



United Nations Population Fund (UNFPA)

Evaluation
of the 3rd Country Programme 2015 – 2019/2020
in Timor-Leste

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DISCLAIMER

This report represents the results of consultations and observations by the evaluation consultants. Views expressed do not necessarily reflect the views of the United Nations Population Fund.

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The evaluation matrix is a separate document.

MAP OF TIMOR LESTE



Source: UN (2019): UNDAF Evaluation, draft April 2019.

ABBREVIATIONS

ADB	Asian Development Bank
ANC	Antenatal Care
APRO	UNFPA Asia and Pacific Regional Office
ASEAN	Association of Southeast Asian Nations
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work plan
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BPP	Birth Preparedness Plan
CCM	Country Coordination Mechanism
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHC	Community Health Centre
CP	Country Program
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CSOs	Civil Society Organisations
DFAT	Australia Department for Foreign Affairs and Trade
DHS	Demographic Health Survey
EmONC	Emergency Obstetric and Neonatal Care
GBV	Gender Based Violence
GDS	General Directorate of Statistics
GoTL	Government of Timor-Leste
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, education and communication
INS	Instituto Nacional de Saúde (National Institute for Health)
IPs	Implementing Partners
LMIS	Logistic Management and Information System
MDGs	Millennium Development Goals
MISP	Minimum Initial Services Package
MOEYS	Ministry of Education, Youth and Sports
MOF	Ministry of Finance
MOH	Ministry of Health
MP	Member of Parliament
MSS	Ministry of Social Solidarity

MTR	Mid-Term Review
NAP	National Action Plan
NGO	Non-Governmental Organisation
PD	Population and Development
PHD	Australia-Timor-Leste Partnership for Human Development (PHD)
PNTL	<i>Polícia Nacional Timor-Leste</i> (Timor-Leste National Police)
RBM	Result Based Management
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health (strategy)
SAMES	<i>Serviço Autónomo de Medicamentos e Equipamentos de Saúde</i> (national medical stores department)
SDG	Sustainable Development Goals
SDP	Service Delivery Point
SDP	Strategic Development Plan
SEED	Supply-Enabling Environment-Demand (Model)
SEII	<i>Secretariado do Estado da Igualdade de Género e da Inclusão</i> (Secretariat of State for Equality and Inclusion)
SRH	Sexual and Reproductive Health
SSYS	<i>Secretaria de Estado pela Juventude e Desporto</i> (Secretariat for Youth and Sports). Formerly: Secretariat of State for Youth and Labour (SSYL).
STI	Sexually Transmitted Infection
TL	Timor-Leste
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United National Population Fund
UNICEF	United Nations Children Fund
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organisation
YAP	Youth Action Plan

KEY DATA ON TIMOR LESTE

Table 1: Key facts and figures about Timor-Leste

	DATA	Source
Geographical Location	Pacific Region	
Surface area	4,545,792 square km	
Population		
Population (inhabitants)	1.183,643 million	2015 Census
Population growth rate	2.9 % in 2010 – 2.1% in 2015.	2015 Census. DHS 2016.
Government of Timor-Leste		
Type	Democratic Republic - Semi Presidential	
Women in parliament	33.85 % (22 out of 65 seats)	Elections of May 2018
Economy		
GDP per capita (PPP US\$)	USD 2,036 in 2018	World Bank data
GDP growth rate	5.1% in 2016; 3.5% in 2017; -0.5% in 2018	Asian Development Bank Outlook 2019 update
Main economic activity	Oil extraction accounts for 80% of GDP	
Social indicators		
Human Development Index	132 out of 189 countries ranked	HDI report 2017
Under-employment	Unemployed 9,000; Inactive 366,000	Labour survey 2010
Life expectancy at birth	67 years men / 70 years women	DHS 2016
Maternal mortality ratio	195 maternal deaths per 100,000 live births	DHS 2016
Under-5 mortality rate	74 deaths per 1,000 live births.	DHS 2016
Infant mortality rate	30 deaths per 1,000 live births	DHS 2016
Neonatal mortality rate	19 deaths per 1,000 live births	DHS 2016
Health expenditure	1.3% of GDP	Human Dev. Report 2018
Births attended by skilled health personnel	Skilled health personnel assist 58% of deliveries, and facility delivery was at 42%.	DHS 2016
General fertility rate	General fertility rate is 4.2 children, a decline from 5.7 in 2009-10.	DHS 2010
Adolescent fertility rate (women aged 15-19)	6.3% in census 2010, Decreased to 5.6% in census 2015.	DHS 2010 DHS 2016
Marital Status (child Marriage rate)	54.6% of persons aged 15 years or more were married. Median age of marriage for women (15 – 49) is 21.7%.	UNFPA Timor-Leste 2015 Census Thematic Report – Marital Status
Contraceptive prevalence rate (CPR)	CPR of 24%, increased from 21% in DHS 2009/10.	DHS 2016
Unmet need for family planning (% of women in a relationship unable to access contraceptives)	Unmet need for family planning is 25%, decreased from 32% in 2009/10 with 6% unmet need for limiting and 19% for spacing.	DHS 2015-16 Teenage Pregnancy in Timor-Leste 2017.
People living with HIV, 15-49 years old, percentage	0.2 % in 2010	TL CPD April 2014 DHS 2009-10
HIV prevalence rate	HIV/AIDS prevalence of the general population is below 1%.	Global AIDS Response Progress Report 2015
GBV – physical and sexual violence	59% women aged 15 – 49 years, who have ever-partnered, had experienced physical and/or sexual violence by an intimate partner in their lifetime.	<i>Nabilan</i> Health and Life Experiences Study, The Asia Foundation, 2015.
GBV – emotional abuse	More than half (55%) of ever-partnered women experienced emotional abuse in their lifetime, and 44% in the 12 months before the interview.	<i>Nabilan</i> Health and Life Experiences Study, The Asia Foundation, 2015
Literacy rate	In 2015, general adult literacy rate was 64.4%	2015 Census monograph of Timor-Leste

EXECUTIVE SUMMARY

Introduction

This report presents the findings, conclusions and recommendations of the final Evaluation of the 3rd UNFPA Country Programme in Timor-Leste (2015-2019/2020), which was conducted by a team of external evaluators and took place in September- December 2019.

Objectives of the Country Programme Evaluation: the Country Programme Evaluation (CPE) had three main purposes: (i) Demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) Support evidence-based decision-making; and (iii) Contribute important lessons learned to the formulation of the 4th Country Programme in Timor-Leste. The audience of the CPE includes the UNFPA Country Office (CO), government counterparts and implementing partners, civil society partners, donors and sister UN agencies. The scope of CPE was to cover activities implemented, deliverables produced and results achieved during the period from January 2015 to end of 2019.

Objectives of the Third UNFPA Country Programme 2015-2019 (CP3)

The objective of the Third UNFPA Country Programme 2015-2019 (CP3) is to create an enabling environment for sexual and reproductive health, while strengthening capacities, targeting interventions for the underserved and addressing inequalities. CP3 focuses on vulnerable and underserved groups, with special attention given to young women (15 to 24 years old) who experience the highest maternal mortality, unwanted pregnancies and highest rate of gender-based violence.

The 3rd Country Programme has four Outcomes and five Outputs as follows:

- **Outcome 1:** Increased availability and use of integrated sexual and reproductive health services including family planning, maternal health and HIV, that are gender-responsive and meets human rights standards for quality of care and equity in access.
 - **Output 1:** Strengthened capacity of the national health system to improve access to and increase the demand for family planning (FP).
 - **Output 2:** Increased national capacity to deliver integrated sexual and reproductive health services and respond to gender-based violence.
- **Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.
 - **Output 3:** Increased national capacity to design and implement community and school based comprehensive sexuality education programmes that promote human rights and gender equality and increase the availability to young people of comprehensive quality, sexual and reproductive health information and services.
- **Outcome 3:** Advanced gender equality, women's and girl's empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescent and youth.
 - **Output 4:** Strengthened capacity of relevant government institutions and non-government organisations to implement the national action plan on gender-based violence.
- **Outcome 4:** Strengthening national policies and international development agenda through integration of evidenced-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.
 - **Output 5:** Strengthened national capacity for using data and evidence to develop, monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and reproductive health, youth and gender equality.

Methodology: the programme evaluation approach was based on OECD/DAC criteria of Relevance, Effectiveness, Efficiency, Sustainability, Coordination and Added Value which were covered under 10 main evaluation questions. The CP evaluation made use of mixed methods to collect primary and secondary data and to analyse and triangulate data by evaluation question as relevant to each source. Secondary data consisted primarily of programme documents and country assessment reports. Primary data was collected during the field phase from programme stakeholders through semi structured

interviews, focus group discussions and site visits / observations. The primary data collection reached a total of 95 individuals in 3 municipalities and at central level (Dili).

Limitations: the evaluation encountered a number of challenges during data collection. Due to recent reorganisation of the electronic filing system of the UNFPA Country Office, a number of annual workplan progress reports and Country Office (CO) staff monitoring reports were not located. During the field phase, the CPE team was able to interview a considerable number of stakeholders from government, civil society, UN and a donor. However, some stakeholders, including higher-level directors of the Ministry of Health, were absent to attend meetings abroad and two national holidays further limited availability of stakeholders for interviews and visits. Some school students and teachers were absent due to the exam period, and due to time limitations, the CPE team was not able to interview health facility users. Some UNFPA staff were unavailable for interview due to illness.

Conclusions

Relevance:

C1 - The UNFPA Country Programme (CP) in Timor-Leste is relevant with its interventions addressing population needs identified in national development plans and through participatory needs assessments and consultations with partners.

C2 - The UNFPA Country Office (CO) was responsive to changes in government policies and managed to reorient programme interventions to optimise buy-in and cooperation from government authorities. The CO also reoriented the CP geographic focus to respond to requests from central government and to changes in intervention requirements.

Added value:

C3 - UNFPA Timor-Leste has demonstrated real added value in its programmatic areas. Its technical expertise is recognised and appreciated by partners. The CO also adds value in engaging actively and effectively in policy dialogue, including in placing sensitive themes on the national policy agenda.

Gender equality and human rights principles:

C4 - The CP effectively takes into account gender equality and human rights principles. It promotes gender inclusion principles for the development of young women and men, promoting opportunities and equal treatment for all young people. The CP supported the rights-based approach of universal access to essential health and GBV response services and information by vulnerable populations. It also supported various assessments and studies which generated knowledge on inequities in access to information and services by vulnerable groups, which influenced the policy agenda of the government and partners and assisted advocacy for greater focus on vulnerable groups such as adolescent girls, people with disabilities, etc.

Sexual & Reproductive Health:

C5 - The CP was effective in contributing towards capacity strengthening of central level government for the coordination of service provision in areas such as Family Planning, emergency obstetric care and the health sector response to Gender-Based Violence. The CP furthermore made a significant contributing to ensuring the availability of contraceptives in the country during the programme period. CP advocacy led to the GoTL's commitment to gradually take over contraceptive procurement funding from domestic resources during the coming years. However, contraceptive stockouts in health facilities are continuing, a situation which MoH, UNFPA and partners are working to address.

Capacity strengthening of health service providers has started, particularly on FP, EmONC, MDSR, HIV/AIDS and on the health sector response to GBV. The capacity strengthening is highly appreciated by stakeholders interviewed. Training participants and stakeholders expressed the opinion that the training had greatly increased the participants' knowledge and ability, and had an impact on their performance. However, so far increases in participants' knowledge and ability has not been documented by the CP. CP training has not covered all relevant health workers due to lack of CP resources. Capacity strengthening was also not always carried out in a way that optimised integration of various subjects and key programme areas. Furthermore, capacity strengthening focused on training of service providers, without much involvement of service managers and municipal coordinators.

Adolescents and youth:

C6 - Advocacy by UNFPA with MoEYS and SSYS was highly effective and allowed them to develop ownership of and commitment to CSE interventions and become champions for raising awareness of adolescents and youth on SHRH/gender/GBV. The CP supported the roll-out of CSE programmes and training of teachers. However, implementation in teaching of students has not yet really taken off. The roll-out of CSE for out-of-school youth has not yet started. The programme area of adolescents and youth is strategic as it focusses on an important vulnerable group within UNFPA's mandate area. Achieving results amongst adolescents and youth can greatly increase the impact of the UNFPA CP on the population of Timor-Leste and its future.

Gender:

C7 - CP advocacy contributed to GBV having become a topic that government and partners feel comfortable discussing and are committed to tackle. With CP support, SEII has become committed and proactive in the coordination of the implementation of the National Action Plan for GBV, and the government has tools to respond to GBV in the health sector in an inclusive manner. CP supported capacity building efforts produced and strengthened relevant policies and tools for the implementation of the National Action Plan on GBV (NAP-GBV), particularly in the health sector and for provision of information on GBV prevention amongst adolescents and youth reached through CSE interventions.

Population dynamics:

C8 – The CP effectively supported capacity building of the GDS and enabled the government to produce an impressive number of high-quality surveys and studies to collect data on population and development issues. The CP was furthermore effective in promoting the use of data in programming and policy development by government institutions at national and municipal levels, who have started to use and request data for decision making and planning.

Efficiency:

C9 - In spite of budget cuts resulting in the CP having only about USD 1.5 million per year to fund activities, UNFPA and IP staff and operational costs, UNFPA and partners managed to implement a meaningful programme and achieve a large part of the planned CP results. The CO performed well in terms of CP financial management and corporate compliance. CP implementation suffered from delays due to political volatility and policy changes, which required frequent reprogramming of CP activities and budgets.

C10 - CP programme management, monitoring and evaluation was carried out well. The CO programme teams generally work in an integrated manner, although there is room for improvement. The M&E team trained UNFPA and IP staff on the CP M&E system. By using the UNFPA monitoring systems, the capacity of IP staff to report to the UNFPA CP monitoring system increased. The CP supported a number of assessments and evaluations in key CP programmes areas. However, the CP did not establish systems for assessing or monitoring the increase in capacity of staff trained and of systems strengthened, which makes it difficult to demonstrate the impact of the CP contributions to systems strengthening. Furthermore, CO staff do not use the CP and CPAP results framework as basis for monitoring CP performance in Timor-Leste.

C11 - UNFPA has established strong working relations with government counterparts in key sectors, which contributed to high-level commitment by these sectors to support - and in some cases champion - priority CP interventions. The CO is also working closely with key national and international civil society organisations and UN agencies.

Sustainability:

C12 - The CP was effective in integrating SRH and rights and concerns for young people, gender equality, gender-based violence and population dynamics into national policy frameworks such as sector development plans, policies and strategies and guidelines.

C13 - The CP was also effective in contributing to building systems and capacities of central level government authorities and civil society partners and increasing ownership and commitment to CP interventions. Documentation of successes, weaknesses and best practices of CP interventions has been limited so far.

Coordination:

C14 - The CO co-chaired and contributed actively to UN coordination mechanisms, and has supported and strengthened national (multi-)sector coordination mechanisms.

Recommendations

Strategic level

- R1 - The next UNFPA Country Programme 2021-2025 should have an overall focus on SRHR programming for adolescents and youth, including through multisectoral programmes with strong advocacy and engagement with government authorities and partners on key issues.
- R2 - UNFPA should continue to promote cohesion between the CP programme areas.
- R3 - UNFPA needs to continue to reflect on and demonstrate its added value and comparative advantage in the areas of GBV and adolescent development programming compared to other UN agencies, while maintaining an inclusive approach to the coordination of these areas.
- R4 - UNFPA should accelerate documentation of best practices and lessons learned of key interventions supported during the current CP, as well as documentation, knowledge generation, collection and dissemination in the new CP, to enable the CO and partners to use evidence for advocacy with government in order to influence policy development and promote replication where appropriate, and other countries can learn from Timor-Leste's example.

Programme Level

- R5 - UNFPA should continue to advocate with MoH and sector partners on the need for domestic financing of FP commodities, while maintaining contingency funding for contraceptive procurement and/or maintaining emergency supplies to avoid stockouts.
- R6 - UNFPA should continue to support capacity building of the health system in family planning, maternal health, emergency obstetric care, HIV/AIDS and GBV, including by supporting supportive supervision and mentoring of in-service trainees and by reviewing and strengthening pre-service training.
- R7 - UNFPA should advocate with Government for greater focus on HIV prevention in upcoming country funding applications to international funding mechanisms.
- R8 - UNFPA should continue to support to MoEYS and SSYS in the roll-out of existing SRHR / gender / GBV interventions targeting young people, while supporting relevant municipal and central authorities to conduct supportive supervision and monitoring of implementation and documenting results and lessons learned to continuously improve the approaches followed.
- R9 - To take advantage of current momentum amongst government and partners for tackling teenage pregnancy, UNFPA should promote and support multisectoral SRHR/HIV/CSE interventions and programmes targeting adolescents and young people which have demonstrated results in Timor-Leste and other countries.
- R10 - To maintain momentum, UNFPA should continue to support and guide the government in the implementation of the NAP GBV 2017-2021, while ensuring that it follows an inclusive approach.
- R11 - UNFPA should continue to support the production of population data by the government while promoting the developing of data literacy within government at central and municipal level and across the development community.
- R12 - UNFPA should continue to strengthen CP management and monitoring & evaluation. The CO should promote the systematic cooperation between programme areas and their integration, including when planning trainings of service providers or managers. Civil society partners should be encouraged to participate in the monitoring of policy implementation. The CP should also strengthen its efforts to promote the exchange of experience and information between IPs.
- R13 - UNFPA should continue to strengthen the capacity of key central government organisations to coordinate priority strategies, such as the NAP-GBV and CSE.

1 INTRODUCTION

This report provides the findings of the external evaluation of the UNFPA Timor-Leste Country Programme between January 2015 to December 2019, commissioned by UNFPA.

1.1 Objectives of the Evaluation

1.1.1 Objectives

UNFPA Timor-Leste Country Office (CO) commissioned an independent evaluation of its 3rd Country Programme of Assistance 2015-2019.

The CPE Terms of Reference define that the UNFPA Timor-Leste Country Programme Evaluation (CPE) serves **three main purposes**:

- (i) Demonstrate accountability to stakeholders on performance in achieving development results and on invested resources;
- (ii) Support evidence-based decision-making;
- (iii) contribute important lessons learned to the formulation of the 4th Country Programme in Timor-Leste.

The **objectives** of the CPE are as follows:

- To provide an independent assessment of the relevance and progress towards the outputs and outcomes set forth in the results framework of the 3rd country programme; including its contribution to the United Nations Development Assistance Framework (UNDAF) for East Timor 2015-2020, and its alignment to the UNFPA Strategic Plan (2018-2021) and the Timor-Leste National Development Strategic Plan 2011-2030;
- To provide an analysis of how UNFPA has positioned itself within the development community and national partners with a view to adding value to the country's development results;
- To draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the 4th country programme (2021-2025);
- To assess UNFPA's comparative advantage in the four programme areas.

1.1.2 Scope of the evaluation

The scope of UNFPA Timor-Leste CPE was to cover activities implemented, deliverables produced and results achieved in the 5 programme areas of the Country Programme (family planning, Sexual and Reproductive Health and Rights, Adolescents and Youth, Gender and Population Dynamics) during the period from January 2015 to end of 2019.

The evaluation covered UNFPA implementing partners (IPs) - government institutions and non-governmental organisations (NGOs) - who implemented programme activities with UNFPA financial support during the period. It also included other partners and key stakeholders relevant to the results areas of the UNFPA Country Programme. The evaluation covered central / national level stakeholders in Timor-Leste's capital Dili, some stakeholders based outside of the country (UNFPA Regional Office in Bangkok and some IPs based abroad) as well as municipal-based stakeholders in three municipalities (Dili, Liquiça and Oé-cusse Ambeno).

1.2 Evaluation methodology and process

1.2.1 Evaluation criteria and evaluation questions

The UNFPA Timor-Leste Country Programme Evaluation (2015 – 2019) used internationally agreed upon evaluation criteria, drawn from OECD/DAC criteria, including: relevance, effectiveness, efficiency and sustainability. In addition, and following the UNFPA Evaluation Handbook, two additional criteria

Coordination and Added Value were added to assess UNFPA’s strategic positioning in Timor-Leste among other UN agencies and partners as well as principles of gender equality and human rights.

An indicative list of main evaluation questions was proposed in the CPE Terms of Reference (ToR). The evaluation team’s review during the inception phase confirmed the relevance of the questions and proposed 2 changes, including one additional question (question 5) and adding a segment to question 10, see table 2 below (with changes underlined).

