

Demand Creation Approaches: A Survey of Local NGOs in Timor-Leste's Health Sector

Research Report¹

Key Findings

Overall Summary

The analysis of Approaches shows a diversity of origins and funding but uniformity in priorities and methodologies, and the discussion of Resources & Capacity and Partnerships & Coordination provides some explanation for this uniformity. Close engagement with government, as well as targeted funding opportunities, have contributed to a well-coordinated and consistent set of projects seeking to improve people's health knowledge and willingness to access services. There is a strong and cohesive campaign to improve demand for health services by a small and committed, but relatively resource constrained, group of local NGOs. However, perhaps due in large measure to this same cohesion, critical programming to improve the accountability of health service delivery is minimal.

Cooperative efforts to increase the quality of services are more easily mobilised around demand creation through health promotion messaging. The value of demand creation work is well recognized, and experience and expertise exist: Only expansion of projects and sustainability of organizations is needed to developed the work. Strengthening the work of accountability creation is more difficult, but can be achieved by encouraging an environment in which organizations can confidently and productively conduct such work. It will be necessary to grow both the motivation and capacity of the health-focused NGOs to carry out better research, monitoring, and complaints handling. Steps to achieving these goals include:

- First support research projects, and thereafter monitoring and participatory accountability projects, leaving grievance redress projects until the understanding and use of accountability projects is more mature.
- Facilitate partnerships between NGOs from the health sector and more traditional political advocacy NGOs.
- Support the development of NGOs monitoring & evaluation of their own projects, building their capacity and systems to better record and critique their own activities before applying similar methodologies to the monitoring of the service delivery of government or others.

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- Similarly, introduce participatory accountability projects (such as citizen charters & community scorecards) in locations where the NGOs have existing commitments, and position the activities as integrated parts of on-going projects.

Summary by Research Topic

Approaches: The origins of organizations and their approaches to strategic programming and access to funding are diverse, but there is consistency with regards to project objectives and methodologies. Project implementation methodologies aim to build demand for services through behaviour change communication and participatory activities (with rights-based and multi-stakeholder emphases) that use clinical or other practical services as a platform for health promotion. Most NGO programs are focused at community- and individual-level activities that include peer education and support, and trainings/workshops.

Capacity & Resources: The NGOs are largely reliant on international donors for funding, and it is primarily on a project basis within limited timeframes, and most organizations have difficulty securing core funding. Project-based funding requires close alignment in strategic and methodological priorities with donors, and – while not always the case – smaller NGOs tend to fulfil the role of contractor for larger organizations. To a large extent, constrained funding also reflects constrained capacity. However, while challenges in keeping experienced staff, conducting rigorous monitoring & evaluation, and reporting extensively on projects and finances are common, the treated NGOs are comparatively strong in the national context. Organizations can mobilize quickly and effectively when funding is available, and are strongly committed to their objectives

Partnerships & Coordination: The key partner for all NGOs sampled is the Ministry of Health, and there is close coordination in programming, including at national and district levels and through MOUs and some funding (or in-kind support) arrangements. NGO programming is aligned to MoH priorities, and while NGOs are focused on demand creation through health promotion, there is minimal programming explicitly aimed at improving the accountability of government services. Regarding coordination with the Church, even those organizations with programs (such as adolescent reproductive health and condom distribution) that might conflict with religious interests state that they cooperate well with the Catholic Church. Absence of significant disagreement in this respect is likely due to the close alignment of NGO and government programming, and that discourse between Church and government occurs separately (or prior to) policy decisions involving NGOs.

Part 1: Background to the Research

1. Research Topic and Key Questions

The research project examines the role played by Timorese Non-Government Organizations (NGOs) in creating demand for, and improving accountability of, health services in Timor-Leste.² The study outlines the programming focus, coverage, capacity and potential role of local NGOs in the fields of demand creation and accountability, and is focused on demand creation and accountability work in the areas of reproductive, maternal, and child health, and nutrition. The study explores qualitatively three aspects of the work being undertaken by NGOs: i) Approaches (including project implementation context); ii) Capacity & Resources; and iii) Partnerships & Coordination.

Approaches: Addresses the origins, rationale and over-arching goals of the organizations, as well as the different methodologies or project types the organizations deploy and project locations. The analysis is concerned with questions relating to the contexts of project design and implementation, including:

- What project implementation methodologies are commonly practiced, how are these aimed to producing sustained changes in health behaviours, and what implementation challenges are commonly faced?
- How does the broader socio-cultural context (relating to health practices and values) inform the design and implementation of specific projects?
- How does the demand creation and accountability programming of the organizations connect to the national policy and research context?
- How do the origins and conceptual or philosophical foundations of organizations inform their programming?

Capacity & Resources: Examines how the organizations are managed, staffed and funded. This includes treatment of leadership and decision-making process within the organizations; numbers, positions and competencies of staff; monitoring and evaluation procedures; and reporting (on strategic planning, project design and implementation, and financial reporting). A summary assessment will also be made of financial management, including funding sources, financial reporting and auditing. Key analytic questions for this topic include:

² *Definitions:* 'Demand creation' work undertaken by NGOs involves activities that seek to raise awareness and understanding of health services, and thus to increase people's ability and willingness to access health services. Such behaviour change and health promotion activities aim to ensure that people can access the right kinds of services at appropriate times. 'Accountability' work involves activities that seek to strengthen the participation ('voice') of communities in the planning and delivery of health services, and to ensure stakeholders (such as, households, village councils and community health facilities) are accountable to each other.

- How do organizations seek funding? How do organizations tailor strategic planning, or make adjustments to existing plans, to secure funding?
- Do organizations receive stable funding, or enough funding to fulfil their strategic planning? If not, how do organizations manage funding constraints (such as in context of maintaining qualified/competent staff, project planning, and organization sustainability)?
- What management structures are commonly used? Do any organizations have different or unique structures? How do different management systems impact on strategic planning, decision-making, fund-seeking and reporting?
- What plans and capacity do different organizations have for organization sustainability and/or expansion?

Partnerships & Coordination: Explores the organizations' engagement with government, with religious organizations (especially the Catholic Church), with funding agencies, and with each other. A focus of this topic is the extent and quality of coordination with the Ministry of Health. Analytical questions for this topic include:

- What key partnerships do the organizations maintain, including with religious institutions and among themselves, and are these partnerships consistent for different NGOs?
- How do organizations plan and implement programming in coordination with the Ministry of Health?

In summary, the research project aims to provide qualitative analysis of the approaches, capacity & resources, and partnerships & coordination of local Timor-Leste NGOs who work in the areas of reproductive, maternal, and child health, and nutrition with projects that either aim to create demand for or increase accountability of health services. The analysis is oriented by several key questions that will shed light on the context in which the organizations are constituted and managed, receive funding and plan and implement projects. The analysis will provide a platform for further discussion and recommendations that will contribute to identifying potential areas of engagement with NGOs.

2. Methodology: Data Collection, Data Management & Sample

The researchers used Key Person Interviews and Document Analysis to collect data. Most data were collected through interviews, but documents were also obtained when available (see Annex 3, list of respondents). When possible the researchers interviewed more than one representative from the same organization to obtain more specific information regarding different topics (such as project and finance staff). Interviews were conducted based on a consistent set of questions that were

applied to all organizations treated (see Annex 2: Question Guide). All interviews were conducted in Tetum, except with international staff/volunteers.

The sample of organizations was originally based on the list provided in the Terms of Reference, and was further developed through consultation with FONGTIL (*Forum ONG Timor-Leste*), snowball sampling with suggestions from treated organizations, and through the researchers' existing knowledge. Seventeen NGOs were sampled, and complete list with summary information based on research topics is provided in Annex 1. Most of the sampled NGOs, including those with a specific district focus, have offices or representatives in Dili. Some NGOs, however, are only district-based and visits were made to their district offices. Field visits were made to Aileu, Baucau and Manatutu (twelve days were allocated to data collection in Dili and districts).

With regards to data management, researchers took handwritten notes during interviews and this raw information was used to create profiles of the organizations using categories reflecting the research questions (see Annex 5: Organization Profiles). Summary information from the organization profiles is also presented in table form in Annex 1: Organization Summary. The organization profiles and summary were used as the basis for the analysis presented in Part 2.

The research proceeded according to plan and few difficulties were faced. Given time constraints, no visits were made to more distant districts, such as Lautem, Oecussi and Covalima – representatives of some organizations that do work in these districts (such as FUSONA, Caritas and CVTL) were met with in Dili. Some organizations initially identified were no longer active (Pastoral Crianca, SHARE) or could not be contacted (AFMET) and are thus not part of the sample. Further, the FONGTIL database lists only basic information about its members' activities – such as 'Health' or 'Water & Sanitation' – and some information is not accurate. It is possible that some NGOs registered with FONGTIL are conducting activities relevant to this research, but are not identified as such in the database. The 17 treated organizations represent a thorough, though not total, view of the activities and context of local NGOs working on demand creation and accountability projects in areas of reproductive, maternal, and child health, and nutrition. Annex 6 provides responses to comments and questions raised during the review of the report.

