watsan iha Hohorai kona ba atu suporta kareta ba programa sisca iha Aldeia Fahilakor Suco uma Naruk					
21/08/2013		halo Sisca	Aldeia Fahi lakor	Comunidade		suporta kareta ba CHC Laclo hodi tula batar u'ut ba programa sisca iha Aldeia Fahi Lacor iha biban ida ne'e halo mos promosau ba comunidade sira kona mal nutrisaun. Iha kalan loke mos filmagem ba comunidade sira.	15	21			
22/08/2013	CBHFA	ke'e fatin lixu	Hohorai			hamutuk ho comunidade sira ke'e no coor ona fatin lixu iha tagki distribuisaun iha suco Hohora,	4				
23/08/2013	CBHFA	Door to door education				voluntario halo ona informasun tama uma sai uma ba comunidade sira ho topico, malaria, diarea.	20	25			
24/08/2013		sai husi Hohorai ba Branch no prepara relatorio iha Branch				sai husi to iha Branch ho diak no iha biban ida ne'e prepara relatorio ba fulan agutus nian.					
							123	121	244		

Manatuto, 24/08/2013

Prepara husi

Health staff

Orlando De Carvalho

Visto pelo

Presidente kdd

Egidio C. Oliveira

Branch coordinator

Mario DC. Moniz

FORMATU MONITORING TAU MUSQUITEIRO IHA UMA KAIN

Naran Chefe Família : Francisco Alves

No.	Ema nain hira mak hela iha uma laran	Musquiteiro hira mak distribui tiha ona	Musquitero hira mak tau / uza tiha ona	Labarik nain hira mak (tinan 5 lima mai kraik) toba iha musquiteiro laran hodi kalan	Inan isin rua nain hira mak toba iha musquiteiro laran hodi kalan	Se karik musquiteiro seidauk tara, karik ita bo'ot bele ajuda hodi tara fudik Sim / No	Any problem need (ie. Rasaun sira la toba iha musquitero laran no la tara musquiteiro
	2	1	1	-	-		-

CRUZ VERMELHA de Timor-Leste

FORMATO RELATORIO DO AKTIVIDADES IHA NIVEL COMUNIDADES (Door to door Education Form to Use In the Community)

Fatin/Bairo (Location) :.....

Data/Date	: 17-5-2012	Suku/Village	: Aubean
SubDistrito/Subdistrict	: manatuto	Aldeia/Sub village	: Mercade
Voluntario /Volunteers	: ana maria pinto	Distrito /District	: natar-Barro-manatuto

I.Edukasaun hosi Uma ba Uma/Door to door Education.

No	Naran Chefe da Familia/Name of Household .	Ema nain hira hela iha Uma-Laran/How many people in household	Topico Nebemak atu Koalia/Explain about what topic.	Total Pamfleto nebe distribui/Total of pamphlet to distribution.	Assinatura Chefe da Familia/Signature of Head household	Keterangan/Remarks
1.	Agostino m	5	Diarea			
2.	Antonio m c	6	Diarea			
3.	Domingas F.	3	Diarea			
4.	Joao calcleiro	5	Diarea			
5.	Jose Lemos.	2	Diarea			
6.	Jose maria	4	Diarea			
		6				

plano ba fulan Maio 2012

Actividades	Fatin	Target	Expt - Result	Buaget	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Encontro voluntario	Aubeon	VV	ho encontro ne'e staff ble recolha relatori husi coord vol ha suco refere																															
Encontro voluntario	Cribas	VV	ho encontro ne'e staff ble recolha relatori husi coord vol ha suco refere																x															
Fahe informasaun iha Escola	Cribas	Estudnte	oinsa estudante sira mos bele hatene oin sa face lima molok han no depois de sintina hotu															x															
fahe informasaun iha programa sisca	Aubeon	inan isin rua no	atu inan sira bele heten no rona informasaun kona ba oinsa prepara sasoro ba labari tinan 5 mai kraik																															
mother cooking group / liu husi programa sisca	Cribas	inan isin rua no labarik													x																			
prepara formatu no equpqmentos nebe atu hodi halo program	Branch																																	
Hatama relatori no foti osan atividades ba fulan oin	NHQ	maneger																																
prepara relatori no plano	Branch	Staff	atu nune'e staff halao servico tuir plano nebe iha ona																						x	x								
Servico ho team Watsan (halo haleu tangki no pontinario no pinta tangki.			Atu animal labele besik no estraga tangki I be'e labe kontamina ho animal nia foer		x			x																										

Aprova husi

presidente CDD

Egidio C. Oliveira

Cord Branch

Mario DC. Moniz

Prepara husi

Staff saude

Orlando de Carvalho

6. Pictures from the field visits (Link)

https://www.dropbox.com/sh/t87jf0h5rbyaons/AACXgR6Uw7Lp-nEbCKeLHE61a