Table 2: Proposed main Evaluation Questions by category

EVALUATION QUESTIONS (EQ) followed by the Evaluation Team
Relevance
EQ 1) To what extent has UNFPA Timor-Leste ensured that the sexual and reproductive health and other needs of young people (including adolescents) are integrated in the planning and implementation of all UNFPA supported interventions under the Country Programme? EQ 2) To what extent has the CO been able to adapt its strategies and programmes over time respond to changes or shifts caused by political changes in the country? What was the quality of the response?
Effectiveness
EQ 3) To what extent have the 3rd CPD outputs been achieved, and to what extent have these outputs contributed to the achievement of the 3rd CPD outcomes? EQ 4) To what extent has UNFPA made good use of its comparative strengths to add value to the development results of Timor-Leste? <u>EQ 5) To what extent did the implementation of the UNFPA programme in Timor-Leste take into account gender equality and human rights principles?</u>
Efficiency
EQ 6) To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 3rd CP outcomes in a timely manner? EQ 7) To what extent has the CO established, maintained and leveraged different types of partnerships to ensure good use of UNFPA’s comparative strengths in the achievement of the Country Programme outcomes?
Sustainability
EQ 8) To what extent has UNFPA support helped to ensure that SRH and rights, and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in Timor-Leste? EQ 9) To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership and durability of effects of the 3rd CP interventions?
Coordination
EQ 10) To what extent did the CO contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities / seeking synergies) within the United Nations system <u>and in the national development sectors of Timor-Leste?</u>

Based on these questions, an Evaluation Matrix was designed which related each evaluation question with its underlying assumptions, associated indicators, sources of information, and relevant methods and tools for data collection. The CPE Evaluation Matrix is included in Annex 5. The CPE team also developed an Interview guide which contains detailed questions for various stakeholders as well as other interview tools.

1.2.2 Evaluation approach

Stakeholder participation

The evaluation was not theory-based as the CO requested for the CPE team to focus on conducting interviews and other CPE tasks rather than on reconstruct the Theory of Change for this CP. The CPE applied an inclusive participatory approach, involving a broad range of partners and stakeholders at

national and sub-national levels in the governance of the evaluation through the Evaluation Reference Group, by interviewing stakeholders and by presenting the preliminary evaluation results to the ERG and to main CP stakeholders to gain their insights and comments. Communication with stakeholders with respect to the evaluation purpose, the criteria applied, and the intended use of the findings was ensured at all stages of the evaluation. The CPE team made an effort to ensure that both women and men working for UNFPA's partners were interviewed and that the beneficiaries interviewed included both women and men, and key populations.

Evaluation audience

As defined in the CPE TORs, the findings, lessons learned and recommendations of the CPE shall be used to assess the achievements of the 3rd CP and inform the development of the 4th CP. For transparency and accountability purposes, the findings of the CPE report will be communicated to all stakeholders including the UNFPA Country Office, key government counterparts in Timor-Leste, civil society organisations who are implementing partners of the CP, and additional users partners of UNFPA including donor Australia-East-Timor Partnership for Human Development, international and national NGOs and other civil society organisations, and sister UN agencies such as WHO, UN-Women and UNICEF.

1.2.3 Methods for data collection and analysis

As defined in the CPE Terms of Reference, the CP evaluation made use of a mixed methods approach to collect primary and secondary data and to analyse data by evaluation question.

Document review Secondary data was collected primarily from programme documents and related research report including UNFPA Country Programme Document (CPD); Country Programme Action Plan (CPAP); UNFPA Country Office Annual Reports; Implementing Partner Annual Work Plans (AWPs); annual budget and expenditures reports; list of Atlas projects; Resource Mobilization Strategy, progress reports, visit reports and monitoring reports; as well as reports, studies and technical strategies and guidelines produced by government, other UN agencies, technical partners, civil society organisations and donors. Additionally, the evaluation used other sources such as thematic evaluation reports and findings of assessments conducted by other donors and international organisations during the current CP. The list of documents consulted in the preparation of this CPE report is included in Annex 1.

Key Informant Interviews Semi-structured Key Informants Interviews (KIIs) were conducted with UNFPA programme leadership, management, technical and operational staff, as well as with heads of agencies and technical staff of Implementing Partners (IPs) - government institutions and non-governmental organisations (NGOs) - involved with UNFPA in program implementation; senior official and technical staff of relevant government ministries and agencies; relevant UN Agencies and members of cluster working groups, other civil society organisations providing technical assistance in relevant programme areas and donors. Annex 3 contains a list of all institutions consulted.

Focus Group Discussions Focus Group Discussions (FGDs) were conducted with several groups of beneficiaries, including: health service providers trained in EMONC and FP (10 women; 5 men, teachers trained in the use of tools such as the CSE manual (4 women; 7 men), communities benefitting from Birth Preparedness Plan interventions (6 women; 3 men), and adolescents and youth in school benefitting from teaching on life skills and CSE (1 girl). The aim was to solicit the opinion of these groups on the intended and non-intended achievements, strengths, weaknesses and challenges of the CP and to identify recommendations for the current and future CP.

Questionnaire A short questionnaire was circulated by the CPE team to the twenty UNFPA Country Office staff before the start of the Field Phase, to identify main strengths, achievements, weaknesses and challenges of the Country Programme, as well as recommendations for how the current CP can be further strengthened and recommendations for the next CP. Two UNFPA staff returned a filled-in questionnaire to the CPE team.

Site visits / observation Field visits were conducted to four health facilities (one health post, one health centre, one regional hospital and one national hospital) and three schools that benefitted from UNFPA programme support. Site visits aimed to 1) conduct short KIIs with the centres' managers / staff,

and 2) conduct FGDs with beneficiaries present in the location at the time of the visit, 3) conduct site observations.

Data Analysis Data analysis and validation mechanisms took place at the end of the field phase. Once all information and data was collected, a systematic organisation, comparison and synthesis process was undertaken. The analysis included an assessment of what the data is saying about each of the evaluation questions, triangulating in the process information generated through qualitative and quantitative methods to ensure robust findings. Data analysis was structured by the evaluation’s primary criteria and questions. Data analysis triangulated data from multiple sources – e.g. key informant interviews, programme reports, studies, national assessments - as relevant to each evaluation question. Additionally, the validation of data was sought through exchanges with UNFPA programme staff and the evaluation manager. At the end of the field phase, the CPE team validated findings with key stakeholders.

1.2.4 Selection of the sample of stakeholders

Based on the CPE Terms of Reference, the evaluation team completed the stakeholder mapping by identifying UNFPA direct and indirect partners. Every effort was made to include key stakeholders as part of the evaluation process either as sources of data (primary/secondary) or through their representation in the Evaluation Reference Group (ERG) and/or the CPE validation meeting.

Table 3: Overview of the type and number of persons interviewed during the CPE:

INSTITUTIONS INTERVIEWED	Nr of persons interviewed	Women	Men
UNFPA	18	7	11
Central government and public agencies	19	6	13
Municipal government	5	3	2
Civil society Implementing Partners	13	5	8
Other civil society partners	10	6	4
Academic institutions	1	1	0
UN agencies	4	1	3
Donors	1	1	0
Health providers and health facility managers trained in EmONC and FP	15	10	5
Teachers and students trained in in-school Comprehensive Sexuality Education (CSE)	11	4	7
Communities benefitting from Birth Planning Programme	9	6	3
Total number of persons interviewed	106	50	56

In view of the evaluation purpose, the CPE team then proposed a purposive sampling approach for the selection of stakeholders to participate in the evaluation interviews and focus group discussions. The sampling of specific stakeholders was determined on the following basis:

- UNFPA Country team: senior management and all staff directly involved in programme implementation, operations and monitoring.
- Government counterparts: primarily managers and UNFPA focal points in ministries and directorates who are relevant to the UNFPA mandate and the current programme cycle, plus the Ministry of Finance which coordinates development assistance on behalf of the GoTL.
- Implementing Partners: all government and civil society organisations who were Implementing Partners (IPs) of the CP during the period 2015 to 2019.
- Other partners such as technical agencies, NGOs, academic partners and donors supporting SHRH and GBV interventions in Timor-Leste, based in the country or abroad.
- Programme beneficiaries: health workers, schoolteachers, youth and adolescents receiving services, training and awareness sessions. For the visits to schools, programme beneficiaries were selected amongst managers, teachers and students available for interview at the time of the CPE visit. Regarding the health providers and education teachers who benefitted from capacity building, UNFPA coordinated with the structures to be visited to invite groups of trainees to participate in focus group discussions.
- UN Agencies: active in similar sectors with focus on thematic coordination mechanisms.

During the field phase, the CPE team interviewed a total of 106 persons, of which 50 women.

Geographic coverage

The UNFPA Country Programme Document states that the CP would target five priority municipalities in the country (Ainaro, Baucau, Bobonaro, Covalima and Oé-cusse Ambeno) with comprehensive maternal health and SRH interventions. However, after CP implementation started, the Ministry of Health requested for UNFPA to focus CP support mainly at central level through the strengthening of capacity of national institutions to develop policy and coordinate the implementation of national programmes throughout the country, instead of using its resources to target specific municipalities.

Therefore, the bulk of the CP support was provided at national level and capacity strengthening interventions were supported throughout the country, such as the training of health workers in Family Planning and EmONC. The CP did support the piloting of a few specific interventions linked to single CP output areas, such as maternal health awareness raising in communities in Oé-cusse-Ambeno and later in Baucau through the NGO Alola Foundation, the roll-out by INFORDEPE of the in-school CSE manuals in Liquiçá: Municipality, and the piloting of the new Girls & Boys Circle CSE approach in schools in Dili Municipality by the NGO FOKUPERS.

For the evaluation, the UNFPA Country Office (CO) therefore proposed that the CPE team interview central level stakeholders in the capital Dili, in addition to conducting field visits to the three municipalities in Timor-Leste with the largest support to CP interventions: Dili, Liquiça and Oé-cusse Ambeno. The ERG members and CPE team agreed with this suggestion.

1.2.5 Evaluation process

Evaluation phases

The evaluation design was informed by the Evaluation Handbook “How to design and conduct a CPE at UNFPA” of April 2019. The CPE evaluation process entails five phases: 1) preparatory; 2) design; 3) data collection; 4) analysis and reporting; and 5) dissemination & follow-up.

Preparation Phase (undertaken by the Country Office)

This phase included: drafting the evaluation Terms of Reference; approval of the ToR by IEO; recruitment of a team of evaluators; establishment of the Evaluation Reference Group; and orientation of key national government counterparts to the evaluation process.

Design Phase

This phase included: desk review of all relevant documents provided by the CPE team; development of the CPE Design Report by the CPE team; UNFPA CO and ERC providing comments on the Design Report and its annexes; finalisation of the report addressing all comments received; clearance of the design report by the Regional M&E Advisor and CO Approval.

Field Phase

The evaluation team was deployed to Timor-Leste for 3.5 calendar weeks in November-December 2019 to conduct interviews and further desk reviews to answer the evaluation questions. At the end of the field phase, the CPE team facilitated a validation workshop to present to key stakeholders - main government counterparts and implementing partners - the preliminary findings and recommendations of the evaluation in an effort to validate it.

Synthesis and Reporting Phase

During this phase, the evaluation team continued the analytical work initiated during the field phase and prepared a first draft of the evaluation report, taking into account comments made by the CO at the field phase debriefing meetings. The draft report was submitted to UNFPA Timor-Leste, the evaluation

reference group and UNFPA APRO and the reference group for their comments. The final report was developed taking into account comments received. The Report will be cleared by the CO and the draft EQA will be submitted from the Regional Office to EO for finalisation. The quality of the report will be assessed based on the criteria set out in the CPE Guidance.

Management Response, Dissemination and Follow Up (by Country Office)

The CO management will provide a management response to the evaluation recommendations. APRO will quality assure the response. The final response will be uploaded in the corporate tracking system within six weeks of CPE submission. The CO will be responsible for periodically updating the status of implementing the management response. The CO senior management will be responsible for ensuring that the lessons and evidence emerging from the CPE informs the design of the 3rd CP. A dissemination strategy will be in place to share findings and lessons internally within UNFPA and externally. The evaluation and the management response will be posted on the CO website within six weeks of CPE submission.

1.2.6 Limitations and risks

While this CP was deemed 'evaluable', it is important to highlight the fact that this evaluation has a broad programme relevance, effectiveness and connectedness scope rather than a beneficiary / outcome / sustainability lens. Thus, the evaluation design with regards to sampling for data collection emphasized the first layer of UNFPA programming i.e. implementing partners, and reached the beneficiary population only marginally to illustrate programme outcomes / results on beneficiary populations.

Furthermore, this CPE was based primarily on qualitative information collected from government counterparts and implementing partners. Consequently, the evaluation assessed the achievement of the CP outputs and the likelihood of results on the outcome level. While this evaluation approach can provide useful illustrations of changes at the beneficiary level, and can examine the contributing causal mechanisms, this data is not statistically representative for the entire population of UNFPA beneficiaries.

To address these limitations, the evaluation triangulated information across multiple sources and with secondary information. It also cross-checked evaluation findings with the CO staff and stakeholders.

The UNFPA CO was able to provide a number of programme documents. However, due to the recent reorganisation of the electronic filing system of the office, a number of documents were not located, including annual workplan progress reports submitted by some Implementing Partners for the years prior to 2018, as well as monitoring reports. Programme reports did not provide disaggregated data on programme performance.

During the field phase, the CPE team was able to interview a considerable number of stakeholders from UN, government and civil society. However, some stakeholders, including higher-level directors of the Ministry of Health, were absent to attend meetings abroad. Two national holidays during the field phase further limited availability of stakeholders for interviews and visits. Most school students and teachers were absent due to the exam period. Some UNFPA staff were unavailable for interview due to illness. Due to time limitations, the CPE team was not able to interview health facility users.

Travel time influenced the selection of the three Municipalities to be visited during the CPE to some extent: programme sites in Dili and Liquiça can be visited during the day while returning to Dili city at night. Oé-cusse Region was reached by a six-hour drive and crossing two international borders. Due to time restrictions, the CPE team only spent 1 full day in Oé-cusse Municipality. No access / security risks limited the access of the CPE team to any geographic areas in Timor-Leste.

2 COUNTRY CONTEXT

2.1 General context and challenges

Timor-Leste is one of the world's youngest countries, having gained independence in 2002 following over four centuries of colonial rule by Portugal and a quarter century of occupation by Indonesia. It is also one of the poorer countries in Asia, yet with tremendous potential for development. Peaceful democratic presidential and parliamentary elections were held in 2012 and the UN 13-year peacekeeping presence ended at the end of the same year.

Timor-Leste is a post-conflict state that has recently emerged as a lower middle-income country. However, despite achieving lower middle-income country status due to offshore oil and gas resources which account to over 80% of government revenues, the country has a large portion of the population (42 percent) below the national poverty line¹. Unemployment is high, employment opportunities in the formal sector are limited, and job creation by the private sector falls far short of demand. Most of the population have no consistent earnings and many are subsistence farmers.

Although SDG indicators show that living standards and human development have improved significantly, considerable disparities in health, education and wealth still exists. The majority of the population (70%) lives in rural areas in small, dispersed villages isolated by mountainous terrain and poor road conditions and experience disparities in access to public facilities.² Timor-Leste ranks 132 of 187 countries on the UN Human Development Index. Access to health services in Timor-Leste poses a major concern. The country also faces significant shortages in human resources for health – fewer than half the country's health posts have staff with midwifery skills. In general, the destruction of all infrastructure prior to Timor-Leste's independence led to a shortage of human resources in all sectors in terms of quantity and technical quality of staff.

In 2010, Timor-Leste approved the national Strategic Development Plan 2011-2030 (SDP), the overarching development strategy of the country. The vision of the SDP is for Timor-Leste to become a middle-upper income country by 2030, by eradicating extreme poverty and developing a sustainable and diversified economy not dependent on oil.³ The social and infrastructure sectors are the key sectors for national development. Together with these two important sectors, petroleum industries, agriculture and tourism are identified as potential sectors that will significantly drive the economic development of the country. This strategic plan also recognizes that young people are the future leaders, and it is they who will contribute to the social and economic transformation of the society. The NDP states that the Timor-Leste government will do everything within its power to support young people and provide them with opportunities to gain experience, skills and positive values so that they may be able to participate in the national development.

2.2 Emergencies and humanitarian responses

Timor-Leste frequently suffers from localized, extensive disaster events related to climate variability. The country ranks 12th on the World Risk Index due to its' high exposure to natural hazards (including flooding, drought, typhoons, wave surges, landslides, earthquakes and tsunamis) and poor economic and social setting.⁴ The rainy season from November to April impacts on field activities and makes access to much of the country more difficult. Rural communities rely heavily on agriculture and natural resources for their livelihoods. At the same time, they have limited capacity to adapt to climate change and other environmental challenges. In Timor-Leste, forest and soil degradation is a major problem. Unsustainable land management practices, including slash and burn agriculture, have led to rapid deforestation. With poor infrastructure and insufficient disaster preparedness and response capacity, even small events can

¹ Asian Development Bank, Poverty Data, Timor-Leste <https://www.adb.org/countries/timor-leste/poverty>

² UN Timor-Leste (2019): UNDAF evaluation. Draft April 2019.

³ Democratic Republic of Timor-Leste (2011): Timor-Leste Strategic Development Plan 2011-2030.

⁴ United Nations University Institute for Environmental and Human Security (UNU-EHS) (2016): The World Risk Report.

have a major impact on the lives of people. 78.5 percent of Timorese are reported to have experienced shocks due to natural hazards.⁵

The GoTL has a Humanitarian Country Team – led by government and co-chaired by the UN Resident Coordinator - that responds to emergencies in the country. The GoTL developed a Disaster Risk Reduction (DRR) Policy in 2008 and established national and municipal disaster risk management committees.⁶ However, although the GoTL considers Disaster Risk Management (DRM) as a priority and supports the dissemination of DRR policy to municipal levels, the SDP 2011-2030 does not explicitly reflect or integrate DRM as development priority.⁷ With assistance from UN and other development partners, in 2014-2015 the GoTL established sub-municipal / village (Suco) level disaster risk management committees and developed a Community-Based Disaster Risk Management (CBDRM) Guide to guide municipalities and communities in improving their disaster preparedness. The UN Development Assistance Framework (UNDAF) for 2015-2020 also supported the development of Community-based Disaster Risks Management (CBDRM) plans in municipalities most affected by natural disasters.⁸ UN and NGOs are supporting emergency preparedness training for schools, health services, churches and community disaster management centres to increase local resilience to hazards with focus on health and livelihoods.⁹

2.3 Population dynamics

By 2015, Timor-Leste had a population of 1,200,379, of which 51 percent are male and 49 percent are female.¹⁰ The proportion of people living in urban versus rural areas (30% urban and 70% rural) has not changed much since the last census in 2010. Fertility has been declining quickly in Timor-Leste. The 2015 census found an average of 4.5 children per woman. The 2016 DHS estimates a lower fertility rate at 4.2 children per woman.¹¹ Even so, according to the most probable population growth projection scenario of the 2015 Census, the population will reach 1.85 million by 2050.¹² The Timor-Leste population growth is expected to exert increasing pressure on the economy, resources and social service alike. The GoTL has not (yet) developed a national policy on population.

The General Directorate of Statistics (GDS), which is the National Statistics Office of the Government of Timor-Leste (GoTL), has undertaken a number of population and housing censuses since independence, including in 2004, 2010 and 2015, and published a number of general and thematic reports. The GDS also led the Demographic and Health Survey (DHS) in 2016 where tablets were used for the first time to collect data. Until recently capacity and practice amongst national and sub-national government institutions to use data for evidence-based planning and decision making was low. Recently this situation has improved as described in chapter 4. The Government is currently preparing to conduct another Population and Housing Census in 2020.

2.4 Sexual and Reproductive Health and Rights

Timor-Leste is one of nine countries worldwide estimated to have reduced maternal mortality ratio by over 75% since 1990. Since 2003 UNFPA has been working with the GoTL to maintain and further enhance this trend. Standards of care and protocols have been developed for antepartum, intra-partum and postpartum care at secondary and tertiary care facilities, and a maternal death surveillance and

⁵ UN Timor-Leste (2015): United Nations Development Assistance Framework (UNDAF) 2015-2019.

⁶ Ministry of Social Solidarity Timor-Leste (2008): National Disaster Risk Management Policy.

⁷ Center for Excellence in Disaster Management and Humanitarian Assistance (2016); Timor-Leste Disaster Management Reference Handbook.

⁸ UN Timor-Leste (2019): UNDAF evaluation. Draft April 2019.

⁹ <https://www.australianhumanitarianpartnership.org/timorleste>

¹⁰ General Directorate of Statistics (GDS), UNFPA (2018): 2015 Timor-Leste Population & Housing Census; Thematic Report Vol. 9; Population Projections by age and sex, National level and Municipality level.

¹¹ General Directorate of Statistics (GDS), UNFPA (2018): 2015 Timor-Leste Population and Housing Census; Thematic Report Volume 13; Analytical Report on Gender Dimensions.