Part 2 : Findings & Discussion

1. Approaches

1.1. Organization Backgrounds and Priorities

The origins of organizations are diverse, and there is also some diversity both in how programming is organized at a strategic level and in how funding is sought and received. However, there is consistency among organizations with regards to how projects are rationalized (the identification of problems to be addressed) and the methodologies that are deployed (solutions to the identified problems). That is, despite the variety of backgrounds, strategic planning processes and funding mechanisms, the organizations all coalesce with similar project methods.

1.1.2. Origins

Analytical Question: How do the origins and conceptual or philosophical foundations of organizations inform their programming?

The origins of the NGOs treated can be broadly classified into three different 'origin groups,' as follows:

- Locally constituted members of international organizations (including religious groups):
 - Includes, for example, Red Cross (CVTL), YMCA, Caritas, FUSONA, SVD.
- Former branches of international organizations now separate and constituted locally:
 - Includes, for example, HealthNet Timor-Leste and HIS.
- Locally created organizations:
 - Includes, for example, HIAM Health, Alola Foundation, SHC, FTH, Moris Foun.

Differences in origin do not, however, impact greatly on the way that programming is decided upon, managed and implemented. To explore this issue it is possible to make further distinction between organizations based on the questions of whether organizations: i) focus on one or multiple issues; ii) source funding from one or multiple sources, and; iii) focus on one or multiple project locations. When organizations are cross-matched based on these categories, the heterogeneity of the organizations becomes clear.

Most organizations from across the three different origin groups have a diverse portfolio of projects. For example, Moris Foun, a Manatutu-based association, has several on-going projects in the fields of food security, education, agriculture, child

protection, youth development, health and hygiene promotion, reproductive and HIV, and nutrition. This is not unusual, even among the smaller NGOs. SHC is similarly placed, with education, livelihoods, HIV/AIDS, and reproductive health programs, although they anchor all programs around a 'youth focus'. Bigger organizations (that is, greater funding and more staff – see Section 2: Capacity and Resources), such as CVTL and Alola, both with different origins, also cast their net widely over numerous issues. The organizations with more specific issue focus are fewer, but also from a variety of origin groups. FTH (HIV/AIDs), HIAM Health (nutrition), HIS (health promotion through SISCa), and YMCA (MCH) all focus exclusively on one issue, but have different origins.

With regards to funding models, there is equally diversity. For example, two organizations that have a similar 'single issue focus' - FTH and HIAM Health - have very different funding models. The former receives funding almost exclusively from Global Fund, while HIAM Health has a multitude of small donors (more specific information on funding will be provided in Section 2). The management of project locations is also diverse: Some NGOs, such as SHC and YMCA, have a quite specific focus on a handful of villages within one sub-district or district, while other larger organizations, like CVTL and Alola, have wider reach across several districts. Two implementation modalities also affect project reach: i) Projects oriented at village level provide services to a small geographically bound area (e.g., CVTL, SHC, Caritas), and; ii) Projects working out of Dili or District capital based facilities provide services to a more fluid population of potential beneficiaries (e.g., FTH, HIAM Health).

1.1.2. Identification of Priorities

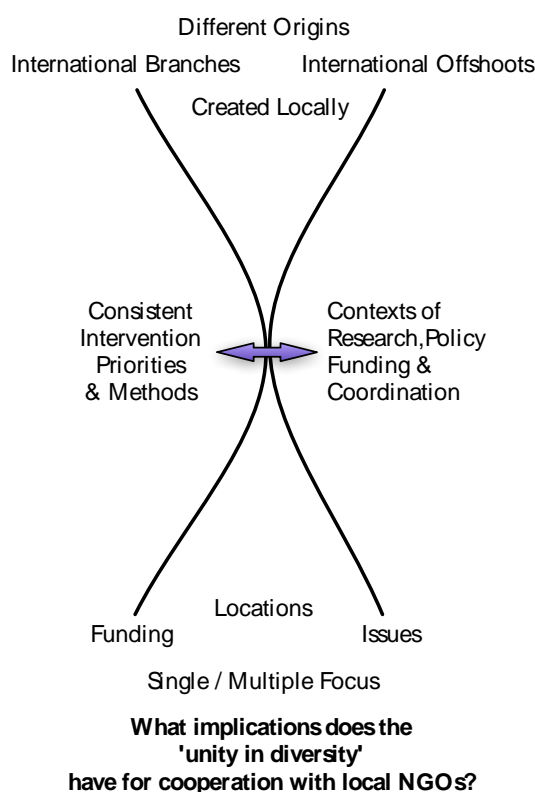
Analytical Question: How does the broader socio-cultural context (relating to health practices and values) inform the design and implementation of specific projects?

Analytical Question: How does the demand creation and accountability programming of the organizations connect to the national policy and research context?

Identification of the diversity of different NGOs across categories such as origin, funding, location, and issue focus is an important first analytical step because it highlights a contrast with the uniformity of NGOs in the ways they determine problems or challenges to creating health demand and accountability, as well as the methods they deploy as solutions (which will be addressed in the next sub-section). This high degree of uniformity, emerging from a diverse background, is notable because it highlights the authority of national- and international-level priority setting, funding and coordination over the local level activities of the NGOs. In this sub-section we address the way that NGOs rationalize the design of their projects.

Annex 4 explains at more length the research, policy and major project context in which local NGOs operate, including summaries of the *Timor-Leste Health Care Seeking Behaviour Study: Recommendations for Health Promotion* (2009), the *National Behaviour Change Communication Strategy* (2008-2012), the Health Improvement Project / HADIAC (2011 - 2015), the Community Driven Nutrition Improvement Project (CDNIP) (2014-2017), and MoH's *Situation Analysis of Community Practices in Health Activities* (2014).

Based on these document, the findings, recommendations and priority activities that are raised by leading research and propounded by official Ministry of Health programming are reflected consistently in the statement and activities of all local NGOs. In summary, key consistencies include:



- *Community Attitudes & Practices*
 - People are demotivated to access services due to distance and associated costs, lack of privacy, and negative experiences with health care workers (such as blame);
 - Some local medical beliefs and expectations sometimes remain a prevalent alternative to western biomedical systems. For example, that as most births are 'normal' they can take place at home without a bio-medically trained practitioner and that attribution of causes of illness are not always linked with bio-medical solutions. The importance of this dual system (customary and western) of medical systems cannot be underestimated: People have an option to choose between two different systems, both have legitimacy, but the failures of one serve to reinforce the other.
 - Improvements are occurring, but gradual. While most organizations have only basic M&E systems, and measurement of belief or expectation is qualitatively difficult, NGO representatives affirmed that demand for services is increasing. For example, FTH shows increased use of their testing service, Alola for their maternity packs, and CCT for their clinics.
- *Priorities for Response*
 - Improve health literacy and the performance of health service providers with coordination between schools, local authorities, development partners and the MoH;

- Promote health seeking behaviour through interpersonal communication; develop educational materials for use by community health workers; community mobilization (training; participatory planning); and edutainment (drama, theatre).
- Focus on health promotion messaging on Reproductive and MCH including delaying pregnancy, space birthing, birthing with skilled birth attendant, and postnatal care.

In sum, despite the diverse backgrounds of NGOs, they inform their project design with an understanding of community attitudes and practices and by prioritising health promotion responses that align closely with national government and international recommendations and practices.

1.2. Project Implementation Methods

Analytical Question: What project implementation methodologies are commonly practiced, how are these aimed to producing sustained changes in health behaviours, and what implementation challenges are commonly faced?

Project implementation methodologies are characterised by attempts to build demand for modern medical services that apply behaviour change communication and participatory activities (with rights-based and multi-stakeholder emphases) that leverage clinical or other practical services as a platform for health promotion. Most NGO programs are focused at community- and individual-level activities that include peer education and support, and trainings and/or workshops. The activities are, for the most part, designed to provide opportunities for one-to-one information sharing and counselling that, when possible, involve practical demonstrations or examples of the potential benefits of modern health services.

Regardless the issue focus – be it Reproductive health, MCH, HIV/AIDs or nutrition – all NGOs deployed similar methodologies which aim at improving people’s health seeking behaviour (including knowledge of causes of illness and healthy behaviour, types of services available and how to access services). Some NGOs gave more weighting to some sub-sets of activities, and it is at this more detailed level that differences between the organizations can be discerned. Key methods include:

Link health promotion messaging to tangible actions, examples and materials:

All organizations position their behaviour change communication within a context of either clinical or practical/demonstration activities. Linking health promotion to medical services (MCH) or cooking/gardening (nutrition) is considered essential to making messages meaningful to people. Organizations whose activities are weighted heavily in favour of this approach are HIAM Health (with their in-patient rehabilitation centre), CCT, YMCA and FUSONA (with their medical clinics), Alola (with maternity packs), CVTL (with their integrated program linking nutrition and

hygiene to water systems), Caritas (with example gardens and toilets), and HealthNet (with food preparation and cooking classes). HIV/AIDS programs, such as from FTH, SHC, Caritas, and Cailalo always include condom distribution along with their messaging through pamphlets and meetings, and are part of the government coordinated VCCT program (Voluntary, Confidential, Counselling, Testing).

A related function of the emphasis on concrete activities is the aim of NGOs to also provide models of good practice that can not only build the confidence of patients to access better quality services, but also act as an exemplar for state services. This is particular the case for NGOs with well-established medical clinics (such as CCT) and for those whose work directly feeds into government services (such as HIS's work with SISCa).