¹² General Directorate of Statistics (GDS), UNFPA (2018): 2015 Census; Thematic Report Volume 9.

response system established. Yet, maternal mortality in Timor-Leste is still among the highest in Asia. The maternal mortality ratio was 426 per 100,000 live births for the period 2010–2015¹³, down to 195 in 2015.¹⁴ Skilled health personnel assist 58% of deliveries, and facility delivery was at 42%. The proportion of women who give birth in a health facility varies widely across the country. In Dili, 78 percent of births occur in a health facility compared to Ermera District where only 15 percent do. The infant mortality rate (IMR) in Timor-Leste was estimated at 56 deaths per 1,000 live births, and only exceeded by Afghanistan (68.6) and Pakistan (69.8). This reflects insufficient care for mothers during pregnancy and delivery and poor access to health care.¹⁵ Seven out of 13 municipalities in the country have no functional emergency obstetric and newborn care.¹⁶

According to the 2016 DHS, the total fertility rate was 4.2 – a decline from 5.7 in 2010 - with much higher fertility rates in rural areas (4.4) than in urban areas (3.5).¹⁷ Contraceptive prevalence of modern methods among married women was 24%. The demand for family planning (FP) was 51.3% and nearly one in four women aged 15 to 49 had an unmet need for family planning.¹⁸ Despite progress in improving access to FP, unmet need is still very high: only 47% of the demand for FP among currently married women is being met. Lack of knowledge about fertility and contraception is still widespread amongst the population, as well as harmful gender norms that undermine women's ability to take control of their own bodies and their fertility. Capacity of health service providers to provide FP is still insufficient, and traditional beliefs result in many health service providers being more comfortable in promoting traditional FP methods rather than modern contraceptives. So far, the GoTL left the procurement of modern contraceptives to partners such as UNFPA but is now showing signs of increased commitment to contributing domestic resources.

Several years ago, the Ministry of Health (MoH) and partners developed the National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) 2014-2018.¹⁹ The Strategy was approved by the Minister of Health at the time, and a few months later withdrawn from circulation and use by the next Minister due to disagreement about strategies and interventions in the area of sexual and reproductive health (SRH) and FP service provision, particularly to unmarried adolescents.²⁰ Consequently, the MoH has not yet approved the RMNCAH Strategy.

There is a growing body of evidence that suggests the HIV epidemic in Timor-Leste is moving into the general population. Up until recently, Timor-Leste was considered to have a low HIV prevalence rate (0.2 percent reported in 2015), with a higher prevalence among key affected populations, including sex workers (1.5 percent) and their clients, men who have sex with men (1.3 percent) and transgender persons (2.6 percent).²¹ Timor-Leste also faces specific vulnerabilities which may accelerate the transmission of HIV and sexually transmitted infections, such as high levels of population movement and social displacement (rural to urban and cross-border migration), high unemployment, low awareness of HIV and sexually transmitted infections and low condom use. Results from the 2016 TLDHS show that only 10% of women and 16% of men have comprehensive knowledge of the virus, and that 3% of women and men age 15-49 have ever been tested for HIV and received their test results.²² The same survey also shows that knowledge about where to get tested is declining.²³ Condom distribution and availability

¹³ GDS, UNFPA (2018): 2015 Census; Thematic Report Volume 13; Report on Gender Dimensions.

¹⁴ GDS (2016): DHS 2016.

¹⁵ MoH, UNFPA Timor-Leste (2015): Maternal Health at a Glance; Timor-Leste. April 2015.

¹⁶ MoH Timor-Leste (2015): Emergency Obstetric and Newborn Care Needs Assessment Timor-Leste 2015.

¹⁷ General Directorate of Statistics (GDS), MoH and ICF (2016): Timor-Leste DHS 2016.

¹⁸ GDS, MoH and ICF (2016): Timor-Leste Demographic and Health Survey 2016.

¹⁹ Ministry of Health 2014. National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health 2014-2018.

²⁰ Ministry of Health 2014. National Strategy on RMNCAH.

²¹ Ministry of Health Timor-Leste (2015): Global AIDS Response Progress Report, Timor-Leste. National AIDS Programme, Ministry of Health.

²² General Directorate of Statistics (GDS), MoH and ICF (2016): Timor-Leste DHS 2016 (TLDHS).

²³ Comparing the results of the 2016 TLDHS with the 2009-10 TLDHS, the proportion of respondents who know where to get an HIV test declined from 17% to 7% among women and from 35% to 26% among men.

is far from optimal, which undermines HIV prevention efforts. At the same time, the conflicting messages of the National AIDS's Commission on the topic (replacing the 'C' in the ABC HIV prevention messaging from 'Condom' to 'Control Yourself') creates another obstacle to obtaining positive results in the promotion of condom use.

2.5 Adolescents and youth

Timor-Leste is experiencing a youth bulge, with 60.7 percent of the total population younger than 25 years old. 33.3 percent of the population is between the ages of 10 and 24, and youth aged 15-24 constitute 21% of the population.²⁴ School attendance of adolescents and young men and women has been increasing since Timor-Leste became independent, but 2010 data shows that only 11% of 25-34 year-olds finished pre-secondary education, and 26% finished secondary school.²⁵ Youth unemployment is high (12.3 percent), above the national unemployment average (4.8 percent) as many young people seeking work cannot find employment and remain unemployed, with youth affected by lack of opportunity and perceived disadvantages and marginalisation.²⁶

Adolescents and youth lack information about sex and contraception. The 2016 TLDHS show that 23 percent of young women and 20 percent of young men aged 15-24 have received information on reproductive health.²⁷ The GoTL developed a policy on inclusive education.²⁸ The policy defines that young pregnant women should have access to education. In reality however many pregnant adolescents and girls are turned away from school and are only allowed back during exams. This practice is likely contributing to school dropouts of adolescent girls and young women.

Teenage pregnancy is high in Timor-Leste: 19 percent of girls are married before they turn 18 and 24 percent are already with a child by the time they turn 20.²⁹ 26 percent of women age 25-49 had first sex before the age 18. The adolescent birth rate is 54 births per 1,000 women aged 15-19. Adolescent fertility is much higher in rural areas (6.7% of girls aged 15-19 have given birth) than urban (3.3%).³⁰ Of all 15-19 year old women with children, half already have more than one child. Teenage mothers aged 15-19 years die nearly twice as much as mothers aged 20-24 years. The teenage pregnancy study suggests that teenage pregnancy in Timor-Leste is related to lack of information, knowledge and access to SRHR and contraception of girls and boys.³¹ It is also related to lack of confidence and empowerment of girls, who suffer from unequal power balances in relationships. Adolescents and young girls and boys are also victims of domestic and gender-based violence, which will often affect the self-confidence and psychological health of girls and boys survivors. Teenage pregnancy negatively affects young girls. Adolescent girls are at risk because their biological and psychological condition does not allow them to best carry a pregnancy and give birth. Adolescent mothers are often under pressure to abandon their studies and are less likely to return to school after giving birth or stay in school during pregnancy. This will impact the ability of adolescent mothers to pursue an education, which has long term implications with regard to their future employment opportunities.

The 2016 Youth Policy States that HIV/AIDS cumulative case records from 2003 to 2014 show a number of 484 infected people, of which 76 are males and 65 are females between the ages 15 and 24. Many young people are not equipped with the knowledge and life skills to manage and limit sexually transmitted infections and HIV risk in an increasingly challenging environment. The 2010 DHS reported that only 12%

²⁴ GDS, UNFPA (2018): 2015 Timor-Leste Population and Housing Census; Thematic Report Vol. 9; Population Projections by age and sex, National level and Municipality level (2015 - 2030).

²⁵ Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2016): National Youth Policy.

²⁶ GDS, UNFPA (2018): 2015 Timor-Leste Population and Housing Census; Thematic Report Vol. 10; Analytical Report on Labour Force.

²⁷ General Directorate of Statistics (GDS), MoH and ICF (2016): DHS (TLDHS).

²⁸ Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2016): National Youth Policy.

²⁹ GDS, MoH and ICF (2016): Timor-Leste DHS (TLDHS).

³⁰ General Directorate of Statistics (GDS), UNFPA (2018): 2015 Census; Thematic Report Vol. 13.

³¹ SSYS, UNFPA, Plan International (2017): Teenage Pregnancy and Early Marriage in Timor-Leste.

of unmarried young men aged 15-29 reported having used a condom the last time they had sexual intercourse.³²

The GoTL updated and approved the National Youth Policy in 2016, after country wide consultation with youth and communities.³³ The Policy defines youth as young people aged 15 to 24 years, disaggregated into adolescents (15-19) and young adults (20-24). It identifies as priority target groups: young women and men in rural areas; out of school youth and school drop-outs; youth with disability; young people who earn living in the streets; young women; young people without enough opportunities to practice their skills and apply their knowledge; illiterate youth; unemployed youth; and most at risk youth including those who live with HIV, who use drugs, alcohol, etc. The Policy defines the government's priorities in the areas of education, healthy lifestyles, employment, civic participation and the fight against crime. The government took a long time to develop the National Youth Action Plan and finally approved it in 2018.³⁴

2.6 Gender equality and women's empowerment

Gender-based violence (GBV) is endemic in Timor-Leste: 29 percent of women aged 15-49 have experienced physical violence in the past 12 months and 33% in their lifetime. In 2015, 59% of ever-partnered women had experienced physical and/or sexual violence by an intimate partner in their lifetime and about 47% experienced one of these forms of violence in the previous 12 months.³⁵ While robust data on violence against people with disability in Timor-Leste is not easily accessible the problem exists. In a small-scale study conducted in 2017, 45% of women and men with disabilities reported being subjected to violence during the previous 12 months.³⁶ Timor-Leste women and girls are also subject to early and forced marriages and human trafficking. Although the legal age of marriage is 18 years for both men and women, the recent 2016 DHS shows that among women aged 20-24 years old in Timor-Leste, 2.6% percent were married before the age of 15, and 14.9 percent before the age of 18.³⁷ The 2018 Human Development Report (HDR) ranks Timor-Leste 132 out of 189 countries, with a gender inequality index estimated at 0.567, compared to 0.663 for males.³⁸ The employment gender gap in Timor-Leste is quite large: women in the work force represent 24.9% of the women of working age – compared to 52.5% among males.³⁹

In 2010, the national law against domestic violence was passed, followed by a comprehensive national action plan focused on multi-sectoral coordination of services. The first National Action Plan for the Elimination of Gender-Based Violence (NAP GBV) 2012-2015 was developed and approved in 2012. The second NAP GBV 2017-2021 was approved in 2017. The Secretariat of State for Equality and Inclusion (SEII) (previously called SEIGIS) is in charge of monitoring the implementation of the NAP GBV. However, despite strong policy reform and a dynamic role by civil society organisations, gaps between informal and formal justice mechanisms, capacity of service providers and implementation challenges, particularly in the health sector, indicate that violence against women and girls remains a significant problem throughout the country.

³² GDS, MoH and ICF Macro (2010): Timor-Leste Demographic and Health Survey 2009-2010.

³³ Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2016): National Youth Policy.

³⁴ SSYS (2018): National Youth Action Plan 2018-2022.

³⁵ The Asia Foundation (2015): Nabilan Health and Life Experiences Study, Timor -Leste. Fact sheets.

The Asia Foundation (2016): Understanding Violence against Women and Children in Timor-Leste: Findings from the Nabilan Baseline Study; Main Report.

³⁶ Belun NGO / UN Timor-Leste (2018): Leave No One Behind in Timor-Leste. Policy Brief nr 5 – Young People With a Disability. Quoting findings from 2017 interviews with women with disabilities by Ra'es Hadomi Timor Oan (RHTO), the Association of Persons with Disabilities in Timor-Leste.

³⁷ General Directorate of Statistics (GDS), MoH and ICF (2016): DHS 2016.

Azzopardi, Peter (2018): Adolescent and Youth Sexual Reproductive Health Scoping Report on Adolescent pregnancy in Timor-Leste. Brunette Institute, Australia for Partnership for Human Development Timor-Leste.

³⁸ UNDP (2018): Human Development Indices and Indicators: 2018 Statistics Update. Briefing note for countries on the 2018 Statistical Update. UNDP Timor-Leste.

³⁹ ILOSTAT, <https://www.ilo.org/ilostat>

2.7 The role of external assistance

The government health budget in absolute terms increased from US\$ 38.19 million in 2011 to US\$ 67.2 million in 2014. However, government expenditure on health as a percentage of total government expenditure remained around 5%.⁴⁰ This is below the WHO South-East Asia Region average of 8.7% (which itself is significantly lower than rates of government investment in several other regions). The proportion of the national budget invested in capital has declined steadily over recent years from 25% of the total in 2008 to 10% in 2014.

In 2014, development partners contributed approximately one third of the combined health budget of US\$ 100 million. A challenge is that in 2011, Timor-Leste achieved lower middle-income status and as a consequence donor funding is expected to decline, which is likely to make it more difficult to mobilise resources for development interventions in the country.

Since the adoption of the SDP, Timor-Leste has undertaken several steps in ensuring transparency and accountability towards donors, development partners and the public at large. The Government Portal for Transparency⁴¹ was set up. This includes the Aid Transparency Portal, a central repository for all aid information in Timor-Leste and managed by the Ministry of Finance.⁴²

Figure 2: Overview of top external assistance donors of Timor-Leste in 2019

 TOP 10 DONORS IN THE LAST YEAR	
Donor Agency	Actual Disbursements (USD)
Government of Australia	89,102,138.09
European Union	20,244,945.2
Japan International Cooperation Agency	17,255,454.6
Portugal	13,055,217.4
United States Agency for International Development	11,290,900
World Bank	10,730,197.45
United Nations Children's Fund	7,953,339.59
Global Environment Facility Trust Fund	4,602,561.95
Government Of Japan	4,519,841.16
Korean International Cooperation Agency	4,335,506.49

Source: <https://www.aidtransparency.gov.tl/portal/>. Downloaded on 15 December 2019.

Timor-Leste is still among the most aid-dependent countries in Asia. Despite the progress towards sustainable development, Timor-Leste continues to need external assistance (technical and financial) from donors for realisation of economic and social development programmes and the targets identified in the country's national Strategic Development Plan of 2011-2030 (SDP).

⁴⁰ WHO (2015) : WHO Country Cooperation Strategy Timor-Leste 2015-2019. And WHO (2017) : Health financing profile 2017, Timor-Leste.

⁴¹ www.transparency.gov.tl/english.html

⁴² <https://aidtransparency.gov.tl/portal> The Development Partnership Management Unit at the Ministry of Finance manages the Aid Transparency Portal (ATP). ATP is an initiative of the Ministry of Finance of Timor-Leste with support from the Governments of Japan, Australia, USAID, and the ADB.

Australia, Japan, the EU (including bilateral donors such as Portugal and Germany), and the USA are among Timor-Leste's largest contributing donors, as shown in Figure 2 above.

The costing of the National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy Operational Plan by WHO estimated that the total cost would amount to USD 67 million, that MoH could contribute USD 14.8 million, and the Development Partners would contribute USD 21.6 million, which would leave a funding gap of USD 30.6 million.⁴³

The RMNCAH Strategy 2015-2019 lists the following as key development partners for RMNCAH:⁴⁴ Finland (community based health program to improve knowledge and health practices); DFAT Australia (Department for Foreign Affairs and Trade) (maternal and child health and family planning, clinical services support); EU (health and nutrition); GAVI (immunisation); Global Fund (GFATM) (HIV/AIDS and malaria related to maternal health); USAID (maternal, neonatal and child health, FP); UNICEF; WHO; KOICA Korea (maternal health and FP) and DFAT, EU, WB (Health Sector Strategic Plan support).⁴⁵

DFAT Australia provides USD 2.3 million a year to the NGO Marie Stopes for FP service delivery with a focus on long-acting methods in 11 of 13 municipalities and supports Health Alliance International (HAI) in 12 districts to develop the capacity of MoH midwives in safe and clean delivery, newborn care, and family planning.⁴⁶ USAID supports a comprehensive family planning project (USD 1 million per year) managed by John Snow International (JSI) in Covalima Municipality. KOICA supports a multi-year maternal health project in Ainaro Municipality. The World Bank and EU have a USD 3 million trust fund with MoH for health systems strengthening. Currently the Global Fund is the only donor – apart from UNFPA with UNAIDS regional funding - supporting HIV prevention and response in the country. The Australian Government and the EU also supports gender and GBV programmes. EU recently approved a large multi-agency programme to respond to GBV (see sections 4.3.1 and 4.4.1), which will include funding to UNFPA.

⁴³ MoH Timor-Leste (2015): RMNCAH Strategy 2015-2019. ANNEX V: costing of 5-years operation plan.

⁴⁴ MoH Timor-Leste (2015): RMNCAH Strategy 2015-2019.

⁴⁵ UNFPA Timor-Leste (2017): Timor-Leste final non-core funding request and monitoring. Report July 2017.

⁴⁶ <https://www.australianhumanitarianpartnership.org/timorleste>

3 UNFPA / UNITED NATIONS RESPONSE AND COUNTRY PROGRAMME STRATEGIES

3.1 Strategic response of the UN and UNFPA in Timor-Leste

United Nations Strategic Frameworks

The United Nations strategy for Timor-Leste is set out in the United Nations UN Development Assistance Framework (UNDAF) 2015-2019.⁴⁷ The 4 UNDAF Outcomes are:

- Outcome 1 - Social Sector: People of Timor-Leste, especially the most disadvantaged groups, benefit from inclusive and responsive quality health, education and other social services, and are more resilient to disasters and the impacts of climate change.
- Outcome 2 – Infrastructure Sector: People of Timor-Leste, especially the rural poor and vulnerable groups, derive social and economic benefits from improved access to and use of sustainable and resilient infrastructure.
- Outcome 3 – Economic Sector: Economic policies and programmes geared towards inclusive, sustainable and equitable growth and decent jobs..
- Outcome 4 – Governance Sector: State institutions are more responsive, inclusive, accountable and decentralized for improved service delivery and realization of rights, particularly of the most excluded groups.

See section 4.2.1 for an analysis of how the UNFPA Country Programme relates to the sub-outcomes of the Timor-Leste UNDAF.

UNFPA Strategic Plan

The previous UNFPA global Strategic Plan for 2014-2017 informed the development of the UNFPA Timor-Leste CP.⁴⁸ The Strategic Plan set out a vision for the changes in the lives of women, adolescents, and youth that UNFPA sought to bring about. Sexual and Reproductive Health (SRH) and reproductive rights were placed squarely at the centre of the work of the organisation. This strategic direction – colloquially known as the “bull’s eye” – is depicted in figure 3 below.

The bull’s eye defines the goal of UNFPA: the achievement of universal access to sexual and reproductive health, the realization of reproductive rights, and the reduction in maternal mortality. The work of the organisation is centred on attaining this goal, particularly through an enhanced focus on family planning, maternal health, and HIV/AIDS. Women, adolescents and youth are the key beneficiaries of UNFPA work. The organisation is prioritizing the most vulnerable and marginalized, particularly adolescent girls and also indigenous people, ethnic minorities, migrants, sex workers, persons living with HIV, and persons with disabilities. UNFPA will work to improve their health and their ability to participate in the decision-making process on the issues that affect their lives, whether those decisions are made at the individual, familial, community, or national levels. The outer ring of the bull’s eye contains the key factors that enable the attainment of the goal. Respect for “**human rights**” is a principle that underpins all of the Fund’s work. A human rights-based approach can be seen in how UNFPA operates, such as in the emphasis on ensuring that family planning services are free of coercion or that HIV/AIDS interventions are stigma-free.

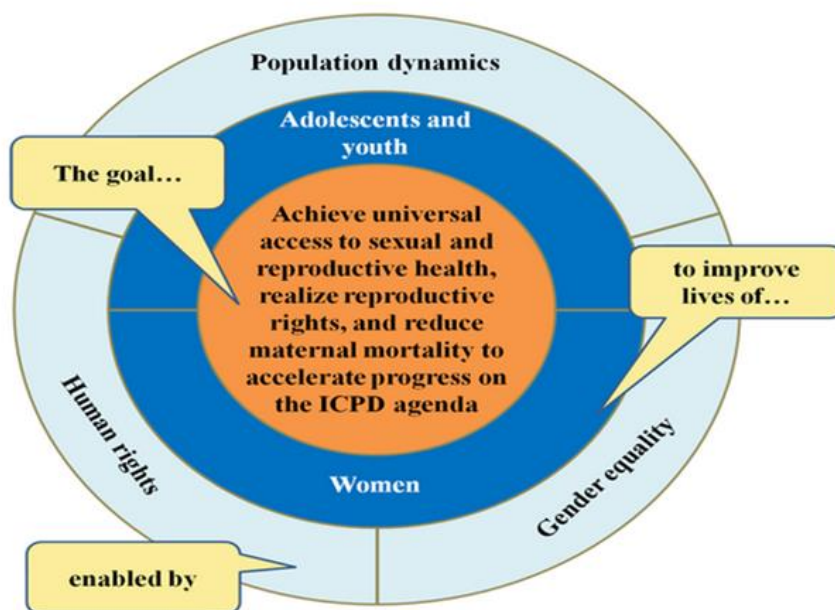
The promotion of “**gender equality**” is another central principle of the Fund’s work. It is both a key programmatic area for UNFPA and a cross-cutting approach that influences all interventions. For example, the focus on gender equality manifests in an emphasis on ensuring that SRH services are provided in a gender-responsive manner, and in promoting the collection and use of disaggregated data to enable identification of the specific needs of women and girls. The third element of the outer ring – **population dynamics** – concerns the support provided to the preparation and analysis of censuses and

⁴⁷ UN Timor-Leste (2015): United Nations Development Assistance Framework, Timor-Leste 2015-2019; supporting equitable and sustainable development in a rising young nation.

⁴⁸ UNFPA (2014): UNFPA Strategic Plan, 2014-2017.

other population-based surveys is a critical means of ensuring that women, adolescents, and youth are at the centre of sustainable development policies, and that programmes have the evidence needed to improve SRH services. Helping national stakeholders understand and plan for the implications of emerging population issues such as migration, urbanization and ageing for the SRH needs of women, adolescents and youth is a key area for UNFPA.