Train and deploy volunteer peer educators: Training and deploying volunteer peer educators is a dominant BCC methodology among the NGOs. The objective of such programs is to nest trained people within beneficiary communities to communicate with them on a regular basis, with repeated opportunities for example setting and mentoring to build knowledge and acceptance of healthy behaviour. Example programs include CVTL's ICBRR program that deploys 25 volunteer peer educators in each of its 22 target villages; CCT's 'community extension program' has 50 extension workers operating in a similar way to PSFs (HealthNet and Caritas have similar programs). CCT's Men's Health program also trains key male village leaders to act as role models in their communities. Along with CVTL, the most established and extensive network of peer educators is that of FTH, which has 172 peer educator volunteers in five districts. Establishing support groups, such as Alola's 'Mother Support Groups', is a variation on the peer educator methodology emphasising collective mentoring. This method will also be central to the Community Driven Nutrition Improvement Program through its 'Care Group Model' (in which Cailalo participates via CRS).

Training & information dissemination: As well as training of volunteers/peer educators, most NGOs carried-out training and information dissemination to target groups (such as youth, pregnant women, mothers, community leaders). While some NGOs (such as CVTL, SHC and Caritas) also disseminate information more widely during large-scale activities (such as celebrations for world days, for HIV/AIDs for example), information in the form of pamphlets is most frequently linked to trainings, workshops or presentations that have a more select audience. Some organizations, such as HealthNet and SHC, also use (or are in the process of creating) multi-media and theatre as part of training or presentation (such as presentation in schools). For all NGOs, the focus is less on large scale/mass media campaigning, but on a more targeted dissemination of information.

In sum, the methodologies of the NGOs treated focus on working closely with individuals and small communities through trained volunteer peer educators, with

targeted information dissemination for groups of constituents, and with health promotion linked directly with practically meaningful activities.³ Such specific targeting and personal attention, which is recognized as vital to introduce sometimes very new concepts and affect significant changes in people's behaviour, is necessarily resource intensive. The challenges of reconciling these methodological priorities with a constrained funding environment are addressed in the next section.

2. Capacity & Resources

2.1. Funding, Dependency & Sustainability

Analytical Question: How do organizations seek funding? How do organizations tailor strategic planning, or make adjustments to existing plans, to secure funding?

Analytical Question: Do organizations receive stable funding, or enough funding to fulfil their strategic planning? If not, how do organizations manage funding constraints (such as in context of maintaining qualified/competent staff, project planning, and organization sustainability)?

The NGOs are largely reliant on international donors for funding, including that which is administered through the Ministry of Health (such as Global Fund). Some organizations seek funding from alternative sources, such as donations and professional services, but these are generally small amounts. Funding is primarily on a project basis within limited timeframes, and most organizations have difficulty securing core funding. Project-based funding necessitates close alignment in strategic and methodological priorities with donors, and – while not always the case – smaller NGOs tend to fulfil the role of sub-contractor for larger organizations.

There are several different funding modalities that local organizations utilize. Many NGOs are largely dependent on international funding from bi-lateral and multi-lateral agencies, which is often channelled through sub-contracted work with international NGOs or administered through the MoH (Global Fund). Few receive small amounts or material contributions (such as medicines) directly from the Ministry of Health. Organizations with larger budgets (specifically for their health programs) include FTH, HIAM Health, Alola and CVTL, with annual spending between \$250,000 - \$700,000, while smaller organizations like SHC, HealthNet, HIS, Cailalo, YMCA and FUSONA range between \$1000 (HIS which is essentially working on a completely volunteer basis at the moment) – \$100,000.

Organizations that rely almost exclusively on a large single-sourced fund to support their activities include Global Fund supported projects in HIV/AIDS, TBC and malaria of FTH, Caritas Dili and HealthNet (note, HealthNet has MCH and nutrition focused

³ One organization, HIAM Health, that had been criticized in some circles for its in-patient service being too disconnected from locally embedded conditions, has now expanded its services to involve more household-level casework and mentoring in Ermera.

projects that do not benefit from this fund). CCT sources most funding through the National Cooperative Business Association (NCBA), but supplements its work with funding from USAID and Family Planning NSW for specific sub-projects (such as the Men's Health initiative). Other NGOs have a multiple of funding sources, which are usually of a much smaller value. HIAM Health for example receives funding (past and present) from the Sunrise Joint Venture, Jose Ramos-Horta Fortimo Fund, Hart (Humanitarian Aid Relief Fund), AusAID (ETCAS) and numerous individual donors. Similarly, Alola, Moris Foun and SHC – all locally grown organizations like HIAM – take funding from numerous sources, including UNFPA, UNICEF, USAID, GIZ, and Rotary.

It is notable that, even those with relatively long-term funding (such as FTH which is funded through 2016), are exploring options for alternate sources of funds that are not necessarily tied to particular projects specified by donors. For example, Alola and HIAM have become members of the Australian Foundation for the Peoples of Asia and the Pacific Limited (AFAP), a registered charity. CVTL's relatively stable funding through the international network of the Red Cross is an example to which these organizations aspire. SHC provides professional training services to local government and civil society in youth health issues, and also offers English and computer courses to supplement income.

The government's (Prime Minister's Office) Civil Society Fund is designed to support the sustainability of local NGOs, and this is seen as a potential source of stable funds. However, few of the NGOs treated had received funding (for example, Moris Foun) so far, and some are wary of the professionalism of the grant management (both on selection of grantees and timeliness of disbursement). But the fund is relatively large (approximately \$18 million in the previous budget) and organizations such as Cailalo, Moris Foun and SHC have registered recently as 'associations' with the Ministry of Justice to become eligible for funding.

The programming of local NGOs is responsive to the priorities and methodologies endorsed by the larger funding agencies. For example, programming momentum is evident, swinging towards focus on TBC (under the influence of the Global Fund – FTH and Caritas Dili) and nutrition (influence from Technical Working Group for Nutrition & Community Driven Nutrition Improvement Program – HealthNet, Cailalo, Caritas Baucau, FUSONA). Further, some smaller NGOs, such as Cailalo, SHC, and HealthNet's MCH program, have mostly worked as sub-contractors for international NGOs such as Health Alliance International, Care International and Save the Children to provide on-the-ground implementation support.

While NGOs are, at the moment, dependent on project funding from large donors it would be a mistake to suggest that the NGOs are passive in setting project priorities and methodologies. Specific funding requirements do limit activity options, and although all NGOs stated the need for more funding, it was not asked for novel

project types to fill conspicuous gaps neglected by donors or government planning, but for continuation and expansion of existing projects. In other words, some NGOs might often function as contractors for larger bodies, but the work program is consistent with their own priorities. Priorities coalesce based as much on local implementation experiences and research as that originating internationally. There is a well-defined feedback loop between local and international NGOs, donors and government through reporting, consultations and involvement in policy decision-making (such as through issue-based working groups). However, there are perhaps some opportunities falling outside of this dialogue, such as the capacity of local NGOs to both better design and evaluate projects, and influence and lead interventions in health service accountability. This shortfall will be addressed in the next sub-section and in Section 3: Partners & Coordination.

2.2. Organization Capacities

Analytical Question: What management structures are commonly used? Do any organizations have different or unique structures? How do different management systems impact on strategic planning / decision-making, fund-seeking and reporting?

Analytical Question: What plans and capacity do different organizations have for organization sustainability and/or expansion?

To a large extent, constrained funding also reflects constrained capacity. However, a qualitative assessment of the capacity of organizations in the health field must be made in context to other local organizations, such as other NGOs and public and private sector. In this respect, while challenges in keeping staff, conducting rigorous monitoring & evaluation, and reporting extensively on projects and finances are common, the treated NGOs are comparatively strong. Organizations can mobilize quickly and effectively when funding is available, and are strongly committed to their objectives.

Management: All organizations have boards of directors and clear decision-making structures, with managing directors and department coordinators. A significant difference between organizations is the extent to which they receive input from international staff, volunteers or board members into project planning and implementation. Organizations with strong management, such as CVTL, FTH, Alola, HIAM Health and CCT, have significant input from international advisors, which respondents (including those from organizations without such advisors) stated can be particularly useful for producing funding proposals and establishing rigorous reporting systems.

While the availability of skilled international advisors is seen as a plus, some NGOs, such as HealthNet, SHC and Cailalo, explicitly stated that their national management is a point of pride and difference, but that it is nonetheless difficult to develop

capacity in this area. Representatives from these organizations explained that funding to build management capacity, through better recruitment, conditions and professional development, is just as important as project funding to grow these organizations. However, most of their funding is necessarily allocated to project implementation, and it is thus difficult to maintain high capacity staff during dips in project funding (HealthNet and Caritas), and difficult to budget for management activities such as strategic planning (SHC). One organization, HIS, recently transformed from SHARE Japan into a locally registered and managed organization, has little budget for core costs and management development (\$1000 start-up grant from SHARE), and relies on volunteer labour and Ministry of Health in kind support for office space and transportation. These organizations all stated that have the track record of implementing well-managed, complex projects, but now lack organizational sustainability because of scarce funding.