Figure 3: Bulls Eye for the UNFPA Strategic Plan for 2014-2017



Source: UNFPA (2014): UNFPA Strategic Plan, 2014-2017.

To achieve the goal of the bull's eye, the strategic plan 2014–2017 identified four strategic outcomes:

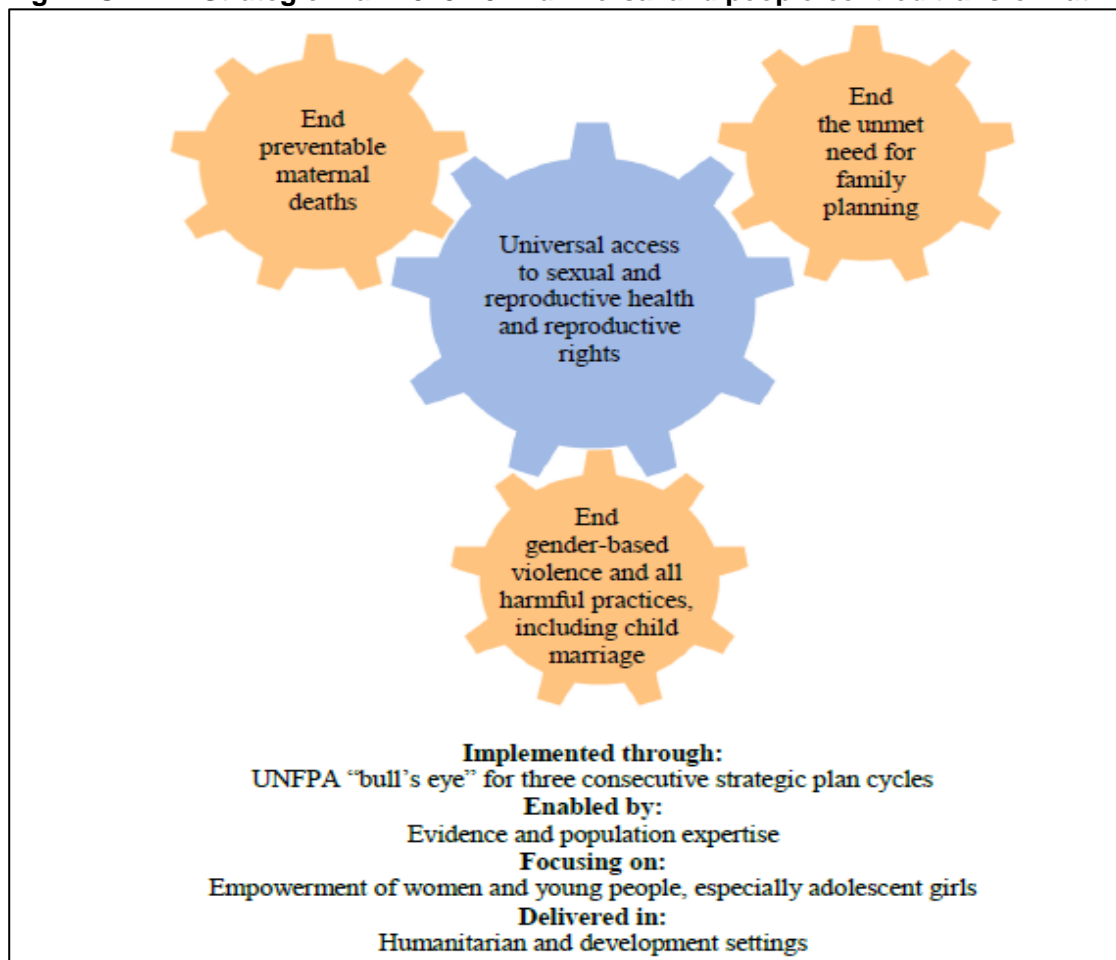
- **Outcome 1:** Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.
- **Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services.
- **Outcome 3:** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth
- **Outcome 4:** Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

In accordance with UNFPA policy, these 4 strategic outcomes have been adopted into the Timor-Leste Country Programme as the 4 CP outcomes.

In 2018 UNFPA published its new Strategic Plan 2018 – 2021.⁴⁹ The SP has as goal to “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality.”

⁴⁹ UNFPA (2018): UNFPA Strategic Plan 2018-2021.

Fig. 4: UNFPA Strategic Plan 2018-2021 universal and people-centred transformative results



Source: UNFPA (2018): *UNFPA Strategic Plan 2018-2021*.

Additionally, in accordance with the strategic direction of UNFPA and General Assembly resolution 70/1 on the 2030 Agenda for Sustainable Development, the UNFPA Strategic Plan 2018-2019 will seek to ensure that “no one will be left behind and that the furthest behind will be reached first.” In the period leading up to 2030, UNFPA will organize its work around three transformative and people-centred results:

- a) an end to preventable maternal deaths;
- b) an end to the unmet need for family planning; and
- c) an end to gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage.

3.2 Previous Country Programme 2009-2013/2014

UNFPA has supported the Government of Timor-Leste since 1999 in the areas of reproductive health (RH), population and development (PD), and gender. After its restoration of independence, UNFPA signed the first Country Programme (CP1) of support for 2003-2005. In 2005, in order to harmonize its planning cycle with the National Development Plan, the CP1 was extended until 2007, which was further extended to December 2008 due to the security situation.

The Second UNFPA Country Programme (CP2) covered the period of 2009-2013 with a one-year extension until 2014. It sought to work collaboratively with stakeholders to ensure: (a) equitable access to quality RH services; (b) comprehensive responses to gender-based violence; (c) awareness raising for young people to make informed choices for a healthy, productive life; and (d) strengthened institutional capacity of the national statistics office and its operating systems.

The CP2 evaluation in 2012 highlighted a number of key achievements, which included: (a) revision of the national reproductive health strategy; (b) development of a behaviour change communication strategy;

(c) standardization of the midwifery curriculum at the National University of Timor-Leste; (d) strengthened family planning units in 67 percent of community health centres; (e) development and advocacy on law against domestic violence; (f) approval of a national action plan on gender-based violence; and (g) undertaking of the 2010 population and housing census.

The CP2 evaluation also identified lessons learned and made recommendations relevant to the next programme cycle, 2015-2019. In the area of reproductive and sexual health, it recommended: (a) developing the capacity of national trainers and supervisors in safe motherhood, family planning, gender-based violence and adolescent sexual and reproductive health; and (b) continuing to strengthen integrated sexual and reproductive systems, including the logistics management information system capacities of the Ministry of Health. In the area of gender equality, it recommended (c) reinforcing the role of the health sector in addressing gender-based violence issues; and (d) stepping up capacity building at the national, district and community levels to improve prevention, intervention and advocacy on gender-based violence. In the area of population and development, it recommended: (e) continuing support in the preparation of five-year censuses and other surveys; and (f) continuing work to formulate a national population policy that ensures population, reproductive health and gender concerns are integrated into all sectoral programmes.

3.3 The current Country Programme 2015-2019/2020

3.3.1 General focus of the CP

In the second half of 2014, UNFPA CO prepared the Third UNFPA Country Programme (CP-) and the Country Programme Action Plan (CPAP) for Timor-Leste in consultation with partner UN agencies and relevant government institutions. In the first quarter of 2015 a new government was appointed. Due to internal political situation the approval and signing of the CPAP was substantially delayed until September 2015.

The UNFPA assisted programme is being implemented by major government counterparts such as Ministry of Health (MoH), the General Directorate of Statistics (GDS), the Ministry of Education (MoEYS), Secretary of State for Equality and Social Inclusion (SEII), Secretary of State for Youth and Sport (SSYS) and a number of national and international Non-Governmental Organisations in Timor-Leste.

The **objective of the Third UNFPA Country Programme 2015-2019 (CP3)** is to create an enabling environment for sexual and reproductive health, while strengthening capacities, targeting interventions for the underserved and addressing inequalities.

CP3 focuses on vulnerable and underserved groups, with special attention given to young women (15 to 24 years old) who experience the highest maternal mortality, unwanted pregnancies and highest rate of gender-based violence. The CP Document stated that the Country Programme would address disparities found in geographic locations by focusing on the capital (Dili) and five Municipalities (Ainaro, Baucau, Bobonaro, Covalima and Oé-cusse Ambeno) with the weakest sexual and reproductive health indicators.

The 3rd Country Programme has four Outcomes and five Outputs as follows:

- **Outcome 1:** Increased availability and use of integrated sexual and reproductive health services including family planning, maternal health and HIV, that are gender-responsive and meets human rights standards for quality of care and equity in access.
 - **Output 1:** Strengthened capacity of the national health system to improve access to and increase the demand for family planning (FP).
 - **Output 2:** Increased national capacity to deliver integrated sexual and reproductive health services and respond to gender-based violence.
- **Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.
 - **Output 3:** Increased national capacity to design and implement community and school based comprehensive sexuality education programmes that promote human rights and

gender equality and increase the availability to young people of comprehensive quality, sexual and reproductive health information and services.

- **Outcome 3:** Advanced gender equality, women's and girl's empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescent and youth.
 - **Output 4:** Strengthened capacity of relevant government institutions and non-government organisations to implement the national action plan on gender-based violence.
- **Outcome 4:** Strengthening national policies and international development agenda through integration of evidenced-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.
 - **Output 5:** Strengthened national capacity for using data and evidence to develop, monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and reproductive health, youth and gender equality.

The CP3 is aligned with the priorities of the Timor-Leste National Strategic Development plan 2011-2030 and plans of the social sector ministries. It addresses national priorities to (a) reduce poverty, (b) ensure the rights of most vulnerable are protected, and (c) improve the quality, timeliness, accuracy and availability of statistical data.

The UNFPA Country Programme was to contribute to the outcomes of the United Nations Development Assistance Framework (UNDAF) for 2015-2020, particularly UNDAF Outcome 1: People of Timor-Leste, especially the most disadvantaged groups, benefit from inclusive and responsive quality health, education and other social services, and are more resilient to disasters and the impacts of climate change; and UNDAF Outcome 4: State institutions are more responsive, inclusive, accountable and decentralized for improved service delivery and realization of rights, particularly of the most excluded groups.

Furthermore, the Country Programme is guided by international conventions such as the Convention on Elimination of All Forms of Discrimination against Women (CEDAW), the International Conference on Population and Development (ICPD) Programme of Action and supports the Sustainable Development Goals (SDGs).

To achieve these outputs, the CP3 would support the following key interventions:

- **Output 1:** (a) enhancing the knowledge and skills of service providers through quality training; (b) improving the logistic management information system, forecasting and distribution of FP and other reproductive health commodities and supplies in health facilities; (c) improving the quality of behaviour change communication for increased use of SRH services; and (d) strengthening the knowledge base and provision of strategic information for programme and policy development and advocacy.
- **Output 2:** (a) develop national guidelines and quality assurance mechanisms, including on building capacity for maternal death surveillance and response; (b) strengthen competency-based training capacity of national training institutions by formalizing relationships with regional training institutes; (c) strengthen human resources for midwifery, basic emergency obstetrical care and adolescent sexual and reproductive health; (d) strengthen the capacity of the health sector to respond to gender-based violence; and (e) partner with civil society for adolescent SRH information and services.
- **Output 3:** a) collaborating with the Ministry of Education to implement a school-based comprehensive sexuality education; and (b) supporting comprehensive sexuality and reproductive health education for youth outside the school environment through innovative approaches and partnerships.
- **Output 4:** (a) advocate at the national level for pre-service curriculum development for health sector response, in-service training, and capacity strengthening and outreach in selected districts; (b) piloting a multi-sectoral response, including referral mechanisms for gender-based violence; and (c) providing capacity building and technical assistance to relevant institutions and organisations to effectively implement and monitor the national action plan.
- **Output 5:** (a) providing technical support for the 2015 population and housing census and other population surveys; (b) strengthening the institutional and technical capacity of the general directorate of the national statistics office; (c) strengthening the capacity of selected line ministries in integrating relevant population issues into plans and policies; and (d) promoting awareness

and policy dialogue among the public and decision makers on population dynamics, with particular attention to youth and women.

The CP3 was to contribute to emergency preparedness by strengthening the Government's capacity of emergency response and management, through the dissemination and implementation of the Health Sector Contingency and Preparedness Plan prepared by the UN Emergency Health Cluster Coordination Group. UNFPA would also support the integration of the Minimum Initial Service Package (MISP) into policy documents and national guidelines on health disaster management.

3.3.2 Financial structure of the CP

The Country Programme Document for the programme cycle 2015 – 2019 indicated UNFPA resources of a total of USD 15.5 million, with USD 10 mln. (67%) from regular resources and USD 5.5 mln. (33%) to be mobilised through co-financing modalities and other resources.

Table 3: CP Indicative Resources by Outcome Area (2016 – 2019) in USD million

Budget per Strategic Plan Outcome Areas	Regular Resources	Other resources	Total (USD mln)
Outcome 1: Sexual & Reproductive Health	4.5	3.5	8
Outcome 2: Adolescent and Youth	1.5	0.5	2
Outcome 3: Gender equality and women empowerment	1	0.5	1.5
Outcome 4: Population Dynamics	2	1	3
Programme Coordination & Assistance	1	0	1
Total in USD million	10	5.5	15.5

Source: UNFPA Timor-Leste (2015): Country Programme Document 2016-2019

Table 4 below shows the indicative resources per programme area and per year, estimated in the CPAP.

Table 4: CPAP Indicative Resources by Outcome Area (2015 – 2019) in USD million

CP Budget per Outcome Areas	Regular Resources: R Other resources: O in USD MILLION										TOTAL 2015 - 2019		GRAND TOTAL 2015-2019
	2015		2016		2017		2018		2019		R	O	
	R	O	R	O	R	O	R	O	R	O			
Outcome 1: Sexual & Reproductive Health	0.9	1.0	0.9	0.8	0.9	0.8	0.9	0.5	0.9	0.5	4.5	3.5	8.0
Outcome 2: Adolescent and Youth	0.4	0.1	0.3	0.1	0.3	0.1	0.3	0.1	0.2	0.1	1.5	0.5	2.0
Outcome 3: Gender Equality and women empowerment	0.2	0.1	0.2	0.1	0.2	0.1	0.2	0.1	0.2	0.1	1.0	0.5	1.5
Outcome 4: Population Dynamics	0.6		0.5	1.0	0.5		0.2		0.2		2.0	1.0	3.0
Programme Coordination & Assistance	0.2		0.2		0.2		0.2		0.2		1.0	-	1.0
Total in USD million	2.3	1.2	2.1	2.0	2.1	1.0	1.8	0.7	1.7	0.7	10.0	5.5	15.5
Total by Year in USD million	3.5		4.1		3.1		2.5		2.4		15.5		15.5

Source: UNFPA Timor-Leste (2015): Country Programme Action Plan 2015 - 2019.

Section 4.4.1 of this report includes an analysis of the CP expenditure and implementation rates.

4 EVALUATION FINDINGS (RESPONSES TO EVALUATION QUESTIONS)

This chapter summarises the main findings of the UNFPA Timor-Leste CP Evaluation.

4.1 Relevance

EQ 1) To what extent has UNFPA Timor-Leste ensured that the sexual and reproductive health and other needs of young people (including adolescents) are integrated in the planning and implementation of all UNFPA supported interventions under the Country Programme?

EQ 2) To what extent has the CO been able to adapt its strategies and programmes over time respond to changes or shifts caused by political changes in the country? What was the quality of the response?

SUMMARY

The 3rd UNFPA Country Programme (CP) for Timor-Leste is based on a clear understanding of the population needs and takes into account the national policies and strategies for the population and for maternal health, family planning, youth and gender issues in the country. Most CP-supported interventions were informed by needs assessments and participatory consultations with government and development partners.

UNFPA programme interventions addressed information and service needs of vulnerable groups, particularly young women (15 to 24 years old) who experience the highest maternal mortality, greatest percentage of mistimed births and highest rate of gender-based violence, as well as young men as supporters of family planning and maternal health and acknowledging their role in reducing gender-based violence. Interventions also targeted younger adolescents and key populations such as uniformed personnel, People Living with HIV, female sex workers and MSM.

The CP was in line with the mandate and priorities of UNFPA expressed in its global Strategic Plans (SP) for 2014-2017 and 2018-2021, as well as to the United Nations Development Assistance Framework (UNDAF) 2015-2019/2020 for Timor-Leste.

The UNFPA Country Office (CO) was responsive to the frequent changes in government leadership and policies and managed to reorient programme interventions to optimise buy-in and cooperation from government authorities. The CO also reoriented the CP geographic focus to respond to requests from central government and to changes in intervention requirements.

4.1.1 Integration of population needs into the Country Programme

The UNFPA Country Programme was relevant as it focussed on the needs of adolescent girls and young women and was in line with national strategies and policies in Timor-Leste.

The 3rd UNFPA Country Programme 2015-2019 in Timor-Leste focussed on needs identified in the national Strategic Development Plan for Timor-Leste and in sector strategies such as the RMNCH Strategy, the National Youth Policy and the National Action Plan on Gender-Based Violence.⁵⁰ The CP document describes that the CP will target vulnerable and underserved groups, with special attention given to addressing young women (15 to 24 years old) who experience the highest maternal mortality, greatest percentage of mistimed births and highest rate of gender-based violence. Attention would also

⁵⁰ Democratic Republic of Timor-Leste (2011): Timor-Leste Strategic Development Plan 2011-2030.

Ministry of Health, Timor-Leste (2015): National Strategy on RMNCAH 2015-2019.

Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2016): National Youth Policy.

Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2018): National Youth Action Plan 2018-2022.

Secretariat of State for the Support and Socio-Economic Promotion of Women (SEM) (2017): National Action Plan on Gender-Based Violence 2017-2021.

be given to addressing young men as supporters of family planning and maternal health and acknowledging their role in reducing gender-based violence.

During the CP period, UNFPA and Implementing Partners (IPs) carried out a number of assessments which further informed CP programming. These include the situation assessment of the Emergency Obstetric and Newborn Care (EmONC) in 2015⁵¹, the national SRHR assessment in 2017,⁵² the assessment of the Reproductive Health Commodity Security in 2018⁵³, and the CSE curricula assessment in 2017⁵⁴. In addition, the CP supported a number of assessments which specifically looked at how to address inequities and challenges by vulnerable groups in accessing knowledge and services. These include the SRHR assessment by the national ombudsman for human rights (PDHJ) in 2017⁵⁵; the teenage pregnancy study in 2017⁵⁶; the Leave No One Behind series focusing on various vulnerable youth groups in 2018⁵⁷; and the assessment by Nossal Institute on the access of People with Disability to GBV services in the health sector⁵⁸. The CP also supported national surveys such as the 2015 Population & Housing Census and the 2016 Demographic and Health Survey, which provided further data on needs of young people.

The evaluation team finds that the Timor-Leste CP was in line with the mandate and priorities of UNFPA expressed in its global Strategic Plans (SP) for 2014-2017 and 2018-2021.⁵⁹ The CPD was defined around the 4 strategic outcomes of the UNFPA SP. The CP is furthermore fully aligned to the United Nations Development Assistance Framework (UNDAF) for Timor-Leste⁶⁰, as illustrated in table 5 below.

Table 5: Alignment of the 2nd CP Outputs to the UNDAF

Intervention area	Output of the 2nd UNFPA Country Programme	UNDAF Results
Outcome 1: Sexual and reproductive health -	Output1: Strengthened capacity of national health system to improve access to and increase demand for FP. Output 2: Increased national capacity to deliver integrated SRH services and respond to GBV.	Contributes to the UNDAF outcome 1: People of Timor-Leste, especially the most disadvantaged groups, benefit from inclusive and responsive quality health, education and other social services, and are more resilient to disasters and the impacts of climate change. Sub-Outcome 1.3 Population of Timor-Leste, in particular the most excluded, benefit from equal access to quality health and nutrition services and behaviour change promotion interventions.

⁵¹ MoH Timor-Leste (2015): Emergency Obstetric and Newborn Care Needs Assessment Timor-Leste 2015.

⁵² Ombudsman for Human Rights and Justice (Provedoria dos Direitos Humanos e Justiça - PDHJ), UNFPA Timor-Leste (2017): 2017 Country Assessment on Sexual Reproductive Health Rights in Timor Leste.

⁵³ MoH Timor-Leste, UNFPA (2018): Reproductive Health Commodity Security Situational Analysis of Timor-Leste. December 2018.

⁵⁴ UNFPA Timor-Leste (2018): Assessment of Comprehensive Sexuality Education in Timor-Leste's School Curriculum. Dili, June 2018

⁵⁵ Ombudsman for Human Rights and Justice (Provedoria dos Direitos Humanos e Justiça - PDHJ), UNFPA Timor-Leste (2017): 2017 Country Assessment on Sexual Reproductive Health Rights in Timor Leste.

⁵⁶ SSYS, UNFPA, Plan International (2017): Teenage Pregnancy and Early Marriage in Timor-Leste.

⁵⁷ Belun NGO / UN (2018): Leave No One Behind in Timor-Leste. Policy Brief nr 1 – Young Female Farmers. Policy Brief nr 2 – Migrant Youth in Dili City. Policy Brief nr 3 –Young People neither in Education, Employment nor Training. Policy Brief nr 4 – LGBTI Youth. Policy Brief nr 5 – Young People With Disability.