Reporting and Monitoring & Evaluation: While organizations are experienced in on-the-ground project implementation, there is a clear need to improve reporting process, especially with regard to project design documents and monitoring and evaluation systems. Basic financial reporting and the reporting of activities through activity 'action plans' are better developed, and the fiduciary aspects of funding arrangements prioritize this (for example, Global Fund requires regular reporting of activities to the Ministry of Health and also require regular auditing; other major donors have similar minimum reporting requirements for activities and expenditures). Larger, higher capacity organizations, such as CVTL, CCT and FTH, have relatively good design documents and M&E systems for their institutions, but smaller and less well funded organizations, and without a lot of support from international advisors, such as SHC, HIS, FUSONA, Cailalo, Moris Foun and Caritas, have only basic reporting and monitoring procedures.

There is, however, recognition that these processes should be core parts of project management and institutional procedure (for example, SHC has recently established an M&E staff position for the organization), but lack of funding and/or funding modalities means that these cannot be prioritized as well as other, more immediately practical, activities. It is common that donors conduct project design and evaluation, and these are not responsibilities devolved to grantees. This is a major shortfall in the capacity of local organizations, especially those conducting behaviour change communication activities that require locally sensitive project design and fine-grained monitoring and evaluation to measure results and impact.

Staffing: All organizations – even the smallest sampled NGO, HIS, with very limited budget and five staff – have staff with some form of training in health care (particularly nursing and midwifery) and/or health promotion which (with qualitative and self-assessment) places them equal to, and sometimes better than (CCT clinics being an example), with equivalent government services at a technical level. At the same time, and as can be expected, all also seek to improve the quality of

their work (FUSONA and Caritas for example are allocating budget to allow staff to obtain formal degrees in nursing). It is generally acknowledged that relative to national standards in health services, NGOs make a strong contribution considering budget limitations.

However, consideration must not only be given to technical competency to provide basic health care, but also abilities to design, implement and evaluate demand creation and accountability work. In terms of project implementation, there is a high degree of overlap, especially given the methodological orientation that emphasises practical links or demonstrations as part of health promotion. Training and deployment of peer educators is a strong facet of the work of most NGOs, as is conducting community meetings and workshops, and NGO staff are strong in this area. In fact, there is difficulty in keeping valuable staff after or between projects, as they can be sought after by other organizations and government.

The areas for improvement come, rather, at the level of project design and monitoring and evaluation. As stated above, organizations are not without ideas or influence in consultative processes, but due to funding modalities can lack opportunities to take more responsibility in the technical aspects of project design and evaluation – and this includes developing staff capacities to fulfil these roles. There are exceptions; CVTL and CCT for example have stable and flexible enough funding to initiate some projects (such as the ICBRR and Men’s Health projects), and HIAM Health has an established Malnutrition Rehabilitation and Education Centre that donors feed into (but is nonetheless difficult for HIAM to maintain necessary funding). A further distinction must also be made between demand creation and accountability work. As will be explored further in the next Section: Partnerships & Coordination and the Conclusion, accountability projects are few, and the capacity of staff to conduct research, analysis and writing to this end are limited.

3. Partnerships & Coordination

3.1. NGO’s in National Political & Institutional Context

Analytical Question: How do organizations plan and implement programming in coordination with the Ministry of Health?

The key partner for all NGOs sampled is the Ministry of Health, and there is close coordination in programming, including at national and district levels and through MOUs and some funding (or in-kind support) arrangements. The research did not interview members of the MoH, and is not in a position to draw conclusions about the extent to which MoH influences or approves NGO planning. For present purposes it is possible to conclude that all NGO programming is aligned to MoH priorities and would currently unlikely to be otherwise. Further, while NGOs are focused on

demand creation through health promotion, there is minimal programming explicitly aimed at critiquing the accountability of government services.

The close engagement with MoH is immediately noticeable through the number of NGO programs that either feed directly into government, or government supported, programs. For example, the Alola Foundation's birth preparedness plans and newborn care program involve work with district health services and hospitals. Similarly, the projects of HIS, SHC and CCT which provide support to SISCa, either through training of PSFs or operating some of the SISCa 'tables'. HealthNet and SHC as part of the PDSS (Village Health Development Plan – as part of *HADIAK*) works with local government, village authorities and communities to support grassroots planning for health needs and access. Organizations that link health promotion with clinical services (such as CCT, FUSONA, and YMCA) coordinate closely with district health services to provide better patient coverage and tracking. Some provide training to public servants, such as HIAM Health's training of agricultural extension workers on nutrition issues. Organizations carrying out work on HIV/AIDs, TBC and malaria (such as FTH and Caritas) are funded through the Global Fund, which is administered by the MoH. All these NGOs work under MOUs or other agreements with the government (such as CVTL's status under Decree Law as an institution auxiliary to government).

The relationship is symbiotic: It is mutually advantageous and requires close coordination. NGOs that engage with mainstream government programming, which is also established with input from international agencies such as through the National Health Sector Strategic Plan Support Project and the like, put themselves in a strong position to receive endorsement from MoH and attract international funding. And the government receives assistance to its programs: Supporting SISCa is a clear example of the benefits the NGO sector can bring to a government program that might otherwise struggle to achieve its objectives with rural populations). NGOs can also develop initiative that eventually can integrate into government planning government, and is a desirable pathway to sustainability for projects (such as HIAM Health's Atauru child nutrition project).

NGOs are, without exception, conscientious about coordinating their district level activities with the DHS and through the District Administration (such as participating in district integration meetings). Health promotion messaging on issues from family planning, sexual health to child feeding is clearly consistent with MoH prescriptions (such as outlined in the National Behaviour Change Communication Strategy (2008-2012)). There are undoubtedly differences of opinion and criticism about certain practices and conditions: For example, the unavailability of certain medicines (such as for STIs or general lack of supply of basic medicines) and the cleanliness and service standards of health clinics and hospitals arose as frequent criticisms. But the coherence of NGOs, government and donors on broad priority issues and methodologies presents a united front.

This unity, however, might also constrain the critical work of NGOs. The sampled NGOs are not traditional advocacy organizations, like Lao Hamutuk or Luta Hamutuk for instance, that maintain a degree of independence from government (these two, for example, do not seek government funding). Instead they are better defined as service delivery organizations that also have a health promotion focus. These organizations, for the most part, lack research and advocacy capacities (exceptions are Alola, which recently conducted a study on women in the private sector to feed into the 2012 Labor Law, FTH which is exploring injecting drug use, and CCT with a study on men's health). Equally importantly, the organizations have an ideological disposition to promote better services through setting an example to the state, rather than through formal critique. The one critical piece of work from a local NGO viewed as part of this research that sought to bring public health service deficiencies to the public attention was from Luta Hamutuk, which is a multi-sector advocacy and not a health sector specific organization.

3.2. Church & Peers

Analytical Question: What key partnerships do the organizations maintain, including with religious institutions and among themselves, and are these partnerships consistent for different NGOs?

Several of the NGOs sampled are part of, or closely connected with, the Church or religious institutions (such as Caritas and FUSONA). Even those organizations with programs (such as adolescent reproductive health and condom distribution) that might conflict with religious interests state that they cooperate well with the Catholic Church. Coordination between peers is perhaps more fraught, with some protectiveness apparent.

Those organizations with Family Planning and Reproductive Health programming are careful to engage with the Catholic Church, and few serious objections have been encountered. In fact, many religion-based organizations, such as Caritas, FUSONA and SVD also implement such projects, with a focus on birth spacing, natural birth control methods, but also condom distribution. Projects are routinely socialized/explained to parish priests and locally influential religious orders, and some projects work directly with the Church to distribute information (including FTH). Absence of significant disagreement in this respect is likely due to the close alignment of NGO and government programming, and that discourse between Church and government occurs prior to policy decisions or exterior to planning that involves NGOs. That is, NGOs are diligent about following government guidelines, and so any issues that might arise are bracketed in negotiations between church and state.

The coordination between local NGOs seems to be less cohesive than coordination between local and international NGOs. Local NGOs are much more connected with

international NGOs than with each other. Many have partnerships with INGOs, most based on funding (for example, HealthNet works often with Health Alliance International, recently on a film production, SHC has long-term engagements with GIZ and UNFPA), but some coordinate in other ways. For example, CCT allows Marie Stopes International to use CCT clinics where MS doesn't have its own. A previous MOU has been ended and a new one is in draft after a breakdown relating to CCT asking MS to use different contraception procedures in their clinics.

During the research respondents from local NGOs tended not to speak about their peers and/or were unwilling to discuss their peers when asked, and were more knowledgeable and open about international organizations. Competition for funding is perhaps partly responsible: One NGO questioned the need to survey new or other local NGOs working in the same field because (with justification) their NGO has a proven record and yet still struggle to attract necessary funding. Further, the centrality of government, and its prime importance as a partner for local NGOs who tend to work in a straightforward service delivery mode (rather than advocacy) might perhaps subordinate the need for cooperation between NGOs in setting coordinated policy and objectives. Or perhaps other factors are significant. In either case, the NGOs sampled represent quite a segmented group in terms of peer coordination.

4. Conclusions

The analysis has moved from an examination of approaches, which shows a diversity of origins and funding but uniformity in priorities and methodologies, to a discussion of Resources & Capacity and Partnerships & Coordination that provides some explanation for this uniformity. Close engagement with government, as well as targeted funding opportunities, have contributed to a well-coordinated and consistent set of projects seeking to improve people's health knowledge and willingness to access services. In sum, there is a strong and cohesive campaign to improve demand for health services by a small and committed, but relatively resource constrained, group of local NGOs. However, perhaps due in large measure to this same cohesion, critical programming to improve the accountability of health service delivery is minimal.

Standing (2004)⁴ outlines five key demand side approaches to improving to health services and outcomes. As the table below illustrates, Timor-Leste's NGOs are currently implementing variations on several of these approaches:

Demand Side	Characteristics	NGO Focus
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⁴ Standing, Hilary. 2004. *Understanding the Demand Side in Service Delivery: Definitions, frameworks and tools from the health sector*. London. DFID Health Systems Resource Centre.

Approaches		
<i>Behaviour Change Communication</i>	Information sharing, education (mentoring, training), campaigns & media contributing to more knowledgeable citizens, empowered to make better decisions.	All NGOs use this approach, having strong foundations, experience and willingness, especially when messaging is combined with the practical instruments to apply knowledge.
<i>Rights-based</i>	Increase recognition of and conduct advocacy for vulnerable communities to access their rightful services.	An influential core principle of the work of all NGOs, who work with vulnerable or at risk groups, such as remote and poor populations, pregnant women, children, and those with illnesses such as HIV/AIDs and TBC. Currently a push by some (such as FTH and SHC) to have legal framework for work with injecting drug users.
<i>Participatory</i>	Involve local community leaders and citizens more closely in the provision of services, such as in planning and using local labor and expertise when possible.	NGOs have a strong focus on working with community-level volunteers and peer educators. Many engage with broader community and local leaders through training/workshops. Some explicitly work on developing community planning process, such as through the PDSS.
<i>Multi-sector</i>	Partnerships between civil society, government, and private sector, commonly around a single issue (such as malaria, HIV).	This is especially evident around the HIV/AIDS work, with the Global Fund, MoH and local NGOs cooperation. CCT link with NCBA shows engagement with industry.
<i>Demand-side financing</i>	Providing 'purchasing power' to certain groups, such as vulnerable or at risk communities, to buy the goods or services they require (e.g., using vouchers).	This is not a part of local NGOs work in Timor-Leste in the context of limited NGO funding and free health care.

It is evident that Timorese NGOs are engaged with most orthodox approaches to demand creation. Existing commitment and experience can be grown through continued and increased funding in these areas. The situation with regard to accountability creation is somewhat different: Capacity and willingness is more limited. Several accountability approaches, including some recently reviewed by Hoffman (2014),⁵ show good results internationally, and the table below illustrates the limited work by the Timorese NGOs in this area.

Accountability Approach	Characteristics	Situation in Timor-Leste
<i>Research & Monitoring</i>	Data collection and analytical work to identify constraints in and	Rarely or unsystematically conducted by health-focused NGOs. The PDSS program,

⁵ Hoffmann, K.D. *The Role of Social Accountability in Improving Health Outcomes: Overview and Analysis of Selected International NGO Experiences to Advance the Field*. June 2014. Washington: DC. Core Group.

	opportunities for better service provision, to inform policy and procedures. Options include discrete research projects based around specific issues or on-going monitoring of service delivery.	with involvement from SHC and HealthNet is the most notable project with accountability creation components (see Annex 6 for more detail). General political advocacy focused NGOs are stronger in this area, but themselves rarely focus on the health sector. Some NGOs do conduct a kind of 'informal' monitoring by virtue of being involved in health service delivery (such as through involvement in SISCa), but systematic monitoring or research projects are needed. There is a great deal of opportunity for novel work in this regard.
<i>Citizen Charters</i>	Agreements about service delivery quality and outcomes made between service deliverers and citizens, and formalized through community meetings. Charters can be part of participatory planning process and include key performance indicators for participatory monitoring.	No instances of implementation of Citizen Charters by the sampled NGOs.
<i>Community Scorecards</i>	Separate from or part of participatory monitoring systems, community members regularly score the performance of service delivery based on key indicators.	No instances of implementation of Community Scorecards by the sampled NGOs.
<i>Grievance Redress Mechanisms (Complaints Handling)</i>	Provides avenues for users of services to voice problems and have them dealt with, as well as provide recommendations for improvements. Can include participatory feedback collections and the use of telecommunications.	No instances of implementation of GRMs by the sampled NGOs.

Strengthening the work of accountability creation is not simply a matter of funding, but also of encouraging an environment in which organizations can confidently and productively conduct such work, especially with regard to their engagement with the Ministry of Health. The NGOs sampled are in a sensitive position because of their primary role and ideological orientation as supporters, rather than critics (even if constructive critics), of public service provision.

Cooperative efforts to increase the quality of services are more easily mobilised around demand creation through health promotion messaging. The value of demand creation work is well recognized, and experience and expertise exist: Only expansion of projects and sustainability of organizations is needed to developed the work. On the other hand, accountability work can be a thankless task, and requires a different skill-set. NGOs can have a role in this regard, but it will be important to springboard

from their technical capacity in health care & promotion and grow both their motivation and capacity to carry out better research, monitoring, and complaints handling. Some steps that might be taken include (more specific recommendations for different NGOs are presented in Annex 6):

- First support research projects, and thereafter monitoring and participatory accountability projects, leaving grievance redress projects until the understanding and use of accountability projects is more mature. Grievance redress mechanisms can be more politically sensitive than other methodologies. Building basic research capacity in data collection, management and analysis also provides a foundation that is necessary for other accountability methods.
- Facilitate partnerships between NGOs from the health sector and more traditional political advocacy NGOs. The latter have more research and monitoring experience, although mostly related to non-health issues. If well designed and managed to ensure a balance of inputs and mutual agreement on findings (or at least presentation of findings) this could be an effective way of introducing health-focused NGOs into the field of social accountability .
- Support the development of NGOs monitoring & evaluation of their own projects, building their capacity and systems to better record and critique their own activities before applying similar methodologies to the monitoring of the service delivery of government or others.
- Similarly, introduce participatory accountability projects (such as citizen charters & community scorecards) in locations where the NGOs have existing commitments, and position the activities as integrated parts of on-going projects. Most of the NGOs have applied programming (such as clinics), and trust can be built between NGOs and government (and between both and citizens) by showing commitment to self-evaluation and gradually introducing government activities into established accountability systems.

Annex 1: Summary of NGOs

Name	Issue Focus	Project Approaches	Project Locations	Funding Sources	Management, Capacity Summary
Associacao Moris Foun-Manatuto (AMFM)	Reproductive health and HIV, health and hygiene promotion, child and maternal health and nutrition.	Training and workshops: Information on breast feeding and how to improve nutrition of babies are provided and given to the mothers to bring home to read. Those who do not know how to read, they are visited by the community volunteers in their area to explain to them. Information personal hygiene. Demonstration toilets. House to house visits; Pamphlets containing information on personal sanitation and hygiene are provided and distributed to the community. If NGO does house visiting, the pamphlets are pasted in the community houses to become the source on information for their family.	Manatutu District: Sub districts of Manatuto, Lacro and Laleia	Child Fund Timor Leste funds the health program and provides 36000 a year. UNICEF & USAID for hygiene programs.	Moris Foun association is consisted of board members to oversee the overall function of the association. They have the right to recruit a manager to manage the association and the manager can further staffs to work under him or her. Currently, the association has more than 30 staffs. One health staff oversees all health related projects program implemented by the association. Under the health staff there are seven health, hygiene and sanitation promotion staffs, three reproductive health and HIV facilitators, and 21 voluntary community members based in all 21 SISCAs centers in the district. One SISCAs center has one facilitator.
Associaçao Nacional Juventude Christian Timor-Leste (ANJUCTIL) (YMCA)	Maternal and Child Health	YMCA identified the need of midwives and Xefe suku and xefe aldeias recommend voluntary community members to attend training at the Bairro Pite Clinic (BPC) to become voluntary midwives in the villages. YMCA takes care of the transportation costs to transport voluntary midwives to come to Dili to attend two week training in BPC. They have one week training and one week practical session with BPC before going back to the villages to deliver babies or help women for labors. YMCA run workshops and information sessions with the community to improve their knowledge	Rotutu and Letefoho villages of Same Sub-District, Manufahi	YMCA Korea; Chest Foundation Korea	The YMCA has 11 staffs, five full time and six volunteers. Out of these three people are managing health sector in the village, though they do work together. None of the staffs have health backgrounds and highly school is their highest qualification. Reports for finance and activities are written on monthly basis as the fund is allocated every month to the village. The reports include number of