⁵⁸ Pearce, Emma (2019): Improving integration of prevention and management of GBV for people with disabilities in the health sector; final report, 9 July 2019. Nossal Institute for Global Health, Melbourne University, Australia.

⁵⁹ UNFPA (2014): UNFPA Strategic Plan, 2014-2017.

UNFPA (2018): UNFPA Strategic Plan 2018-2021.

⁶⁰ UN Timor-Leste (2015): United Nations Development Assistance Framework, Timor-Leste 2015-2019; supporting equitable and sustainable development in a rising young nation.

Intervention area	Output of the 2nd UNFPA Country Programme	UNDAF Results
Outcome 2: Adolescents and youth	Output 3: Increased national capacity to design and implement comprehensive sexuality education programmes that promote human rights and gender equality and increase availability to young people of comprehensive quality SRH information and services.	Contributes to the UNDAF Outcome 1, Sub-Outcome 1.2 Children, youth and adults benefit from inclusive and quality education at all levels in an equitable manner. Sub-Outcome 1.5: In an enabling environment, young men and young women make informed choices for a healthier and more productive life as citizens who actively contribute to the peace and development of their country.
Outcome 3: Gender equality and women's empowerment	Output 4: Strengthened capacity of relevant government institutions and non-government organisations to implement the National Action Plan GBV.	Contributes to the UNDAF Sub-Outcome 1.1: The most disadvantaged groups of men, women and children benefit from gender-responsive and inclusive social protection, social cohesion and behaviour change programmes, including for the prevention and protection of women and children from violence.
Outcome 4: Population dynamics	Output 4: Strengthened national capacity for using data and evidence to develop, monitor and evaluate national policies and programmes in areas of population dynamics, sexual and reproductive health, youth and gender equality.	Contributes to the UNDAF outcome 4: State institutions are more responsive, inclusive, accountable and decentralized for improved service delivery and realization of rights, particularly of the most excluded groups. Sub-Outcome 4.4: Relevant state institutions have improved capacity to collect, analyse and use reliable and timely socio-demographic disaggregated data for evidence-based planning, budgeting, monitoring, reporting and decision-making targeting disadvantaged groups.

In terms of global commitments, the UNFPA CPD and CPAP reflect the International Conference on Population and Development (ICPD) Plan of Action and the Sustainable Development Goals (SDGs).

The CPE team finds it important that UNFPA continue to work on its entire mandate, including promoting rights-based SHRH programming for population groups such as non-married adolescents and young persons and other vulnerable groups such as key populations, for whom the access to SRHR knowledge and service is a sensitive topic in Timor-Leste.⁶¹

4.1.2 Response to changes in the country

The UNFPA Country Office (CO) was able to adapt CP approaches and speed of implementation to developments in the sectors, such as changes in high-level Ministerial staff, changes in sector priorities and policies, and to the recommendations from the CP Mid-Term Evaluation.

In terms of geographic focus, the CPD described that the CP would address disparities found in geographic locations by focussing on specific areas, namely the capital (Dili) and five municipalities (Ainaro, Baucau, Bobonaro, Covalima and Oé-cusse Ambeno) with the weakest sexual and reproductive health indicators, including a lower percentage of skilled birth deliveries and family planning demand satisfied and higher prevalence of gender-based violence, HIV and other sexually transmitted infections. It had been envisaged that the CP would support a comprehensive package of SRHR interventions in those five municipalities. However, once the CP got underway, the government and UNFPA no longer felt that the geographic focus defined in the CPD was relevant. Also in the meantime, other development partners has started to provide comprehensive maternal health interventions in the municipalities of Ainaro and Covalima.

Instead, at the request of the government, the CP shifted most of its support to capacity strengthening of government capacity at central level in Dili in combination with supporting capacity strengthening of service providers throughout the country. Later during the CP period, UNFPA and government authorities

⁶¹ Including Sex Workers, Men having Sex with Men (MSM) and LGBT persons (Lesbians, Gays, Bisexuals and Transsexuals).

decided that the CP would support the piloting of a few key interventions in selected municipalities. Thus Liquiça municipality was selected by the Ministry of Education for the first phase of the in-school CPE roll-out; Dili municipality was selected for the piloting of the Girls & Boys Circles CPE programme in schools implemented by NGO FOKUPERS; and Oé-cusse Ambeno and Baucau municipalities were selected for the Birth Preparedness Plan programme implemented by the Alola Foundation).

The advocacy of UNFPA has contributed to changing attitudes amongst senior officials from the Ministry of Education and the Secretariat of State for Youth and to them becoming committed to providing SRHR information to adolescents and youth, including unmarried girls and boys, and to teaching girls and boys about gender and the prevention of GBV.

With the arrival of the new Minister of Health in 2016, and ministerial reticence to only promote the use of modern contraceptives, UNFPA and partners agreed to include traditional FP methods into the FP guidelines. The CP then worked with MoH and WHO to update the national FP training curriculum, and supported the Instituto Nacional de Saude (INS) strengthen the capacity of their national trainers and to roll out the updated FP training of midwives and nurses. The CO also adjusted the CP focus based on the recommendations identified by CP mid-term evaluation carried out in 2017.⁶²

4.1.3 Main external challenges

During the evaluation, stakeholders interviewed and background documents reviewed identified a number of external challenges in Timor-Leste, which had a considerable impact on the environment in which the Country Programme had to operate and which adversely affected the implementation and timely achievement of the CP targets. Rather than repeating these external challenges in the various sections of this chapter, we prefer to list them here.

One external challenge for the UNFPA Timor-Leste Country Programme is the cultural context in the country with traditionalism and conservatism of some parties. This has an impact on the willingness of authorities and communities to act on all issues in UNFPA's mandate, particularly those related to the right to access to SRHR, as well as an impact on the ease of UNFPA to openly advocate on these issues.

Another challenge was the political instability and changes in government structures and staff, which contributed to a lack of clear and consistent leadership by higher level government authorities as well as to the loss of staff whose capacity has previously been strengthened by UNFPA and partners. The reshuffle of ministers and secretaries of state and the formation of a new government in 2015 resulted in the delay of the signing of the UNFPA Country Programme Action Plan (CPAP) until September 2015. This delayed the start of Country Programme implementation by about 9 months.⁶³ In 2017 Parliamentary elections were held. The new government's programmes and budgets submitted to Parliament were rejected twice, resulting in policy decisions being put on hold. Overall these changes in central level government led to delays in CP implementation.

Another challenge is the fact that the coordination by government of the implementation of sector strategic plans and annual work plans is still not strong. CP programme implementation in Timor-Leste is also affected by the shortage and limited technical capacity of human resources in the various sectors. Furthermore, in terms of implementation environment during the year, the rainy season from November to April impacts on field activities and access to much of the country. In addition, government implementing partners usually do not have access to their annual budget until Quarter 2 of each calendar year. This is taken into account in scheduling CP activities.

A major challenge was the reduction in core funding from UNFPA for the Timor-Leste Country Programme by about 23% during the first two years of the CP, which adversely affected programme implementation. For example, implementation of the revised right-based family planning health worker training curriculum was projected to cost USD 230,000 of which a small portion was available from Government and a donor

⁶² UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

⁶³ UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

(USAID-JSI) and from the UNFPA CP. The UNFPA Country Office was able to align the family planning programme with USAID to support key activities, but their support covers only one municipality.⁶⁴

Since the United Nations Development Assistance Framework (UNDAF) in Timor-Leste was only approved in late 2015, the UN decided to extend the duration of the UNDAF with one year to December 2020. This resulted in the 3rd UNFPA Country Programme for Timor-Leste being extended to December 2020. This was also in line with the recommendation from the UNFPA Country Programme Mid-Term Evaluation in 2017.

4.2 Effectiveness

EQ 3) To what extent have the 3rd CPD outputs been achieved, and to what extent have these outputs contributed to the achievement of the 3rd CPD outcomes?

EQ 4) To what extent has UNFPA made good use of its comparative strengths to add value to the development results of Timor-Leste?

EQ 5) To what extent did the implementation of the UNFPA programme in Timor-Leste take into account gender equality and human rights principles?

SUMMARY

The UNFPA CP was effective in contributing towards capacity strengthening of central level government for the coordination of service provision in key mandate areas such as Family Planning (FP), emergency obstetric care (EmONC), Comprehensive Sexuality Education (CSE) for young people in-school and out of school and the health sector response to Gender-Based Violence (GBV). The CP also strengthened capacity of central government to coordinate and support the provision of HIV prevention services, particularly for professionals at risk such as police officers, health workers groups and key populations in border areas.

CP support provided 100% of all contraceptives procured in the country's public sector over the past 5 years, and was thus able to ensure that contraceptive availability is maintained in the country. CP advocacy has led to the GoTL's commitment to gradually take over contraceptive procurement funding from domestic resources. However, contraceptive stockouts in health facilities are continuing, a situation which MoH, UNFPA and partners are working to address.

The CP was effective in contributing to capacity strengthening of the public system for family planning and maternal health services, with focus on emergency obstetric and newborn care (EmONC) and maternal death surveillance. Capacity building of health care providers has contributed to improving the availability and accessibility of quality family planning services and of emergency obstetric care. Survey results show that the proportion of married women who know at least one modern contraceptive method is increasing. The CPE does not have information on to which extent the training of a part of health workers in the new FP guidelines supported by the CP is contributing to this increase. The CP did not have sufficient resources to support any large-scale SRHR behaviour change communication interventions. Community-based approaches supported by the CP such as the Birth Preparedness Plan contributed to increasing deliveries assisted by qualified personnel, whereas EmONC capacity building of health workers reportedly contributed to decreasing maternal morbidity and mortality in CEmONC facilities supported. In late 2019 the CP supported an evaluation of the impact of the EmONC training on quality of EmONC care provided. The evaluation results should be available soon.

UNFPA supported emergency preparedness by ensuring that Reproductive Health needs are included in the National Emergency Plan. In addition, UNFPA developed a minimum preparedness plan for the CP and regularly trained CO staff on the Minimum Initial Service Package (MISP). UNFPA also oriented relevant Ministerial staff and stakeholders on MISP.

The CP was highly effective in conducting advocacy with high-level officials of the MoEYS and the Youth Secretariat, who have developed ownership of and commitment to CSE interventions and have become champions for raising awareness of adolescents and youth on SHRH/gender/GBV. This is an impressive result in a country such as Timor-Leste with its traditional cultural values. The CP supported the roll-out of CSE programmes in all schools in the country, followed by training of teachers in one municipality in the use of CSE teaching aids. However, the roll-out has not been monitored by central government and the CSE results not yet documented. Assessments and interviews suggest that many

⁶⁴ UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

teachers do not yet feel comfortable to teach CSE subjects to students. The approval and roll-out of CSE materials developed for out-of-school youth has been delayed due to cultural sensitivities amongst government staff and the Catholic Church stands on contraceptives information sharing to young people.

Advocacy efforts have resulted in GBV having become a topic that government and partners feel comfortable discussing and are committed to tackle. With CP support, SEII has become committed and proactive in the coordination of the implementation of the National Action Plan for GBV. CP supported capacity building efforts produced and strengthened relevant policies and tools for the implementation of the NAP-GBV, particularly in the health sector and for GBV prevention amongst adolescents and youth reached through CSE interventions.

The CP effectively supported capacity building of the GDS as the government central entity to coordinate and conduct key population surveys, including the Population & Housing Census of 2015 and Demographic and Health Survey in 2016. This enabled the GoTL to produce an impressive number of high-quality surveys and studies, enabling the government to collect important data on population and development issues. The CP also supported key sector ministries in the integration of population, SRHR and GBV issues into plans and policies.

The CP was furthermore effective in promoting the use of data in programming and policy development by government institutions at national and municipal levels, who have started to use and request data for decision making and planning.

The CPE team was not able to identify any unintended effects of the CP.

4.2.1 Achievement of CP outputs and outcomes

Output 1 – Effectiveness Analysis Findings for Family Planning

CP Strategic Result 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.

CP Results Indicators	CP Targets	Level of achievement	Comments
R.1.1 Percentage of FP demand satisfied (15-49), baseline: 42%, target: 70%	Baseline: 42%. Cumulative CP target: 70%. (source: DHS)	47% amongst currently married women age 15-49 using modern methods. 67.1% (47/70) of total CP target achieved by 2016 (source DHS 2016) -	
R.1.2 Proportion of births attended by skilled birth attendants (15-49), baseline: 30%, target: 65%	Baseline: 30%. Cumulative CP target: 65%. (Source: DHS)	57% of live births in the five years prior to the survey were delivered by a skilled birth provider. 87.7% of total of total CP target achieved by 2016 (source DHS 2016)	

CP Output 1	Strengthened capacity of national health system to improve access to and increase demand for family planning (FP).
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CP Output indicators	CP Targets	Level of achievement	Comments
O.1.1 Number / Percentage of health facilities in UNFPA supported districts reporting no stock-outs of contraceptive in the last six months	Baseline: 59 / 45%. Cumulative CP target: 133 / 100%. (Source: FP Facility Audits)	1) Ainaro: 0%, 2) Baucau: 3%, 3) Bobonaro: 12%, 4) Cova Lima: 5%, 5) Oé-cusse Ambeno: 4.5%. Average of 4.9% achieved in the 5 priority municipalities.	Based on data from Facility Audit 2017, all facilities in the priority municipalities had stock-outs of contraceptive. Therefore, the CPE measures “no progress” against this indicator. However, it should be noted that other factors, such as supply chain

CP Output indicators	CP Targets	Level of achievement	Comments
		4.9% of cumulative CP target achieved. (Source: FP Facility Audit 2017). Collected data on stock out in last 3 months (question 17)	challenges, contribute to stock-outs in facilities. FP Facility Audit report of 2018 does not provide information per municipality.
O.1.2 Number / percentage of health facilities in UNFPA supported districts providing at least three or more methods of family planning	Baseline: 94 (71%). Cumulative CP target: 133 (100%). (Source: FP Facility Audits)	1) Ainaro: 29%, 2) Baucau: 40%, 3) Bobonaro: 48%, 4) Cova Lima: 55%, 5) Oé-cusse Ambeno: 68%. Average of 48% achieved in the 5 priority municipalities. 48% of cumulative CP target achieved. (Source: FP Facility Audit 2017)	Data from Facility Audit 2017 suggest that there is “no progress” against this output indicator. The FP Facility Audit report of 2018 does not provide information per municipality. There is a need to review and analyse the country's RH commodity security status and identify challenges and opportunities for reproductive health commodity security. In addition, it is important to know whether the CP has trained all health providers in FP methods or only a part of them.
O.1.3 Percentage of married women aged 15-49 in UNFPA supported districts who have knowledge of three or more FP methods	Baseline: 40%. Baseline percentage of married women aged 15-49 who know at least one modern contraceptive method: 1) Ainaro: 57.4%, 2) Baucau: 55.8%, 3) Bobonaro: 78.3%, 4) Cova Lima: 95.5%, 5) Oé-cusse Ambeno: 94.9%. Average knowledge is 76.46% in the 5 priority municipalities. Cumulative CP target: 80%. (Source: DHS 2009-2010)	Percentage of married women aged 15-49 who know at least one modern contraceptive method: 1) Ainaro: 65.8%, 2) Baucau: 72.9%, 3) Bobonaro: 92.9%, 4) Cova Lima: 82.6%, 5) Oé-cusse Ambeno: 92.7%. Average knowledge is 81.4% in the 5 priority municipalities. 101% of total cumulative CP target achieved. (Source: DHS 2016)	DHS 2016 data suggest that knowledge amongst married women of at least one modern method in the 5 priority municipalities is an average of 81.4%. This can be categorised as progress compared to the average in 5 municipalities of 76.4% in 2010. While knowledge in Ainaro, Baucau and Bobonaro increased, it decreased in Cova Lima and Oé-cusse. There are no data available for the period after 2016. The degree of knowledge of married women in priority districts can only partially be attributed to the CP, as the CP only supported training of some health workers in FP and did not support mass awareness-raising campaigns in communities on FP.

The analysis of the level of achievement of the output indicators shows that by November 2019 for Output 1 – FP, one out of three indicators had achieved their cumulative CP target.

The CP was effective in contributing to increasing capacity of the national health system to improve access to Family Planning. The CP procured 100% of the FP commodities and reproductive health supplies consumed in the public sector during the 5 CP years and was thus able to ensure that contraceptive availability is maintained in the country. The CP also strengthened capacity of MoH and SAMES staff in the areas of logistic management information system, forecasting and distribution of FP and other reproductive health commodities and supplies to municipal medical stores, and contributed to increasing the knowledge base in this area. However, contraceptive stockouts and expirations continued, which shows that capacity building and systems strengthening needs to continue.

The CP was partially effective in strengthening capacity of public sector health workers in some municipalities to provide FP counselling and prescription, and thus contributed to increasing demand for FP. The FP training of health workers reached 116 midwives and nurses but could not be scaled up due to lack of CP resources.

Apart from supporting provision of SRHR information to adolescents and youth through in-school CSE, the CP did not support any significant behaviour change communication efforts and did not contribute to the CPD planned improvements of the quality of behaviour change communication for increased use of SRH services.

The strategic partner of UNFPA in this programme area is the Timor-Leste Ministry of Health (MoH), assisted by the national medical stores department SAMES, the National Health Institute (INS) and the municipal Departments of Health.

CP achievements are in line with the CP Output, as the programme focussed on capacity building of MoH and SAMES staff in the areas of quantification for contraceptives and Reproductive Health (RH) supplies, of the supply chain management system and the Logistics Management Information System (LMIS).⁶⁵ The HSCS Situation Analysis supported by UNFPA formed the basis for the National Reproductive Health Commodity Security Strategy 2019-2023 and Action Plan, which set out the priorities for capacity strengthening of the Timor-Leste supply chain management, monitoring and information systems for health sector commodities.

The CP contributed to the development of national policy documents, including the updated RMNCAH Strategy 2015-2019 (still awaiting approval)⁶⁶; the National Family Planning Policy (still awaiting approval)⁶⁷; training modules on Family Planning (approved and in use)⁶⁸; and the National Reproductive Health Commodity Security Strategy 2019-2023 and Action Plan (in development)⁶⁹. It also supported national assessments such as the Situation Analysis on Health Sector Commodity Security (HSCS).⁷⁰

The CP supported access to FP through provision of FP commodities in combination with strengthening of the supply chain, and through improvement of the quality of FP services provided through training of health providers. During the five CP years 2015-2019, UNFPA continued to procure 100% of the contraceptives and RH supplies needs for Timor Leste's public sector, completely funded by UNFPA, to a total value of USD 820,580 for the 3 years 2017-2019. At the same time, the CP contributed to increased FP demand by increasing the FP knowledge of health facility users who received FP counselling. This is much appreciated by the MoH and other stakeholders interviewed during this evaluation.

Forecasting for contraceptives for MoH supported programmes is carried on a yearly basis jointly by the MCH Department of National Public Health Directorate and Pharmaceutical Department of MoH and SAMES with technical support from UNFPA. UNFPA staff and stakeholders interviewed feel that the quality of the national annual quantification exercises is adequate. During previous years, some health sector NGOs were allowed to participate in the forecasting exercise and/or were kept informed of the results of the forecasting, which was appreciated by the NGOs concerned. However, health sector partners interviewed by the CPE team reported that the annual quantification of contraceptives in 2019 was carried out by MoH and UNFPA without participation of or communication to other partners.

⁶⁵ UNFPA Timor-Leste (2015): 2015 Annual Report – Timor-Leste. Report generated by UNFPA SIS system.
UNFPA Timor-Leste (2016): 2016 Annual Report – Timor-Leste. Report generated by UNFPA SIS system.
UNFPA Timor-Leste (2017): 2017 Annual Report – Timor-Leste. Report generated by UNFPA SIS system.
UNFPA Timor-Leste (2018): 2018 Annual Report – Timor-Leste. Report generated by UNFPA SIS system.

⁶⁶ MoH Timor-Leste (2015): RMNCAH Strategy 2015-2019.

⁶⁷ MoH Timor-Leste (20XX): National Policy on Family Planning.

⁶⁸ MoH Timor-Leste (2017): Family Planning, a Manual for Participants; based on training by UNFPA, WHO and USAID Training Resources Package for Family Planning.

⁶⁹ MoH Timor-Leste (2019): National Reproductive Health Commodity Security Strategy, Timor-Leste 2019 – 2023. First draft February 2019.

⁷⁰ MoH Timor-Leste, UNFPA (2018): Reproductive Health Commodity Security Situational Analysis of Timor-Leste. December 2018.

The 2018 HSCS assessment documented some improvement in capacity by MoH and SAMES staff to forecast, manage and distribute contraceptives and RH supplies, partly due to UNFPA support to capacity strengthening. The CP supported central level staff of the MoH Reproductive Health Unit, Pharmacy Department and HMIS Department and of the SAMES staff to attend trainings abroad on Reproductive Health Commodity Security (RHCS) and the LMIS and by accompanying them in the HSCS assessment and development of the strategy. The CP is currently supporting preparations for capacity building during 2020 of commodity managers at municipal and health facility levels.