		regarding mother and child health.			pregnant mother visiting the clinic, number of delivery, types of medicine used and needed and sometime they bring their report every week to Same. These reports are also share with the district health office and the Ministry of Health of Timor Leste.
Cailalo	Nutrition; HIV/AIDS	HIV: Schools: power points to explain the information, provide pamphlets with HIV information and counseling to encourage students to visit hospitals to get themselves tested for HIV. Now discontinued, focus on nutrition only. Nutrition: education and promote key hole garden in the community to improve their livelihood and increase nutrition for the family. The NGO staff give information and teach communities to collect stones, dirty water (water from the kitchen) woods and build key hold garden near their house to plan vegetables. The facilitators demonstrate it by building the key hold for the communities to use and plan vegetables and anions. These crops are to consume in the family to improve nutrition.	Health: Baucau Vila Sub-district; Nutrition: Communities in Osohuna and ceisal of Baucau district, Builale in Viqueque, Kairui in Manatuto and Serelao in Lospalos.	CRS	Cailalo has 7 staffs one administration officer and six program facilitators working to implement projects. In terms of reporting, NGO provides both narrative and financial reports to UNDP every three months for the three years where the project was taken place. The project was also monitor by UNDP every three months to see its progress. There were also reports written to FONGTIL every three months as FONGTIL was the main umbrella for all NGO's operating in Timor Leste. CRS provides 20,000 a year for the project to be implemented by CAILALO. CAILALO is a donor dependent association and currently it has only \$2000 in their account.
Caritas Dili	HIV/AIDS; TBC; Basic Health; Leprosy; Medicine distribution.	HIV/AIDS; TBC: Recruit volunteers at SD level, work closely with DHS to indentify and manage cases; workshops with local authorities & already established women's groups; brochures and presentations in schools; Films (shown in village offices); Counseling. Basic Health: example toilets for 5 households.	Dili Diocese. TBC program also covers Oecusse; Aileu, Likisa, Ainaro, Ermera (presence in all sub-districts). Basic Health: Oecussi (SD Oesilu) & Ermera	Global Fund (-2016); Caritas International; CRS (recently ended); Yayasan Bestheda Timor-Leste.	15 staff (formerly 38 staff when running CRS/Caritas funded disaster risk management program). Financial reporting and auditing per funding requirements (i.e., reporting when necessary to donors).

			(Hatulia)		
Caritas Baucau	HIV/AIDS; Primary Health Care (mobile clinic); Nutrition	For mobile clinics, CARITAS staff visit remote and isolate households to provide basic information and basic health treatment to the communities in the area. For HIV projects senior high school and colleges under the diocese of Baucau are the target groups. Caritas staffs visit high schools and colleges to explain signs and symptoms of HIV and how a person can get infected to school student to improve their knowledge related to HIV.	Baucau Diocese	Ford Foundation; CRS	29 staff. Finance and project activities report are written twice to three times a year. Yet it depends on the donors which approved the fund. When there is project taking place, the project is audited internally by staff in CARITAS.
Clinica Café Timor (CCT)	MCH; men's health; Family Planning; Immunization; Basic Health Promotion	Community extension program: community mapping, extension workers recruited & trained in basic health promotion who assist with SISCa and provide health promotion at clinics; house visits. CCT clinic staff trained in health promotion. Men's health: training 'peer educators'.	Ermera, Ainaro, Aileu (to be advised)	NCBA; MILK; USAID; UNFPA; Family Planning NSW.	Member of NCBA. Approx. 50 clinical staff and 50 extension staff. M&E systems in place. Monthly reporting to government; Regular Project and Financial reporting internally and to donors.
Cruz Vermelha de Timor-Leste (CVTL) Dili	'Community-based Health' – integrated program of nutrition & MCH. HIV/AIDS	Vulnerability assessment; identifies and trains volunteers (25 per village); provides health promotion through volunteers; use 'hardware' (e.g., toilets) as a basis for practical health promotion messaging & to create demand. Establish volunteer groups for different topics, messaging through schools.	'Filial' offices in 13 districts. Each filial focus on 1-3 villages.	Global Fund; Sunrise Joint Venture; International Red Cross funding; Government funding (core costs)	National organization recognized by Decree Law. 'Auxillary' role to government 144 staff. M&E systems in place with mid-term reviews and project evaluations. Financial reporting and auditing are rigorous.
CVTL Baucau	'Community-based Health' – integrated program of nutrition & MCH. HIV/AIDS	ICBRR as above. CVTL Baucau did have HIV prevention projects in 2013, but it has stopped in 2014 because there has been no fund allocated to it by CVTL national in Dili. Also SISCA (table 5).	ICBRR in villages Oralan; Haurobo; Atelari. Other activities (meetings, trainings,) coordinated out of the central Baucau office.	Australian Red Cross, administered through CVTL Dili.	Three staff. As above.
Fundasaun Alola	Maternal & Child Health	Supporting the Baby Friendly Hospital Initiative & Newborn Care and Safe Motherhood by	All districts except Covalima and	UNICEF; UNFPA;	20 staff (in health department, including field staff). Technical staff trained as

		promoting breastfeeding and distribution of 'maternity packs'; Mother support groups & Suco Hadomi Inan no Oan groups: promoting breastfeeding and complementary feeding; Birth Preparedness Plans	Bobonaro	Sunrise Joint Venture; AFAP; Rotary; AusAID (ANCP)	midwives and in public health; financial reporting and auditing.
Fundasaun Sosial Naroman (FUSONA)	Maternal & Child Health; Nutrition	Pharmacy and basic clinical services in two locations, support to SISCa and also own mobile clinic once per month. Provides health promotion in maternal and child health and nutrition and counselling through the outreach of staff anchored in the pharmacy, clinical services. Nutrition project plans to provide training and exemplars of 'natural medicines'.	Los Palos (Suco Fuiloro); Manufahi (Same SD)	Uniting Church Australia, New Zealand and Netherlands	11 staff in health and nutrition projects, including clinical staff. Technical support from international doctors (through Uniting Church), but local staff do not have formal degrees (but long experience, many working since the 1980s). Budget will be allocated next year for staff to be formally trained in nursing.
Fundasaun Timor Hari'i (FTH)	HIV/AIDS. Potential move to include TBC.	Peer education; testing; 'drop-in' centres. Volunteers recruited from the gay community, trained as peer educators. Targets at-risk population (does not undertake national promotion activities). ToT for FTH staff, training of volunteers to use the 'basic service package'. Volunteers work out of drop-in centres. Developing audio-visual materials for use in drop-in centres.	Dili and four district offices (Covalima, Baucau, Bobonaro, Oecussi)	Global Fund (administered through MoH.	67 staff, 172 volunteers (peer educators). Funded til 2017. Regular project and financial reporting including internal and external audits (inc., quarterly audits from Global Fund).
Grupo Feto Foin Sa'e Timor Lorosa'e (GFFTL)	Women empowerment	Domestic violence, literacy, leadership and women's rights. Provides training to remote and vulnerable women.	Viqueque (SD Ossu, Suku Uabubo and Builale). Baucau (SD Venilale, Suku Fatulia). Liquisa (Suku Neran and Tibar). Also Oecussi and Suai.	Unio Aid Abroad-Apheda. Oxfam Australia.	9 staff. Their program does not include explicit work on health promotion, but they have long experience and strong roots in advocacy on women's rights and empowerment.
Haforsa Informasaun Saude (HIS)	MCH Health Promotion and technical support to SISCa	Primary activity is to complement SISCa (on tables 1, 2, 4 and 5). Also provide training to PSF and other public health workers, and visit schools for reproductive health promotion.	Aileu	Limited carry-over funding from SHARE. No other	4 volunteer staff. Strong experience in health promotion, and knowledge of project management, through previous work with SHARE.

				funding yet.	
Health Net	Nutrition; MCH; Family Planning; Sanitation	Workshops: training for pregnant women and mothers on nutrition, practical cooking demonstrations; research leading to advocacy; training for PSF; community theatre/drama and video production. Formerly worked in Ainaro on supplementary feeding program and case management of malnourished children.	Manatutu (Laleia, Natabora, Laçlo); Likisa; Aileu	Global Fund (Malaria); HAI; HADIAK; Save the Children	Originally operated as HealthNet International, when they withdrew a local organization HealthNet Timor-Leste was constituted nationally in 2006. 50 staff (most on malaria program). First financial audit this year. Board of Directors. National management with one international volunteer.
HIAM HEALTH	Nutrition	In-patient treatment combined with education for mothers; example community gardens; training/workshops.	Ermera (all SDs); Nation-wide referrals	Numerous funding sources, currently Sunrise Joint Venture; AFAP. Previous inc. ETCAS; HART.	Est. 2003. 40 staff. Operational and Financial Reporting annually. External audit annually.
Luta Hamutuk	Advocacy (primarily political and economic)	Have previously conducted monitoring/research on health service delivery in Dili district: <i>Working Paper on Health Service in Dili</i>	Nation wide	Numerous sources: EU, CAFOD, EITI, Revenue Watch, ANSA.	20 core staff with strong background in advocacy in several sectors, but focusing on financial management of petroleum fund. Strong experience in community-level advocacy, and good research experience.
Sharis Haburas Comunidade (SHC)	HIV/AIDS; Community Health (inc. sanitation); Youth Reproductive Health	HADIAK: support implementation of the PDSS (including capacity building for village authorities). Reproductive Health is their focus, seminars and other events in schools and universities. Coordinate with MoH to distribute 'info packets'. Share information through SISCa. Produced radio and television drama.	Manufahi (all SD).	UNFPA; UNCEF; GIZ; Save the Children (HADIAK); Commercial activities (English and computer training)	Youth focused, est. 2003. 19 staff (9 based in Manufahi). Have M&E officer, but recognize need to improve M&E system. Project documents limited to proposals and work plans. Strong, if centralized management. No international volunteers/advisors. Seeking funds to help facilitate strategic planning. Staff begin as volunteers and salaries are largely project dependent.