The HSCS assessment identified a number of remaining challenges in the contraceptives supply chain, information and monitoring systems, including relating to the capacity of staff, policies and procedures at central level MoH and SAMES. The assessment also found a number of contraceptives expiring with a total value estimated at USD 430,000 and that stockouts would be likely in the following months.⁷¹ The Facility Audits conducted in 2017 and 2018 also showed that stockouts at health facility level continued. The RHCS assessment made a number of recommendations for MoH and UNFPA to further strengthen the contraceptives supply chain and monitoring and supervision systems at all levels. MoH and UNFPA are currently working to address the recommendations, which form the basis for the new RHCS Strategy currently being developed by MoH, UNFPA and partners. The assessment also recommended that UNFPA carry out a study of the supply chain to identify the problems and the reasons for the stock-outs and expiry of commodities. UNFPA conducted this study in 2019: it concluded that the contraceptives expiries and the stockouts at national level and health facility level were largely due to challenges in the supply chain system at central (SAMES and MoH), municipal and health facility system, both in terms of lack of capacity and inadequate systems.⁷² The decision by government to change the pharmaceutical management software from M-Supply to Aden Box also contributed to the challenges. MoH, SAMES and UNFPA have taken note of the study results and the CP has formulated a capacity strengthening programme for SAMES and for district authority and health facility staff on forecasting and stock management.

The advocacy conducted by UNFPA with central level government was effective, as the GoTL has agreed to contribute domestic resources for contraceptive procurement in a phased approach, committing to contributing 25% of the national conceptive procurement budget in 2020, 50% in 2021, 75% in 2022 and 100% in 2023.⁷³ This is a demonstration of increasing government ownership over the country's FP programme. The strategy used by UNFPA to have renowned national institutions such as the Ombudsman for Human Rights and Women Parliamentarians discuss SHRH and FP issues was clever, as this has resulted in these institutions having become change agents and champions supporting the rights of individuals to access FP. Working closely together with WHO and with support from the Australian and US Government also added weight to the UNFPA CP's efforts.

Whereas the GoTL has committed to increasing its domestic resource allocation to contraceptives procurement, relying on this commitment represents a risk of gaps in financing and/or procurement. The CP may therefore wish to consider maintaining an emergency stock of contraceptives or a contingency funding for procurement of contraceptives when stockouts seem likely.

Although due to the change in Ministers of Health important policy documents such as the RMNCAH Strategy 2015-2019 and the National Family Planning Policy were not approved by Government, they did provide the basis for the work by UNFPA and partners to submit capacity building of MoH staff at central and municipal levels and of health workers. UNFPA worked with MoH, WHO and other partners such as the US Government to update the previous FP guidelines from 2004, aligning it to international standards, and at the request of the Minister of Health at the time, included traditional FP methods into the guidelines. The training modules on Family Planning were approved by MoH and thereafter used by UNFPA and

⁷¹ MoH Timor-Leste, UNFPA (2018): Reproductive Health Commodity Security Situational Analysis of Timor-Leste. December 2018.

⁷² MoH, UNFPA Timor-Leste (2019): Operational Research on Date Expiry of Contraceptives Leading to Acute Stock Outs in Timor-Leste. March 2019.

⁷³ MoH Timor-Leste (2019): National Reproductive Health Commodity Security Strategy, Timor-Leste 2019 – 2023. First draft February 2019.

other health sector partners to support capacity building by INS of midwives and nurses on FP. The CP directly supported the training of 116 health workers in the new FP guidelines between late 2017 and mid-2019. This represents approx. 8.9% of the total of 1.300 nurses and midwives currently employed in the public sector in the country.⁷⁴ Unfortunately, due to funding constraints, only a part of health workers were enrolled in the FP training so far. The change in knowledge and skills of health workers that benefitted from the FP training has not been documented.

However, no monitoring or evaluation was carried out by MoH or the CP to assess the increase in capacity of health workers trained in FP and its impact on FP use by communities. Therefore, the CPE team does not dispose of any data to assess the impact of the FP training. However, municipal RH supervisors and health workers trained in FP interviewed by the CPE team stated health workers trained felt more confident in prescribing various methods of FP and expressed their observation that FP demand and use in their target populations are increasing.

The CPD stated that a key CP intervention area would be to improve the quality of behaviour change communication (BCC) for increased use of SRH services. The CPE team was not able to identify any actions by UNFPA and its partners here, apart from indirect contributions through the CP's support to the revision of the FP policy and FP guidelines and the training of health workers.

The major external challenge for this CP output was the lack of support for modern FP methods by previous and current senior MoH staff. As a result, policies and programme documents developed with earlier ministerial leadership were revised and approval of some plans / strategies put on hold.

Output 2 – Effectiveness Analysis Findings for Integrated SRHR and GBV

CP Output 2		Increased national capacity to deliver integrated sexual and reproductive health services and respond to gender-based violence (GBV).	
CP Output indicators	CP Targets	Level of achievement	Comments
O.2.1 Number of new / revised sexual and health enabling institutions, policies, strategies and guidelines implemented / initiated	Baseline: 6. Cumulative CP target: 10. (Source: UNFPA reports)	8 policies and strategies initiated by Nov. 2019. 80% (8/10) of cumulative CP target achieved. (Source: UNFPA reports)	Documents revised include: 1. RMNCAH Strategy; 2. EmONC Improvement Plan of Action; 3. EmONC Training Package for Health Care Providers; 4. Standard for programming intra partum and immediate post-partum care; 5. MDSR Guidelines; 6. National Guidelines for Health care providers to address GBV including IPV; 7. National Action Plan for GBV. 8. Guidelines for Safe Disposal of Expired Contraceptives.
O.2.2 Number / percentage of facilities providing 24/7 basic emergency obstetric care services as per national standards	Baseline: 4 / 6%. Cumulative CP target: 67/ 100%. (Source: UNFPA reports)	31% of facilities to provide 24/7 basic EmONC services by the end of the current programme cycle. 60% of cumulative CP target achieved. (Source: UNFPA CO staff)	Based on the annual plan of the MoH Integrated Sexual and Reproductive Health programme, only 60% of facilities will have been strengthened to provide 24/7 basic EmONC services as per national standards by the end of the CP. The 2017 MTR recommended for UNFPA to adjust the target of this indicator accordingly from 100% to 60% but this does not appear to have been done. ⁷⁵

⁷⁴ Cabral, Jorge et al. (2013): Scaling-up the medical workforce in Timor-Leste: Challenges of a great leap forward. In *Social Science & Medicine* (2013). Quoting MoH Timor-Leste (2010): Relatório Estatística Saúde, 2011. Tinan.

⁷⁵ UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

CP Output indicators	CP Targets	Level of achievement	Comments
O.2.3 Percentage of pregnant women in UNFPA supported districts with birth preparedness / complication plan	Baseline: 0%. Cumulative CP target: 50%. (Source: Alola Progress and Annual Reports)	28.5% of pregnant women in Oé-cusse Ambeno were referred to health centres or by Dec 2018 57% of total CP target achieved. (Source: UNFPA reports)	Birth Preparedness Plans developed through Alola Foundation in Oé-cusse Ambeno municipality in all villages in the catchment areas of the local Health Posts. According to Alola Foundation's annual report over 2018, in 2018 29% of the total 1,222 births in the 18 villages took place at health facilities and 47% at home assisted by skilled birth attendants, which amounts to a total of 76% assisted by skilled health staff. During 2018 Alola staff referred 401 (28.5%) pregnant women out of a total of 1,409 deliveries to health facilities or the hospital.
O.2.4 Number / percentage of UNFPA priority districts with functional maternal death surveillance and response mechanisms	Baseline 0/0%, Cumulative CP target: 6/100%. (source: Maternal Mortality annual report)	100% of UNFPA priority municipalities have functional maternal death surveillance and response by Nov. 2019. 100% of total CP target achieved. (Source: annual Maternal Mortality Report)	The CP target was achieved in 2017 two years ahead of schedule. The CP MTR report recommended that during the remaining CP period, UNFPA and partners should focus on quality assurance through regular monitoring.

The analysis of the level of achievement of the output indicators shows that by November 2019 for Output 2 – Integrated SRH and response to GBV, one out of four indicators achieved their cumulative CP target.

The CP achievements are in line with the CP Output's objective to support capacity building of MoH staff on SRH service provision and response to survivors of gender-based violence (GBV), including intimate partner violence (IPV).
The CP was effective in contributing to capacity strengthening of the public system for maternal health services, with focus on emergency obstetric and newborn care (EmONC) and maternal death surveillance. 85 health providers of all 9 CEmONC facilities were trained in EmONC and MDSR systems were established in all 13 municipalities.
The CP also supported MoH in developing policies and tools for the response to survivors of gender-based violence (GBV) in preparation of the start of health worker capacity building.
Furthermore, the CP supported MoH and partners to improve HIV prevention efforts amongst professionals at risk such as health workers in border areas, police officers and key populations. Police officers were reached with information on HIV/STI prevention and treatment, FP and GBV. 268 health workers and 870 key populations were also reached.
UNFPA continued to be a strong advocate with central level stakeholders for SRHR, particularly the provision of SRHR information and services to all population groups, including adolescents and youth. UNFPA supported emergency preparedness by ensuring that Reproductive Health needs are included in the National Emergency Plan in Timor-Leste. In addition, UNFPA developed a minimum preparedness plan for the CP and regularly trained CO staff on the Minimum Initial Service Package (MISP). UNFPA also oriented relevant Ministerial staff and stakeholders on MISP.

The strategic partner of UNFPA in this programme area is the Timor-Leste Ministry of Health (MoH) in Dili, assisted by the National Health Institute (INS) and the municipal Departments of Health, and the Timor-Leste Police Department (PNTL). Civil society partners include the NGO Alola Foundation and the PLHIV association Estrela+.

The CP contributed to the development of national policy documents, including the EmONC assessment and EmONC Improvement plan 2016-2019 (approved and launched)⁷⁶; the standards of care on management of complications during pregnancy, during delivery and after delivery⁷⁷; the EmONC training modules on management of complications during pregnancy and during and after delivery; annual maternal mortality reports; guidelines for the maternal death surveillance and response system (approved and rolled-out)⁷⁸; and guideline for health sector response to GBV (approved by MoH)⁷⁹. It also supported important assessments such as the Country Assessment on SRHR by the national Ombudsman on Human Rights (PDHJ)⁸⁰; the Study on Teenage pregnancy with SSYS and Plan International⁸¹; and the HIV Stigma Index assessment with Estrela+ and MSTL.⁸²

The close cooperation between UNFPA and WHO in promoting key interventions in maternal health, family planning and GBV response contributed to focussing GoTL attention on these key interventions and inspired various partners (Australia, US Government) to support them.⁸³

The 2015 national EmONC Needs Assessment of 75 health facilities⁸⁴ found that only six Comprehensive EmONC (CEmONC) and two Basic EmONC (BEmONC) facilities were functional, meaning that seven out of thirteen municipalities in the country had no functional EmONC facilities. UNFPA then supported MoH, WHO and other partners to develop a costed 4-year EmONC improvement plan (2016-2019) which aimed to reach by 2019 a total of 43 functional EmONC facilities, including the 6 Comprehensive facilities already existing that needed to be strengthened.⁸⁵ MoH and partners standardised antepartum, intrapartum and postpartum protocols and developed a comprehensive training package on intra-partum care, immediate postpartum care and for management of obstetric complications. UNFPA also supported the development of EmONC profiles of each municipality, which were shared with central and municipal authorities and partners,⁸⁶ and were useful for municipalities and their partners to plan their EmONC strengthening efforts, whereas the standards of care provided tools for standardisation and quality assurance. JSI and KOICA used these profiles and care standards to develop their maternal health programmes in the 2 municipalities they are supporting.

The MoH has made EmONC strengthening one of its main maternal health priorities. The CP contributed to considerable strengthening of the EmONC capacity in the country. The CP-supported EmONC assessment and EmONC improvement plan provided a useful basis for UNFPA to advocate with MoH and partners for a common standardised approach to EmONC strengthening and to mobilise resources

⁷⁶ MoH Timor-Leste (2015): Emergency Obstetric and Newborn Care Needs Assessment Timor-Leste. MoH Timor-Leste (2016): Emergency Obstetric and Newborn Care (EmONC) Improvement Plan of Action; Timor-Leste 2015-2016.

⁷⁷ MoH Timor-Leste (2017): Standards of clinical care and clinical protocols; referral facilities (care on management of complications during pregnancy, during delivery and post delivery). August 2017.

⁷⁸ MoH Timor-Leste (2016): Maternal Death Surveillance and Response (MDSR); a Guideline for the establishment of Maternal Death Reviews in Hospitals and Verbal Autopsy in lower level of Health Facility and Community.

⁷⁹ MoH Timor-Leste (2018): Health Sector Response to GBV: National Guideline for Health Care Providers to address Gender-based Violence including Intimate Partner Violence. Final version.

⁸⁰ Ombudsman for Human Rights and Justice (PDHJ), UNFPA Timor-Leste (2017): 2017 Country Assessment on Sexual Reproductive Health Rights in Timor Leste.

⁸¹ SSYS, UNFPA, Plan International Timor-Leste (2017): Teenage Pregnancy and Early Marriage in Timor-Leste; Research on the Decision-Making Pathways of Young Women in the Municipalities of Covalima, Aileu and Dili. May 2017.

⁸² Estrela+, MoH, UNFPA, MSTL (2017): HIV Stigma Index Report Timor-Leste.

⁸³ UNFPA, WHO Timor-Leste (2019): UNFPA and WHO Collaboration to Strengthen Maternal Health, Family Planning and the Health Sector Response to GBV in Timor-Leste 2015-2017.

⁸⁴ MoH Timor-Leste (2015): Emergency Obstetric and Newborn Care Needs Assessment Timor-Leste.

⁸⁵ MoH Timor-Leste (2016): EmONC Improvement Plan of Action; Timor-Leste 2015-2016.

⁸⁶ UNFPA Timor-Leste (2016): Country Office Annual Report 2016. UNFPA Timor-Leste (2017): Country Office Annual Report 2017.

for the EmONC improvement plan. The EmONC improvement plan was useful for unite MoH and partners around a single action plan for reducing maternal mortality.

UNFPA-WHO supported training of human resources in EmONC started in 2018 and focussed on staff of the 6 CEmONC facilities in the country plus 2 additional CEmONC facilities. 85 health service providers of 8 CEmONC facilities in 8 municipalities were trained through national trainers and clinical practice of 5-weeks in the national HNGV hospital in Dili. After the training, the health workers returned to their normal place of work, where they were supervised during several weeks by the national trainers and only received their certificates when they proved to have developed all the required skills. The trainees remain in contact with their supervisors through a Whatsapp group, which enables them to request advice when faced with complicated cases at work. The CP also supported MoH to conduct training of municipal staff and community leaders on EmONC health seeking behaviour.⁸⁷

So far, no data exist to document the increase in EmONC skills of health workers trained. In late 2019 UNFPA supported the mid-term evaluation of the EmONC Improvement Plan, of which the results will come out in 2020. In the meantime, EmONC trainees, their supervisors and facility managers interviewed by the CPE team were highly appreciative of the teaching method and of the continued mentoring support provided by the master trainers through the WhatsApp group. They observed that the skill of the medical doctors and nurses who participated in the EmONC training has increased, with the trainees are now able to deal with complicated cases without having to refer most cases to Dili national hospital. They also observed that maternal morbidity and mortality had decreased in their facilities. The EmONC training mid-term evaluation will hopefully be able to document these results more in detail.

However, the training of health sector staff on EmONC and FP has so far been concentrating on the training of health service providers, without much involvement of health service managers and municipal coordinators. This is a missed opportunity, as having municipal coordinators involved ensures greater commitment to promoting modern contraceptives and ensuring strong supply chain management. Also the chosen approach of the EmONC training lasting for over one month and taking place in in the HNGV National Hospital in Dili to enable trainees to gain practical experience on sufficient number of cases, results in trainee health workers being absent for 4 weeks from their place of work. MoH and UNFPA are currently considering alternative training approaches to reduce health worker absence from their workplace. The CPE team observed that a number of UNFPA supported trainings of health workers tended to focus on one single topic without much integration of other key UNFPA mandate areas.

In 2016, the CP supported the National Midwives Association (APTL) to establish a national midwifery registry/data base. Over the past years the CP also supported APTL members to attend international conferences, including ICM congresses. UNFPA contracted Burnett Institute in late 2019 to conduct an assessment of the midwifery capacity in the country and assist MoH to develop a national costed midwifery workforce plan, which will be incorporated in the national HRH plan.

With support from the CP, Timor-Leste established a Maternal Death Surveillance and Response (MDSR) system, conducting a situational analysis and establishing a road map for MDSR. In 2015 MDR committees were established in the National Hospital and five Referral Hospitals, after which verbal autopsies in communities were introduced in the following year. Hospital and health facility staff were trained with CP support based on the MDSR guideline.⁸⁸ During 2017-2018, the CP supported MoH to continue mentoring and support the six MDR committees and monitoring, and to scale up verbal autopsy capacity to additional districts. Newborn Surveillance and Response was integrated into the MDSR system in cooperation with UNICEF, thus becoming a MPDSR system (Maternal and Perinatal Death Surveillance and Response. According to the MDSR Report of 2018, and to UNFPA and stakeholders interviewed, the MDSR system is operational in all municipalities of the country. By the end of 2017, the MoH published its first ever Maternal Mortality Report over 2016-2017, which analyses the 45 maternal

⁸⁷ MoH Timor-Leste (2018): Annual Work Plan Progress Report over Q3 of 2018.

⁸⁸ MoH Timor-Leste (2016): MDSR; a Guideline for the establishment of Maternal Death Reviews in Hospitals and Verbal Autopsy in lower level of Health Facility and Community.
UNFPA Timor-Leste (2017): Country Office Annual Report 2017.

deaths which were notified in hospitals and CEMONCs in 2016 and the 28 deaths notified in 2017.⁸⁹ The report identified some weaknesses in the MDSR system and formulated recommendations for further strengthening. Municipal health managers, health facility managers and workers interviewed described the system as useful for identifying quality issues and bottlenecks in maternal health services and referral systems. However, the CPE team was not able to identify any evidence of the impact of the MPDSR system on health service performance.

The CP supported the translation of all policy documents and tools into Portuguese and/or Tetum. MoH officials interviewed appreciated the efforts and expenses. However, they mentioned that the translations into Tetum of several documents, such as the RMNCAH Strategy for 2015-2019 and the FP training guidelines, contained errors and that relevant MoH Departments had not been given sufficient time to check and correct the translated documents before printing.

The UNFPA gender programme assisted MoH, SEII and partners to develop guidelines for the response to GBV in the health sector (see below under Output 4). The guideline seems extensive and useful. And once the GBV response in-service training package is approved, it is expected to provide a useful tool for capacity building of health workers. MoH and NGO staff interviewed appreciated the role played by UNFPA to make gender-based violence a topic which government and partners now feel comfortable to discuss and make policy about, and for which service provision such as clinical management of rape and provision of counselling is now accepted within the public health sector.

The CP also supported the piloting and roll-out of the Birth Preparedness Plan (BPP) programme in communities in 2 municipalities (Oé-cusse during 2015-2018 and Baucau in 2018) to promote the attendance of ante-natal care and assisted deliveries by pregnant women, and encourage communities to support transport options for women to reach skilled delivery care. The BPP programme also provided information to communities about birth spacing, risks of early pregnancies, dangers signs during pregnancy and delivery, pregnancy care and post-partum family planning.⁹⁰ By the end of 2018, Alola Foundation had reached all sub-districts of Oé-cusse municipality and one sub-district in Baucau. In Oé-cusse, for a total of 1,222 women given birth during 2018 in the municipality, the BPP programme had contributed to 29% of the deliveries taking place in health facilities and 47% at home assisted by skilled birth attendants, so in total 76% delivered assisted qualified attendants.⁹¹ Municipal health service staff and communities in Oé-cusse interviewed by the CPE team expressed their appreciation for the BPP programme, observing it stimulated health facility attendance by pregnant women and during deliveries, and expressed their regret that the programme was discontinued. The BPP approach has been recognised as useful by the central level MoH and has been replicated by JSI in Cova Lima municipality with funding from the US Government. It seems urgent that the CP document the achievements and lessons learned of this successful approach before more institutional and community memories is lost.

So far health workers and managers have limited awareness on how to assist survivors of GBV / Intimate Partner Violence / Domestic Violence. Similarly, knowledge on HIV prevention and on how to talk to and assist People Living with HIV/AIDS is also very limited amongst health workers and the general population, resulting in continued stigma and discrimination of PLHIV and hampering efforts to encourage HIV testing and treatment. Condom availability and distribution is far from optimal, which undermines HIV prevention efforts. An external challenge is the fact that very few partners support HIV prevention and response in the country, except the Global Fund and UNFPA (including with regional funding from UNAIDS).

With small resources, the CP was able to highlight the stigma experienced by PLHIV in Timor-Leste and provide the impetus to develop a training package for health workers on HIV prevention and stigma reduction, which has been accepted by MoH and is being rolled out. The CP supported the production of the HIV Stigma Index Report by Estrela+ - the association of People Living with HIV/AIDS (PLHIV) in

⁸⁹ MoH Timor-Leste (2017): Maternal Mortality Report, 2016-2017 Timor Leste.

⁹⁰ Alola Foundation (2018): Annual Work Plan Progress Report – Q4 of 2018.

⁹¹ Alola Foundation (2018): Mother and Child Health Report 2018.

Timor-Leste - and Marie Stopes in 2017.⁹² The report showed that stigma and discrimination against PLHIV is significant in the health sector and the community, which reduces PLHIV's access to health care and other essential services and makes them subject to verbal and physical abuse. The index recommends ways to decrease HIV-related stigma and discrimination in Timor-Leste, strengthen existing networks and programmes and opening pathways for people to access judgment-free HIV testing, treatment, care and support. UNFPA supported the presentation of the report to the MoH and INS for inputs and recommendations. The CP also supported the development of a short documentary on HIV stigma and discrimination in Timor-Leste.

Based on the stigma index report's results, the CP further supported the MoH National HIV Programme by organise training of health care workers on HIV stigma and discrimination reduction, starting with in-service staff at hospitals and major health centres in three border municipalities (Oé-cusse, Covalima and Bobonaro), in Ermera and at the national referral hospital in Dili, through which a total of 268 health personnel were reached in 2018.⁹³ The training also addressed HIV testing, dropout of HIV positive patients and retention strategies and emphasised the need for confidentiality. Interestingly the training was provided by a variety of trainers from MoH, UNFPA and other UN agencies and PLHIV through Estrela+ members. In 2019, the CP supported 5-day comprehensive training on HIV and Opportunistic Infections for health personnel in different districts. 23 health workers from health posts, community health centers and the referral hospital in Oé-cusse Ambeno Municipality.⁹⁴ So far, the results of this training have not been documented, but UNFPA staff and Estrela+ members interviewed stated that the training is useful and needs to be scaled up and repeated throughout the country to achieve impact. The CP have also reached a total of 870 key populations in border municipalities with SRH-HIV information, including demand creation for health services and information on health rights.

Recognising the vulnerability of uniformed forces to HIV infection, the CP motivated the National Police in Timor-Leste (PNTL) to create a strong peer-educator system to act as behavioural change agents and serve as link between the PNTL and MoH for referral of police staff. In 2018, UNFPA, MoH and Estrela+ provided peer-educator trainings reaching 63 PNTL officers from all municipalities of the country, whereas in 2019 a further 15 peer educators were trained.⁹⁵ The trainings covered HIV/AIDS prevention, transmission and treatment, Prevention of Mother to Child Transmission (PMTCT), Sexually Transmitted Infections (STIs), TB/HIV co-infection, stigma and discrimination towards PLHIV, FP and GBV. The PNTL peer educators are supposed to share the knowledge gained with their colleagues. Later in 2018, the CP supported sensitisation sessions for uniformed personnel stationed in border areas in Bobonaro and Oé-cusse municipalities, which reached 185 uniformed staff from different branches of the armed forces, such as the border police, Maritime Unit, Immigration, Customs and the Defense Forces of Timor-Leste. The CPE was not able to confirm the number of police officers reached this way. The results of this training have not been documented, but the PNTL HIV Focal Point expressed her appreciation of the training and observed that it contributed to changing attitudes within the police service to HIV prevention and treatment. The HIV focal point of the PNTL suggested that police clinic records show an increase in the uptake of HIV testing and use of condoms and FP by police officers. However, no data were provided.

In 2019, the CP started supporting awareness raising on HIV prevention of Key Populations (mainly sex workers and their clients and men having sex with men) in the three country's border municipalities through key population peer educators.⁹⁶ 31 peer educators from Key Populations were trained and after evaluation 22 educators were selected to provide the awareness raising. By the end of 2019, 870 people had been were reached with SRH-HIV information, including demand creation for health services and

⁹² Estrela+, MoH, UNFPA, MSTL (2017): HIV Stigma Index Report Timor-Leste.

⁹³ UNFPA Timor-Leste (2018): HIV/AIDS 2018 REPORT UNFPA TIMOR-LESTE. Report to UNAIDS.

⁹⁴ UNFPA Timor-Leste (2019): UNFPA TIMOR-LESTE 2019 Q1/2 REPORT HIV/AIDS Programme.

⁹⁵ UNFPA Timor-Leste (2018): HIV/AIDS 2018 REPORT UNFPA TIMOR-LESTE. Report to UNAIDS.
UNFPA Timor-Leste (2019): UNFPA TIMOR-LESTE 2019 Q1/2 REPORT HIV/AIDS Programme.

⁹⁶ Estrela+ (2019): Implementing Partner Progress Reports over Q1, Q2 and Q3.
UNFPA Timor-Leste (2019): UNFPA TIMOR-LESTE 2019 Q1/2 REPORT HIV/AIDS Programme.

information on health rights, and 842 persons had been referred and tested for HIV at the MoH owned Drop-In Centres for Key Populations or during mobile clinics to distant villages.⁹⁷ ⁹⁸

In the area of knowledge generation, UNFPA supported the National Ombudsman for Human Rights to conduct country assessment on SRHR, as requested by the Association of Women’s Parliamentarians.⁹⁹ The assessment concluded that the lack of sexual and reproductive health education of the population, particularly young people, has contributed to the incidence of unwanted pregnancies and early marriage and that global evidence shows that Comprehensive Sexuality Education (CSE) has a positive impact on sexual and reproductive health, notably contributing towards reducing sexually transmitted infections (STIs), HIV and unintended pregnancy, and delaying sexual debut. The report also emphasised the need for HIV prevention and GBV prevention and response in the country. In 2016, the CP also produced a series of policy briefs on SRHR.¹⁰⁰ The SRHR Assessment report – being produced by a national institution – and its dissemination meetings supported by the CP, turned out to be an excellent advocacy tool for UNFPA and partners to promote the provision of SRHR information to adolescents and young people in the country.

However, the National Strategy for Behaviour Change Communication (BCC) on SRHR / RMNCAH not been updated since 10 years or more. This makes it harder for the CP to promote a clear and standardised approach to BCC communication on SRHR.

In terms of emergency preparedness, the CO ensured that Reproductive Health needs were included in the National Emergency Plan when it was developed.¹⁰¹ In addition, UNFPA developed a minimum preparedness plan for the Country Programme and conducted simulation exercises for all staff. The CO regularly trained CO staff on the Minimum Initial Service Package (MISP), a series of crucial actions required to respond to reproductive health, HIV and GBV needs at the onset of every humanitarian crisis.¹⁰² UNFPA also oriented three Ministries and as well as staff of five civil society IPs on MISP.

Output 3 – Effectiveness Analysis Findings for Adolescents and Youth

CP Strategic Result 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services.

CP Results Indicators	CP Targets	Level of achievement	Comments
R.2.1 Percentage of youth (15-24)	Female youth: baseline: 12%; cumulative CP	12% of youth have comprehensive knowledge of	Based on DHS of 2016 there is “no progress” against the Outcome indicators.

⁹⁷ Information provided by the UNFPA CO. The target group were reached through home visits, focus group discussions, community gatherings and special days’ celebrations. 842 people were referred and tested for HIV at the MoH owned Drop-In Centres for Key Populations or during mobile clinics to distant villages within the 3 border districts. Sex disaggregation or per KP is not available.

⁹⁸ UNFPA Timor-Leste (2019): UNFPA TIMOR-LESTE 2019 Q1/2 REPORT HIV/AIDS Programme.

⁹⁹ Ombudsman for Human Rights and Justice (Provedoria dos Direitos Humanos e Justiça - PDHJ), UNFPA Timor-Leste (2017): 2017 Country Assessment on Sexual Reproductive Health Rights.

¹⁰⁰ UNFPA (2016): Timor Leste Sexual and Reproductive Health Series: 1 - Maternal and Child Health; 2 - Family Planning; 3 - Reproductive Health Education; 4- HIV and Sexually Transmitted Infections (STIs); 5 – Gender-Based Violence.

¹⁰¹ UNFPA Timor-Leste (2016-2017-2018): Country Office Annual Reports over 2016, 2017 and 2018.

¹⁰² The five objectives of the MISP (Minimal Initial Service Package) are to: 1) ensure an organisation is identified to lead the MISP implementation; 2) prevent and manage the consequences of sexual violence; 3) reduce HIV transmission; 4) prevent maternal and newborn death and illness; and 5) plan for comprehensive sexual and reproductive health care, integrated into primary health care, as the situation permits. The MISP tool was developed in 2015 through the Inter-Agency Working Group on Reproductive Health in Crises, of which UNFPA is a member. <https://www.unfpa.org/resources/what-minimum-initial-service-package>

CP Results Indicators	CP Targets	Level of achievement	Comments
with comprehensive knowledge on HIV/AIDS.	target: 50%. Male youth: baseline: 20%, cumulative CP target: target 65% (Source: UNFPA reports)	HIV/AIDS: 8% of young women and 15% of young men (Source: 2016 DHS)– CP target likely not achieved.	Since early 2018, UNFPA and partners have scaled up their efforts to increase knowledge of youth (female and male) on HIV/AIDS through communication and behaviour change interventions tailored to youth, through the school system, the youth organisations and community groups. However, there is no system capturing the impact of these efforts.

CP Output 3	Increased national capacity to design and implement comprehensive sexuality education programmes that promote human rights and gender equality and increase availability to young people of comprehensive quality, sexual and reproductive health information and services.
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CP Output indicators	CP Targets	Level of achievement	Comments
O.3.1 Number of schools in UNFPA supported districts offering comprehensive sexuality education programme adhering to national and global standards.	Baseline: 10, Cumulative CP target: 50 (Source: UNFPA reports)	Ministry of Education rolled out sexuality education in all primary schools nationally in April 2017 covering grades 3 to 6. 100% of achievement of CP target by Nov. 2019 (Source: UNFPA reports)	Ministry of Education started the national roll-out sexually education in primary school grades 3 – 6 in April 2017, with the intention to launch CSE in grades 7 to 12 in future. Therefore, we that the number of primary schools reached in 2017 was above 50. However, as no monitoring of CSE implementation has taken place, we do not know whether in practice the CSE curriculum is implemented in all the schools. The CSE assessment conducted in 2018 by UNFPA and the CPE field visits suggest otherwise.
O.3.2 Number of youth organisations and centres in UNFPA supported districts conducting comprehensive sexuality education training programmes for youth in community that adhere to national and global standards.	Baseline: 1. Cumulative CP target: 20. (Source: UNFPA reports)	Youth have been trained on CSE manual in 6 youth centres reaching 120 youth. 30% (6/20) of total CP target achieved. (Source: UNFPA reports)	Roll-out of newly developed Healthy Relationships Manual for CSE of out-of-school youth has not yet started because SSYS has not yet formally approve the manual.

The analysis of the level of achievement of the output indicators shows by that November 2019, one out of two indicators had achieved their cumulative CP targets.

The CP achievements are in line with the CP Output by focussing on capacity building of key government institutions such as MoEYS, INFORDEPE, SSYS and civil society partners in how to design and implement CSE programmes, so as to support government in providing SRHR information to adolescents and young people in in-school and out-of-school settings.

The CP was highly effective in conducting advocacy with high-level officials of the Ministry of Education and the Youth Secretariat, who have developed ownership of and commitment to CSE interventions and have become champions for raising awareness of adolescents and youth on SHRH/gender/GBV. This is an impressive result in a country such as Timor-Leste with its traditional cultural values.

The CP supported the roll-out of CSE programmes in all schools in the country in 2017, followed by training of teachers in 2019 in the use of CSE teaching aids in one municipality, reaching 136 teachers. However, the roll-out has not been monitored by INFORDEPE, MoEYS or UNFPA and the results of these interventions have not (yet) been documented. Assessments and CPE interviews suggest that

after being trained many teachers have not taught the CSE subjects due to the sensitivity of the CSE topic and resistance from school management, parents and community leaders, and suggest that teachers will only feel comfortable to teach the CSE materials if supportive supervision and mentoring is provided after the initial CSE training.

The approval and roll-out of CSE materials developed for out-of-school youth has been delayed due to cultural sensitivities amongst government staff.

The strategic partner of UNFPA in this programme area is the Ministry of Education, Youth and Sports (MoEYS) - supported by the National Institute for Teachers INFORDEPE - and the Secretariat of State for Youth and Sports (SSYS) which functions as part of the MoEYS in Dili. Civil society Implementing Partners included women's organisation FOKUPERS and youth-led organisations such as Sharis Haburas Comunidade (Sharis Community Development, SHC), DMUN, Youth Leadership Development Program (YLDP) and Youth Alumni Parliament (YAP).

The main achievement of the youth component of the UNFPA Country Programme in Timor-Leste is its successful advocacy with the Education and Youth sectors of the GoTL to introduce SRHR/gender/GBV information to in-school and out-of-school school adolescents and youth. This has led to high commitment of MoEYS and SSYS, who approved CSE materials for insertion into in-school curricula for primary schools in 2017, including topics on the difference between girls and boys and menstrual health, and are close to approving CSE materials for out-of-school youth.

The Country Programme led / supported the development of national policy documents in cooperation with government and partners, including the revised National Youth Policy in 3 languages (Portuguese, Tetum and English) (approved and launched)¹⁰³ and the National Action Plan on Youth 2018-2022 (still awaiting approval by Government)¹⁰⁴. The CP also led the development of teaching materials on SRHR, gender and GBV prevention for in-school adolescents and youth (approved by MoEYS for integration into the education curriculum and for roll-out / implementation)¹⁰⁵; and SRHR / Gender / GBV prevention materials for out-of-school youth (including Healthy Relationships manual for facilitators) (still awaiting approval by SSYS).¹⁰⁶

Although the National Action Plan on Youth is still not approved by Government, the Action Plan and the preceding Youth Policy provide policy directions on the importance of adolescent and youth issues for the MoEYS and SSYS and legitimise the CP's focus on promoting CSE for adolescents and youth. The assessments conducted with CP support further stress the importance of providing SRHR to young people.

UNFPA's support to the introduction of CSE in-schools consisted of supporting MoEYS and partners to develop a sexuality education curriculum aligned to international standards in 2015. The materials were piloted in 10 pre-secondary and secondary schools. In 2017 the MoEYS trained teachers and rolled out the materials to all schools nationally through INFORDEPE.

In 2016, the MoEYS and the Women Parliamentarian Group (GMPTL) requested UNFPA's support in assessing the content of the existing curricula from grade 1 to 12 (primary, pre-secondary, secondary (general and vocational) schools) to analyse the integration of comprehensive sexuality education content

¹⁰³ Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2016): National Youth Policy.

¹⁰⁴ Secretariat of State for Youth and Sports Timor-Leste (SSYS) (2018): National Youth Action Plan 2018-2022.

¹⁰⁵ MoEYS Timor-Leste (2018): HATENE HA'U-NIA ISIN-LOLON! HADOMI HA'U-NIA AN, Matadalan ba mudansa sira iha puberdade, Manuál ba Fasilitador (Changes in your body during puberty; Facilitators Manual).

MoEYS Timor-Leste (2018): Feto no mane, hanesan no lahanesan; Mulheres e homens, semelhanças e diferenças (Women and men, similarities and differences; Facilitators Manual).

MoEYS Timor-Leste (2018): Mai hatene kona-ba menstruasaun; Vem saber mais sobre a menstruação (Come Know more about Menstruation; Facilitators Manual).

¹⁰⁶ SSYS Timor-Leste (2018): Relasaun Saudável; Edukasaun ba Juventude, Manuál ba Fasilitador (Healthy Relationships; Education for Young People; Facilitators Manual).

as well as teachers' practice. An assessment of the primary and secondary school curricula was carried out by a UNFPA consultant in 2018.¹⁰⁷ It found that whereas many CSE topics are already covered, the primary and secondary school curricula still present some gaps and that in addition, some topics are included in the curriculum but are not taught by all teachers due to cultural sensitivities. The assessment proposes some measures to strengthen CSE teaching and make it more comprehensive, practical, context-specific and relevant to young people's lives in Timor-Leste.

The CP therefore supported the MoEYS in 2018 to develop teaching aids on CSE subjects, including knowing my body and puberty, the differences between boys and girls, and menstrual health.¹⁰⁸ The material also addresses gender norms, roles and stereotypes. The teaching aids target teachers of primary school children grades 4 to 6, were developed in a participatory process and translated into Portuguese and Tetum. In 2019, UNFPA supported the printing of the materials, followed by the training of national trainers through INFORDEPE and the roll-out of the training of primary school teachers starting in one municipality (Liquiça). 136 teachers were reached in 2019 with the CSE teaching aids. So far no assessment of the results of the in-school CSE efforts has been conducted. MoEYS and partner officials interviewed by the CPE team appreciated UNFPA's support to its School Health programme and the development of in-school and out-of-school CSE materials following a participatory approach. Trainers and teachers interviewed appreciate the CPE materials, which they say have increased their own awareness and confidence about gender and health issues, especially youth reproductive health and GBV prevention. They feel that the subjects are important to teach to adolescents and young people and also to involve parents. Teachers observed that for teaching of some subjects such as menstrual health, they found it easier to teach female and male students separately, as this enabled particularly the girls to have freer discussions. The Government is planning to roll out the CSE teaching to other municipalities.

However, the CSE curricula assessment conducted in 2018 and the CPE interviews in 2019 suggest that having teachers attend one training on the CSE teaching aids does not guarantee that they will actually teach the materials to their students. From the group of primary school teachers in Liquiça trained in mid-2019 to use the CSE teaching aids, by November 2019 only a part of teachers had actually taught the subject to students. The CSE curricula assessment conducted by UNFPA in 2018 suggested a similar finding. According to INFORDEPE staff, school managers and teachers interviewed, some teachers still feel uncomfortable with the CSE teaching or fear reaction from school management, parents and communities.

An important weakness of the efforts to promote the roll-out of CSE teaching in schools found by the 2018 CPE assessment and the CPE team is that MoEYS and INFORDEPE are not specifically monitoring the roll-out process and there are no provisions for providing mentoring support. The reason for this may be due to lack of resources. INFORDEPE staff suggested that supportive monitoring would both emphasise the importance of the CSE roll-out process to school managers and teachers and also provide support to teachers who are feeling uncomfortable to teach the materials. Another weakness is that school management were reportedly not been systematically involved in the introduction of the in-school CSE materials, and that parents and communities had not been made aware of the planned CSE teaching. The CPE team feels that in view of cultural sensitivities in the country, supportive supervision may not be sufficient and that teachers would also benefit from mentoring support, similar to the approach taken in the EmONC capacity building.

INFORDEPE trainers and schoolteachers interviewed also reported that some in-school SRH teaching aids developed with support from UNFPA were not adapted to school environments. For example, some

¹⁰⁷ UNFPA Timor-Leste (2018): Assessment of Comprehensive Sexuality Education in Timor-Leste's School Curriculum. Dili, June 2018

¹⁰⁸ MoEYS Timor-Leste (2018): HATENE HA'U-NIA ISIN-LOLON! HADOMI HA'U-NIA AN, Matadalan ba mudansa sira iha puberdade, Manuál ba Fasilitador (Changes in your body during puberty; Facilitators Manual).

MoEYS Timor-Leste (2018): Feto no mane, hanesan no lahanesan; Mulheres e homens, semelhanças e diferenças (Women and men, similarities and differences; Facilitators Manual).

MoEYS Timor-Leste (2018): Mai hatene kona-ba menstruasaun; Vem saber mais sobre a menstruação (Come Know more about Menstruation; Facilitators Manual).

posters were too large in size, and some other tools consisted of audio-visual materials, which cannot be used in many schools due to lack of electricity and/or of projectors/TVs.

Furthermore, in the area of promoting CSE for in-school youth, the CP supported a national NGO in 2019 to work with (pre-)secondary schools to introduce awareness raising on SRHR / GBV / human rights / respect in relationships using the approach of Girls & Boys Circles. With UNFPA support, FOKUPERS piloted the introduction of Girls & Boys Circles in 3 secondary schools in Dili in 2019 reaching 45 students of grades 10, 11 and 12, aged 16 to 19 years old, as well as 12 teachers. Results and lessons learned will be identified during 2020. Teachers, school management and students interviewed in one school appreciated the Girls & Boys Circle approach for promoting amongst students and teachers critical thinking and respect for each other's person and opinion, and for strengthening confidence amongst students to discuss reproductive and menstrual health issues with teachers and schoolmates. According to school staff interviewed, the parents of the students involved were also happy with the approach. However, school staff and teacher interviewed noted that school management and student parents had not been informed about the Circle initiative, and that so far only 1 teacher and 15 students in each school had been trained and supported to pilot the Circle approach. Another challenge is that the Circle materials made available by FOKUPERS to the teacher and students is provided in soft copy on CD's and memory sticks, which are difficult to use by the majority of teachers and students who do not have access to computers.

In the area of CSE for out-of-school youth, the Country Programme assisted the SSYS to develop a facilitators manual on CSE/HIV/gender/GBV called "Healthy Relationships" in collaboration with the youth-led organisation Sharis Haburas Comunidade (Sharis Community Development, SHC).¹⁰⁹ The draft manual was developed with participation with a variety of government staff from national level, civil society partners, including the Catholic Church, and staff from youth centres in 2 districts. The draft manual was then tested by SHC with the Alumni Association of the National Parliament and with 2 youth centres. 120 youths in 6 youth centres in 3 districts (Dili, Viqueque, Same) were trained by SSYS and UNFPA in the updated manual. UNFPA has also supported some youth organisations to start using some sessions of the manual during workshop at national and municipality level.