Annex 2: Question Guide

<i>Demand Creation Approaches: Question Guide</i>
A. Approaches
1. What projects/activities are the organization currently implementing? (Demand Creation or Accountability projects only).
2. For each of the current projects, what is the rationale for its implementation? - Why is it a priority? What problem is it solving?
3. What is the goal of its implementation? - What is the overall objective/ideal that is being sought? Are specific targets set?
4. What is the methodology of its implementation? - Specific project inputs, activities and outputs?
5. Who are the beneficiaries ? And which districts, sub-districts and villages are covered?
6. How does the program monitor results ? What are the results and sustainability? - If no formal results/evaluations, does the respondent have opinions on project results?
B. Implementation Context
1. How have the community attitudes (e.g., about health and reproduction) affected the implementation of projects? - Are services trusted? Are services thought to be effective?
2. Is there any institutional opposition to projects? - Do any religious or civil society groups disagree with goals or methods? Is there any pressure to avoid criticism of government services?
3. Other challenges/problems/obstacles?
C. Partnerships and Coordination
1. Does the organization have any partnerships with local or international agencies? - How do the organization's projects coordinate with local and national government and faith-based organisations (only for non faith-based organisations)? For example, integrated with District Planning?
D. Capacity & Resources
1. What funding does the NGO have (past, present, future)?
2. What is the organization structure (inc. leadership & decision-making positions)?

3. How many **staff** does the NGO currently have (specifically related to health projects)? Do they all have ToRs; does the NGO provide training for staff? Do all staff work from the NGO's office?

4. How does the NGO manage its **finances**? Bank account; Regular Finance Reports (budget, procurement, payments); Audits?

5. Does the NGO have strategic plans, annual work plans, project design **documents**? Ask for reports/documents if available.

6. Does the NGO have plans for **expansion**, by scaling up and starting new activities?

Annex 3: Interview List

NGO	Respondent Name	Position	Gender
Associaçao Moris Foun-Manatuto (AMFM)	Amadeu Dos Santos	Director	M
Associaçao Nacional Juventude Christian Timor-Leste (ANJUCTIL) (YMCA)	Oracio Mendes	Director	M
Cailalo	Agusto Pires	Director	M
Caritas Dili	Sister Felicia	Finance and Admin Officer	F
	Justinho Pinto	Health Program Coordinator	M
Caritas Baucau	Mario De Carvalho Soares	Director	M
Clinica Café Timor (CCT)	Acacio Sarmento	M&E Manager	M
Cruz Vermelha de Timor-Leste (CVTL) Dili	Juvinal da Costa	ICBRR & Health Promotion Officer	M
	Sonja Almeida	Human Resource Assistant	F
	Stuart Brian	International Advisor	M
	Januario Ximenes	Secretary-General	M
CVTL Baucau	Cipriano Magno Freitas	Branch Coordinator	M
Fundasaun Alola	Macu Guterres	MCH Coordinator	F
Fundasaun Sosial Naroman (FUSONA)	Helena Maplani	Director	F
Fundasaun Timor Hari'i (FTH)	Benedict Mukamba	Program Technical Advisor	M
	Apricio de Oliveira	Acting Director	M
	Gillian Hunt	Communications Advisor	F
Grupo Feto Foin Sa'e Timor Lorosa'e (GFFTL)	Andre Godinho	Interim Director	M
Haforsa Informasaun Saude (HIS)	Agustinha Gomes Madeira	Director	F
Health Net	Carlos Bel	Water & Sanitation Program & Office Manager	M
	Bernie McEvoy	Nutrition Advisor	F
HIAM HEALTH	Rosaria Martins da Cruz	Director	F
	Jill Hillary	Finance Advisor	F
Sharis Haburas Comunidade (SHC)	Sabina Seac	Director	F
	Luis da Costa	Health Program Manager	M

Annex 4: NGOs in Policy and Research Context

The assessment compares the goals, project methodologies and resources of different NGOs, and also addresses the operating context of local NGOs, including how their programmatic focus is informed by government & major donor programming (particularly through the Ministry of Health, Department of Health Promotion and the National BCC Strategy) and recommendations of major analytical work (particularly Health Seeking Behaviour Study).

Box 1: Timor-Leste Health Care Seeking Behaviour Study: Recommendations for Health Promotion

The 2009 study identified several factors inhibiting access to health services, including distance, associated costs, negative experiences with health care workers (anger, blame), and medical beliefs that differ from the western model (such as assumption that as most births are 'normal' they can take place at home. At the same time, the study showed that people tend to have clear expectations of what to expect during consultations, seek holistic treatment (medicine and counselling), value birth spacing, include families in health care decision-making, and obtain information about health from health workers and community leaders.

Based on findings, the study recommended that health promotion take a stronger role, especially improving communication and service links between service delivery agencies and communities. Further, the report recommended that health promotion activities be undertaken to encourage people to:

- Access to health care services and modern medicine (and understanding effective use of medicines);
- Understand and practice prevention;
- Ask questions about their care of health workers (and for health workers to be polite and responsive);
- Engage men in decision about birth spacing;

In sum, the report recommended that 'the MOH, working with local authorities, schools and development partners, should invest in, and evaluate, pilot interventions to improve health literacy' (11-12).

Box 2: National Behaviour Change Communication Strategy 2008-2012.

The BCC strategy focuses on developing key priorities and methodological options for effecting behaviour change in the area of reproductive health to inform Ministry of Health (Dept. Health Promotion) programming. The strategy highlights that, from a

communication perspective, efforts in Timor-Leste must recognize 'high vulnerability to disease, lack of education, language and cultural heterogeneity, and the dispersed population.'

The strategy identified stakeholders' priorities for reproductive health and principal outcomes (including public health messages associated with each). The strategy also examined baseline conditions of public practices and perceptions of reproductive health (based on original and secondary research [such as by HAI]). The strategy outlines the following four priority areas and outcomes:

1. Youth Reproductive Health: Young women delay the age of first pregnancy; Adolescent and young people delay sexual debut; Youth make informed choices about their reproductive health;
2. Family Planning: Women and men of reproductive age space their children by at least three years (from current birth to the next pregnancy);
3. Safe Motherhood: Pregnant women give birth with a skilled birth attendant; Mothers seek postnatal care within 7 days of delivery; Mothers seek second postnatal care within 6 weeks;
4. General Reproductive Health: Single and never married women/men make informed choices about their reproductive health.

The strategy recommends health promotion involve varied activities, including:

- Edutainment (radio and street drama);
- Community mobilization (training; participatory planning);
- Mass media and advocacy (radio, television);
- Interpersonal communication (dv ed. materials for use by cmtly health workers);
- Advertising (brand recognition for RH; t-shirts).

Box 3: Health Improvement Project / HADIAC (2011 - 2015)

USAID and Australian Aid support the Ministry of Health to improve service delivery, particularly in reproductive health, maternal and child health and family planning. The project, HADIAC (*Haforsa Distritu iha Implementasaun Atividade Kuidadus Saúde Primaria*), operates at the national level and in Baukau, Oekusi, Manatutu, Vikeke and Ermera.

HADIAC involves a strong health promotion and education focus to build knowledge and skills of the District Health Service, health workers and communities. It aims, inter alia, to:

- Implement evidence-based protocols in maternal and child health service delivery;
- Increase demand for maternal and child health services through health promotion activities and community mobilization (including working with the integrated community health services system [SISCa]);
- Increase community engagement around key maternal and child health issues, (including village level *Planu Dezenvolvimentu Saúde Suco* – PDSS, and better household nutrition practices).

Two Timor-Leste NGOs, HealthNet Timor-Leste and Sharis Haburas Comunidade, have worked on this project by supporting the PDSS process.

Box 4: Community Driven Nutrition Improvement Project (CDNIP) (2014-2017)

The CDNIP is funded through the World Bank’s Japan Social Development Fund (JSDF) and is implemented by the international NGO Catholic Relief Services with a total project cost of 2.84 million USD. CRS will contract work to local organizations, and thus it is an opportunity for funding for smaller district-based local NGOs.

The pilot project is implemented in Baucau and Vikeke districts and aims to benefit children under two and pregnant and lactating women. The project also works to increase the skills of health promotion workers, agricultural extension workers and community nutrition coordinators. The project will work closely with the Council for Food and Nutrition Security and Sovereignty and the Nutrition Working Group at the national level, and with district health and agriculture departments at district level. The project has three activities:

- Community sensitization and mobilization (Participatory Rural Appraisal and selection of Community Nutrition Educators).
- Increase knowledge and behaviour related to nutrition specific messaging with nutrition-sensitive solutions.
- Train for and implement nutrition-sensitive initiatives at both demonstration plots and household plots.

In relation to the second component (nutrition specific messaging) the project will deploy a ‘Care Group Model’ whereby behaviour change is achieved through the work of care group volunteers (from target communities) and community facilitators (from local partners). Facilitators will be trained in key health promotion messages will meet with care group volunteers twice a month to share health promotion messages. Care group volunteers then promote positive behaviors to the target parents. Facilitators also conduct home visits and small group sessions to build awareness and induce behavior changes around optimal infant and young child care and feeding, appropriate hygiene

(especially hand-washing), proper food preparation, disease prevention, and treatment.

CRS will coordinate with the Technical Working Group for Nutrition (MoH) to ensure Behavior Change and Communication (BCC) materials are aligned with the national nutrition strategy and existing initiatives.

Box 5: Situation Analysis of Community Practices in Health Activities

(Dr Amol Dongre, Consultant – Ministry of Health, Timor-Leste, Under GAVI-Health Systems Strengthening (HSS) Project)

This study is part of the Global Alliance for Vaccine Initiatives (GAVI), co-ordinated by the MoH's Department of Planning. The program involves activities to strengthen the demand side of health care, including in remote populations. The situation analysis aims to identify demand side barriers and make recommendations for future programming. Key recommendations include:

“1) strengthening of capacity building of community leaders and community volunteers in planning, monitoring and evaluation of the health activities in village level, 2) health education of local community through a defined behaviour change communication strategy, which addresses the barriers for desired behaviours, 3) improving the quality of care at all levels of health care delivery, 4) improving the coordination between health staff, NGOs and community for better delivery of health care to local community” (pp. 13).

Specific recommendations for NGOs and health promotion include (quoted in full, pp. 16):

NGOs:

1. **Upscale the innovations by NGOs** (e.g. Maternity packs for facility delivery and nutrition rehabilitation for malnourished children) – Community based groups of NGOs and their volunteers may be used for better delivery of primary care at community level.

Health Promotion:

1. **Involvement of Traditional Birth Attendants (TBAs)** in community mobilization – sensitizing them in various danger signs in MCH care. This is expected to facilitate motivation of mothers to access health facility and timely referral
2. **Strengthen existing schools health education program** through regular school health education activity. CHCs may be given this responsibility. Child to adult health education strategy for the promotion of immunization, personal hygiene and other MCH services may be used

3. **Use of media** such as TV and radio in health promotion activities and dissemination of health messages may be done
4. **SMS reminders for immunization and PNC** – Where there is high coverage of mobile phone user
5. There is a need to develop a behaviour change communication strategy.

Annex 5: Organization Profiles

Separate document

Annex 6: Responses to Review Comments and Questions

Church and Peers

It's great to know that the NGOs are working with the Churches (Religious institution) through several activities but it would be interesting to know about their practical experience on Family Planning, sexual and reproductive health and financial mechanism include the planning/coordination with the Churches?

No formal financial arrangements between NGOs and the Church (except for those NGOs that receive some or all funding through the Church – such as Caritas and FUSONA) were raised during the research. The cooperation (such as between FTH, SHC and nuns who work in the prison on HIV/AIDS health promotion) involved working together to distribute information. For example, brochures/information packs developed by FTH and SHC are given to the sisters to use as part of their own promotion activities. The relationship between NGOs and Church is more ad hoc than strategically planned – when the Church is part of the context, either working in the same location or with the same communities, then a working relationship is formed to share information and some resources.

The question of potential ideological differences between NGOs and the Church on traditionally contested issues like contraception and homosexuality did not come up strongly during the research. The respondents spoke quite carefully, stating that their objective is to present 'options' to citizens, rather than advocate particular family planning methods or sexualities, and that higher level issues of what is 'acceptable behaviour' to promote to people is mediated between Church and government. Most NGO staff are of course themselves Catholic and share the same values as the Church.

Demand Creation Approach And Accountability

Just want to know whether you have any thought about accountability creation between community and their local health post in delivering better service?

The Suco Health Development Planning is a good platform to build on in this respect. SHC and HealthNet were positive about the way it developed mutual knowledge between health service providers and citizens. Part of the PDSS should also be community monitoring of health services, and this is a core accountability activity, but in practice this is perhaps not occurring. Not a lot was written about the PDSS in the main report because not a lot of information came from SHC and HealthNet about what impacts they felt their involvement achieved vis-à-vis accountability: it was talked about more as a health promotion activity (to build people's knowledge of available health services). An evaluation of the PDSS would perhaps tell us why the accountability angle of the program didn't come out strongly (at least in the eyes of the NGOs). But in general I think strengthening accountability initiatives through PDSS would be a good way forward. PDSS outlines a good system in principle, it

might need extra inputs to create more enthusiasm, participation and impact in its accountability aspects.

Monitoring is challenging, and big efforts need to be made to plan and support community monitoring. It something easily asked of people, especially of Suco councils and PSFs, but it is difficult to organize and, more importantly, to be meaningful for both citizens and the service provider. Internationally, community monitoring has successfully been organized around Citizen Charters or Community Scorecards. These involve setting specific indicators to measure the performance of local health services which can then help guide monitoring, and results of which can be useful for service providers. The PDSS involves setting out problems and resources and establishes an action plan with indicators. In principle this is excellent, but talking with the NGOs it is unclear just how successful this has been in mobilizing people to monitor and evaluate over time. Introducing supporting participatory activities like Charters and Scorecards into this framework, and allowing local NGOs longer-term engagement, would help the PDSS build momentum in communities as an on-going and participatory process.

Any suggestions / recommendation from interviews about developing an integrated approach to build better demand creation and accountability creation?

All the organizations at the moment prioritize demand creation (through health promotion) over accountability, so it is a good point to look at integrating the two approaches – bringing in accountability work to complement demand creation. However, the respondents did not make any direct statements about this. In fact, respondents spoke little of potential accountability activities and were almost entirely focused on the need to raise awareness among citizens through health promotion linked with their clinical services or practical demonstrations. Two of the smaller local NGOs – SHC and HIS – touched upon accountability issues more than others (SHC through its PDSS work, and HIS through a recent ‘exchange’ program between SISCa staff from Aileu and Ermera).

Are any of the NGOs/organizations working with TBAs and what is their experience?

Alola Foundation includes TBAs in their women’s community groups (Suco Hadomi Inan ho Oan). Members of the groups receiving training on safe pregnancies, IYCF and other parenting skills for infants. Alola states that the TBA make important contributions to the groups, and are among the most active and influential health promoters. But this is not a development project exclusively targeted at TBAs per se, rather an opportunity or mechanism where TBAs can become more involved, along with other women, in bio-medical practices. Some other organizations (such as CVTL, Moris Foun) work in a similar way, seeking to engage with TBAs through groups and trainings, but not necessarily tailoring interventions specifically for TBAs. Further, the *Situation Analysis of Community Practices in Health Activities*, a summary annexed in Box 5, recommends that government and civil society do more to involve TBAs in health promotion because they are trusted and thus their referrals to state health services will be likely followed. There is a lot of potential in working more closely with TBAs, and further consultation with Alola on this issue would be helpful for more specific recommendations.

Partnerships

Do you have any practical information on how they work closely with MoH at all level? Which is MoH policy / strategies are they aligning with? Are the NGOs participating in quarterly coordination meeting / reviews at district level?

Cooperation between NGOs and government operates at several levels, including:

- Memoranda of Understanding and other formal funding or in-kind agreements: Those NGOs operating clinics (such as CCT) work with MOUs and are required to report monthly to the MoH; Several NGOs (such as CCT, Caritas, FUSONA) receive medicine from MoH; Organizations such as FTH, Caritas) receive Global Fund funding which is administered through the ministry.
- Membership of working groups and input into strategic planning: Larger local organizations such as CVTL, Alola and FTH regularly participate in or are consulted on by the MoH. For example, FTH participate in the Commission of HIV Prevention.
- Direct Assistance to MoH service delivery and training of personnel: Many NGOs engage closely with SISCa (such as HIS in Aileu) by providing personnel to staff many of the SISCa tables. HIS, along with others such as SHC, HIAM Health and Alola, provide training to government staff on MCH, HIV/AIDS and nutrition issues. Alola also works in referral hospitals and health facilities to distribute maternity packs.
- Planning Coordination and Information Sharing at District Level: All NGOs have district level activities, and all stated that they participate in coordination meetings to which they are invited, including district coordination meetings.

The NGOs are diligent in aligning their programs with MoH priorities and strategies, including:

- Those outlined in the National Behaviour Change Communication Strategy (2008-2012) (summary in Annex 4), including prioritising Youth Reproductive Health (e.g., delaying first pregnancy); Family Planning (child spacing); Safe motherhood (facilitating access to skilled birth attendant); and using community mobilization and inter-personal communication for health promotion.
- SISCa: And, more generally, bringing more health assistance to communities. Several NGOs either participate directly in SISCa or (like FUSONA, AJUNCTL, CCT) provide clinics and mobile clinic services to remote populations.
- HIV/AIDS (and leprosy, malaria): Through Global Fund initiative NGOs (such as FTH, Caritas, SCH) work to prevent the spread of these conditions through education, counselling and testing (VCCT), and treatment/management.
- Nutrition: This is a cross-sectoral issue, but the MoH does have a policy for nutrition, including prevention (including breast-feeding – Alola programming aligns), treatment (HIAM Health's Rehabilitation Centre aligns), and community mobilization (community gardens, health promotion, working with women's groups – HealthNET, HIAM, CVTL).
- MoH also has policy on Mental Health, and it is worth noting, while outside of the research sample, that numerous Timorese NGOs are active in this sphere under the coordination of ADTL.