Regarding the out-of-school CSE efforts, the major challenge was the fact that the government has not yet approved the Healthy Relationships Facilitators Manual and therefore roll-out to government youth centres has been delayed. Formal approval of the out-of-school Healthy Relationships CSE manual by the Government has been slow due to the sensitivities around the manual's subject. However, in the meantime youth-led organisations are using the manual for training of their members and for awareness raising activities in communities.

An overall challenge for the UNFPA Country Office was that it had to invest time and effort into a lengthy consultation process for the production of the in-school and out-of-school materials to ensure that CSE would be accepted by Timorese partners. MoH questioned the authority and competency of the NGO SHC to draft the Health Relationships materials at request of SSYS and UNFPA. Another challenge for both the in-school and out-of-school materials is that they had to be produced in both Portuguese and Tetum, which made the process of producing final materials slow. A weakness noted by several stakeholders interviewed is that the CSE materials developed do not clearly integrate concepts of HIV transmission and prevention.

The CP also supported capacity strengthening of SSYS by providing funds for monitoring of the implementation of the Youth Policy, and for the establishment of a web-based database to monitor youth-related activities by government and development partners and in data collection and data use for programming.¹¹⁰ The CO and CPE team have no information on whether the database is functional at this time.

¹⁰⁹ SSYS Timor-Leste (2018): Relasaun Saudável; Edukasaun ba Juventude, Manuál ba Fasilitador (Healthy Relationships; Education for Young People; Facilitators Manual).

¹¹⁰ SSYS Annual Workplan Progress Reports over 2016.

Furthermore, in the area of capacity strengthening of youth centres and youth networks, the Country Programme sought to empower youth-led organisations through trainings of their members on technical topics such as SRHR, teenage pregnancy and early marriage and Demographic Dividend, and on organisational topics such as implementation of awareness raising and Monitoring & Evaluation. The CP also funded the participation of youth-led organisations in national celebrations national and international meetings.

In terms of knowledge generation, at the request of the Female Parliamentarians of Timor-Leste Group (GMPTL), UNFPA, SSYS – with support from UNFPA - and Plan International carried out a study on teenage pregnancy and early marriage.¹¹¹ The CP also supported the production of a series of Leave No One Behind policy briefs for five target groups, including young people with disability, LGBTI youth, young people not in training, education or employment, migrant youth in Dili City, and young female farmers,¹¹² as well as a bulletin on demographic dividend and the importance of investing in Timor-Leste's youth.¹¹³ These documents were used by the Government in some national reviews.¹¹⁴ The studies by the CP generated important knowledge for advocacy and policy development on youth. They showed that teenage pregnancy and early marriage have consequences for many aspects of young people's lives. They documented that the majority of young people have very little knowledge on SRH, and that most of young women who fell pregnant dropped out of school. They also showed that gender imbalances in power relationships put young women at risk of gender-based violence and teenage pregnancy. The studies also helped UNFPA to advocate with Government staff on the importance of ensuring that vulnerable youth have access to youth activities.

A general challenge to the Adolescent & Youth component was that the CP budget allocation was not sufficient to support the roll-out of SRHR teaching for in-school or out-of-school youth throughout the country. Apart from the slow approval by the Government of the Youth Action Plan, the GoTL also does not allocate adequate budgets for adolescent and youth programming.

The CP's efforts to empower youth-led organisations have borne fruit. Youth-led organisations interviewed by the CPE team stated that capacity of their staff / members has been built, which empowered them to be stronger and more confident participants in sector meetings, conferences and in political processes. Interestingly the CP tasked youth-led organisations to pre-test of the Healthy Relationships out-of-school SRHR materials, which was a way to both empower the organisations and to teach its members about the materials content. Another interesting approach by UNFPA was to support the Organisation of the Alumni of the Youth Parliament - a youth-led organisation - to promote a blood drive in Dili inviting people to come and donate blood in support of the National Hospital. This activity increased the visibility of the organisation and increased trust in them by health facilities and the community.¹¹⁵ Whereas the CPAP described that the CP would target capacity building towards the 6 CP priority districts, in reality the CP targeted most of the capacity building towards youth-led organisations based in Dili, with the idea that these organisations would then train their members throughout the country. In practice however the trainings did not trickle down to members outside of Dili.

¹¹¹ SSYS, UNFPA, Plan International Timor-Leste (2017): Teenage Pregnancy and Early Marriage in Timor-Leste; Research on the Decision-Making Pathways of Young Women in the Municipalities of Covalima, Aileu and Dili. May 2017.

¹¹² Belun NGO / UN Timor-Leste (2018): Leave No One Behind in Timor-Leste. Policy Brief nr 1 – Young Female Farmers. Policy Brief nr 2 – Migrant Youth in Dili City. Policy Brief nr 3 – Young People neither in Education, Employment nor Training. Policy Brief nr 4 – LGBTI Youth. Policy Brief nr 5 – Young People With a Disability.

¹¹³ National Transfer Accounts / UN (2017): Research bulletin on Investing in Timor-Leste's Youth: A Resource for the Future; National Transfer Accounts analytical report.

¹¹⁴ Government of Timor-Leste (2019): Report on the Implementation of the Sustainable Development Goals: From ashes to reconciliation, reconstruction and sustainable development; Voluntary National Review of Timor-Leste 2019.

¹¹⁵ SSYS / UNFPA (2016): Quarterly Annual Workplan Progress Report over Q3.

Output 4 – Effectiveness Analysis Findings for Gender Equality and Women’s Empowerment

CP Strategic Result 3: Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.

CP Results Indicators	CP Targets	Level of achievement	Comments
R.3.1 Percentage of ever married women (15-49) who experienced physical or sexual violence from a male intimate partner in the last 12 months.	Baseline: 29.0%. Cumulative CP target: 20.0% (source – DHS)	47% by Nabilan Baseline Study in 2015. 0% of cumulative CP target achieved. (Source: Nabilan Baseline Study 2015)	Nabilan Study found that 47% of ever-partnered women of age 15 and 49 had experienced at least one physical and/or sexual violence by an intimate partner in the previous 12 months.

CP Output 4	Strengthened capacity of relevant government institutions and non-government organisations to implement the national action plan on gender-based violence.
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CP Output indicators	CP Targets	Level of achievement	Comments
O.4.1. Number of targeted public and non-government organisations implementing standard operating procedures on GBV.	Baseline: 12. Cumulative CP target: 20 (source UNFPA reports).	21 organisations by November 2019 105% of total CP target achieved by Nov. 2019. (Source: UNFPA reports)	Organisations implementing the SOPs include: 1. MSI (6 shelters + 1 transit house), 2. PNTL (police), 3. PRADET, 4. FOKUPERS, 5. Salele Shelter, 6. Casa Vida, 7. ALFeLA, 8. Alola Foundation, 9. Fourm Peduli Wanita Oé-cusse Ambeno shelter, 10. Maria Tapo shelter (gov. owned), 11. Uma Mahon Paz shelter, 12. Shelter in Lautem, 13. MoH, 14. Health facilities at municipality level.
O.4.2. Number of monitoring exercises conducted on the implementation of the national action plan on gender-based violence	Baseline: 1. Cumulative CP target: 6 (source UNFPA reports).	6 (number) of exercises by Nov. 2019 (source: UNFPA reports) 100% of total CP target achieved. (Source: UNFPA reports)	Monitoring exercises conducted since 2015 include: 1. The 2015 Evaluation of NAP-GBV. 2. Revised NAP GBV 2017-2021. 3. Workshop on Multi-Sectoral Services to Respond to GBV against Women and Girls in TL, October 2017. 4. Workshop on Strengthening coordination to support the implementation of NAP-GBV, January 2019. 5. Coordination Entity Meeting, August 2019. 6. Coordination Entity workshop on NAP GBV M&E Tool, July 2019.
O.4.3 Number of health facilities in UNFPA priority districts providing integrated services to survivors of GBV and referral.	Baseline: 4. Cumulative CP target: 34 (source UNFPA reports).	5 (number) of health facilities by Nov. 2019 (source: UNFPA reports) 14.7% (5/34) of total CP target achieved (Source: UNFPA reports)	1 national hospital and 4 municipality referral hospitals) have integrated services for survivors of GBV operated by an NGO. 34 or all Community Health Centers are to provide services after the approval and roll out of the national GBV guideline. MoH is also in the process of establishing 6 safe room in health facilities in 6 municipalities.

The analysis of the level of achievement of the output indicators shows that by December 2019, two out of three output indicators had achieved their targets.

The CP achievements are in line with the CP Output in that they focus on capacity building of government, particularly SEII and MoH, and to a lesser extent also of civil society - mainly (former)

implementing partners of the CP3 – for the coordination and implementation of the NAP-GBV 2017-2021. SEII has gained the capacity and commitment to effectively coordinate the NAP-GBV implementation.

UNFPA's advocacy efforts have resulted in GBV having become a topic that government and partners feel comfortable discussing and are committed to tackle.

Capacity building efforts produced and strengthened relevant policies and tools for the implementation of the NAP-GBV, particularly in the health sector and for GBV prevention amongst adolescents and youth reached through CSE interventions. In addition, the CP supported gender and GBV mainstreaming in all its programmes.

The strategic partner of UNFPA in this programme area as the Secretariat of State for Gender Equality and Inclusion (SEII).¹¹⁶ Civil Society partners included PRADET and ALFeLA.

With support and technical inputs from UNFPA, UN-Women and WHO, SEII coordinated the development of the NAP GBV 2017-2021 in a participatory process with several government ministries and partners, which promoted ownership and buy-in by all stakeholders. The CP technical support was instrumental in developing the national guideline and tools for developing the health sector response to GBV, which was successfully included into the NAP-GBV Action Plan. The NAP-GBV was approved by the Government Council of Ministers in early 2017.

UNFPA supported the integration of NAP GBV components into the health sector in combination with supporting the capacity of SEII to coordinate and monitor the implementation of the multisectoral NAP GBV. The CP supported attendance of international meetings and conferences by SEII staff - and funded SEII for key NAP-GBV coordination and monitoring activities. UNFPA also provided technical support to the development of the Annual Action Plan of SEII. SEII established the Inter-Ministerial Commission on NAP-GBV which is responsible for coordination, monitoring and evaluation of the implementation of the NAP-GBV, and is composed of representatives of central government Ministries / Secretariats and civil society organisations and attended by UNFPA and other UN agencies.¹¹⁷ UNFPA also supported the organisation of annual GBV-NAP monitoring exercises in 2015, 2016 and again in 2018, the results of which fed into the revision of the NAP-GBV. The CP also supported SEII to report to the National Parliament on progress of NAP-GBV implementation,¹¹⁸ and to organise technical workshops on the NAP-GBV.¹¹⁹ In 2018 UNFPA supported SEII to re-launch the GBV Referral Network Working Group, an important quarterly mechanism for strengthening coordination on GBV policy advocacy.¹²⁰

As part of the implementation of the NAP GBV, UNFPA conducted multi-disciplinary workshops for MoH staff and partners on the essential service package for survivors of GBV¹²¹ and supported the development of the National Guideline for health sector response to Gender-Based Violence (GBV). UNFPA funded an international consultant to draft the roadmap for the guideline development¹²² as well

¹¹⁶ During the earlier years of the CP, SEII was named the Secretariat of State for Women's Socio-economic Empowerment (SEAPSEM) and the Secretariat of State for Gender Equality and Social Inclusion (SEIGIS).

¹¹⁷ Commission members include: Ministry of Interior, Ministry of Justice, Ministry of Health, Ministry of Social Solidarity, Ministry of Education, Ombudsman Office, Alola Foundation, FOKUPERS and ALFeLA.

UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

¹¹⁸ UNFPA (2015): 2015 Annual Report Timor-Leste.

UNFPA (2018): 2018 Annual Report Timor-Leste.

¹¹⁹ SEII (2019): Report on Strengthening Coordination to support the implementation of National Action Plan of GBV 2017 – 2021, SEII Report to the United Nations, 15th January 2019.

¹²⁰ UNFPA (2018): 2018 Annual Report Timor-Leste.

¹²¹ UNFPA Timor-Leste (2017): Country Office Annual Report 2017.

¹²² Senanayake, Lakshmen (2015): Technical Assistance to Integrate Prevention and Management of GBV in the Health Sector; Consultancy Report, Concept Note and Action Plan. For UNFPA.

as a number of international study tours and visits of MoH, SEII and partner staff.¹²³ The Guideline was developed by MoH, SEII and partners to target all categories of health care providers directly involved in providing care to survivors, and approved by MoH in 2018.¹²⁴ It is currently being disseminated within MoH and municipal health authorities and with other relevant health sectors institutions and stakeholders for follow up plans and implementation.¹²⁵ The CP also supported the development of the GBV response in-service training package for health workers, which is yet to be further improved before approval. A pre-service curriculum for health workers integrating GBV prevention and service provision has been developed and is being piloted by a national University with support from another international organisation.

The CP supported the development of national policy documents in coordination with SEII and other governmental institutes, such as the National Action Plan on Gender-Based-Violence in Timor-Leste 2017-2021 (NAP GBV) (approved by GoTL and rolled out)¹²⁶; the road map for the capacity building of the health sector for integration of GBV within “in-service” training and “pre-service” training curricula of health professionals¹²⁷; and the National Guideline for Health Sector Response to GBV developed and approved by MoH.¹²⁸

In order to ensure that People With Disabilities (PWD) have access to GBV services, UNFPA advocated for the integration of PWD in the National Guidelines for GBV response in the health sector. To this purpose, in 2019 UNFPA contracted the Nossal Institute of Global Health of Melbourne University to conduct an assessment of activities and support services (including referral mechanisms) for GBV survivors with disabilities and make recommendations on how to improve GBV service access for PWD in Timor-Leste.¹²⁹ Nossal developed tools to support the implementation of disability components in existing national protocols and procedures for GBV prevention and response. UNFPA and Nossal presented the tools to MoH. Consequently, the health sector GBV guideline was updated and PWD fully integrated as target group. NGOs working in the area of GBV will use the tools in their daily work with survivors with disabilities. The CPE also finds the CP support to the development by Nossal Institute of tools to support the implementation of disability components in existing national protocols and procedures for GBV prevention and response very useful and it was effective in ensuring the integration of disability components into the final version of the national health sector GBV guideline. The CP has also been effective in ensuring integration of gender and GBV issues into the CSE materials for in-school and out-of-school youth.

¹²³ UNFPA (2016): Field mission report on Health Sector Response to GBV Study Tour in Sri Lanka, 25-28 July 2016. UNFPA (2017): 2017 Annual Report Timor-Leste.

¹²⁴ UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

¹²⁵ UNFPA (2017): 2017 Annual Report Timor-Leste.

UNFPA (2018): 2018 Annual Report Timor-Leste.

¹²⁶ Secretariat of State for the Support and Socio-Economic Promotion of Women (SEM) (2017): National Action Plan on Gender-Based Violence 2017-2021.

¹²⁷ Senanayake, Lakshmen (2015): Technical Assistance to Integrate Prevention and Management of GBV in the Health Sector; Consultancy Report, Concept Note and Action Plan. For UNFPA.

¹²⁸ MoH Timor-Leste (2018): Health Sector Response to GBV: National Guideline for Health Care Providers to address GBV.

¹²⁹ Pearce, Emma (2019): Improving integration of prevention and management of GBV for people with disabilities in the health sector; final report, 9 July 2019. Nossal Institute for Global Health, Melbourne University, Australia.

The CP supported the definition of the GBV Essential Service Package (ESP).¹³⁰ MoH is also in the process of establishing safe rooms for GBV survivors in health facilities in 6 municipalities.¹³² The CP supported gender mainstreaming by ensuring that gender and GBV are included as issues into the CSE materials developed by the MoEYS and SSYS for in-school and out-of-school youth.

The CP supported advocacy with national and municipal government on GBV, including through national days and events, such as a meeting in 2016 with women parliamentarians through the Group of Women in the Timor-Leste Parliament (*Grupo de Mulheres no Parlamento da Timor-Leste, GMPTL*) to advocate against GBV in Parliament and in their constituencies.¹³³ The GMPTL requested that decision-making pathways and experiences that lead to teenage pregnancy and early marriage be investigated, and that the content of CSE teaching in the primary and secondary school curricula be assessed. Consequently, the CP supported a study on teenage pregnancy and early marriage as well as an assessment of school curricula (see above on output 3 - youth). Stakeholders interviewed stated that advocacy efforts supported by the UNFPA CP contributed to high-level commitment of the Government of Timor-Leste to fight gender-based violence in the country, and that the CP's support to GBV awareness raising and service provision has contributed to survivors feeling more confident to report GBV cases and experiencing less stigma from communities. Partners interviewed expressed their regret that the UNFPA gender programme has narrowed its focus to prevention and response to GBV in the health sector - with some focus on other harmful practices such as early marriage. They stated that they had appreciated UNFPA's previous focus on and support to multisectoral GBV programmes and other areas related to gender equality and women's empowerment.

Since 2016, UNFPA CP financial support to SEII and to GBV service providers has been strongly reduced. This was regretted by government and civil society stakeholders interviewed. UNFPA's 2017 CP Mid-Term Review recommended for UNFPA to continue to support these NGOs for coordination, technical assistance and provision of policy advocacy given the importance of essential services to victims of GBV.¹³⁴ However, UNFPA has so far not been able to do so.

Recently UN agencies and partners in Timor-Leste managed to mobilise resources for joint multisectoral programmes to eliminate violence against women and girls. Through the EU SPOTLIGHT initiative, 5 UN agencies including UNFPA managed to mobilise USD 9.9 million from the European Union for a 3 year programme to tackle GBV in Timor-Leste starting in 2020, which will be implemented together with the government to Timor-Leste, civil society organisations at national level and in 3 municipalities Ermera, Viqueque, and Bobonaro.¹³⁵ UN-Women with UNFPA, IOM and UNDP also applied for funding from the Korean Cooperation KOICA for supporting the implementation of the NAP GBV in 3 municipalities Baucau, Covalima and Oé-cusse Ambeno-Ambeno during four years starting 2020.¹³⁶

An overall weakness and challenge to the CP is that the knowledge and awareness amongst government staff and stakeholders on gender and GBV is still limited. Also, coordination between SEII and MOH and other relevant ministries on implementation of NAP GBV is reportedly still weak and needs to be strengthened. Joint annual monitoring of the NAP GBV implementation had also been put on hold in

¹³⁰ UN-Women, UNFPA (2017: Multi-Sectoral Services to Respond to Gender-Based Violence against Women and Girls in Timor-Leste Workshop; Dili, Timor-Leste, 18-19 October 2017.

¹³¹ The ESP is provided by MoH supported by NGOs, including PRADET –providing psychosocial support, urgent medical treatment, forensic examination - and ALFELA – providing legal assistance and conducting advocacy to improve the justice system for GBV survivors. Both national NGOs were UNFPA IPs during previous CPs. Due to financial constraints this CP3, UNFPA only provided funding to them in 2015-2016.

¹³² Information provided by MoH to UNFPA staff during national level dissemination meetings.

¹³³ Gender Programme Report 2019.

¹³⁴ UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

¹³⁵ UN agencies are: ILO, UNDP, UNFPA, UNICEF, UN-Women and WHO.

UN Timor-Leste (2019): SPOTLIGHT Initiative to eliminate violence against women and girls. Country Programme Document, Timor-Leste (V2); Submission 16 September 2019.

¹³⁶ UN-Women, IOM, UNDP, UNFPA (2019): Preventing and Responding to Gender-Based Violence in Timor-Leste. Programme Proposal submitted to KOICA, January 2019.

2017-2018 following political changes. This affected the speed of implementation of CP activities supported by UNFPA. The slow process of the establishment of the NAP-GBV Coordination Entity also represented a challenge to the CP.

Output 5 – Effectiveness Analysis Findings for Population and Development

CP Strategic Result 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

CP Results Indicators	CP Targets	Level of achievement	Comments
R.4.1 Number of line ministries and relevant institutions that use data for planning, monitoring and budgeting, baseline: 2, target:4	Baseline: 2 Cumulative CP target: 2019: 4 (source UNFPA reports).	6 Ministries and Govt. institutions use data for planning 150% of total CP target achieved by Nov. 2019. (Source: UNFPA reports)	1. Ministry of Health, 2. Ministry of Education, 3. Ministry of Finance, 4. Prime Minister’s Office, 5. State Secretary for Youth and Labour, 6. Ministry of Social Solidarity.

CP Output 5	Strengthened national capacity for using data and evidence to develop, monitor and evaluate national policies and programmes in areas of population dynamics, sexual and reproductive health, youth and gender equality.
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CP Output indicators	CP Targets	Level of achievement	Comments
O.5.1. Number of policy and in-depth analysis reports prepared by line ministries on population issues and disseminated	Baseline: 12. Cumulative CP target by 2019: 38 (source UNFPA reports).	38 additional reports produced by Nov. 2019 100% (33/38) of total CP target achieved. (Source: UNFPA reports)	Documents produced include: 2015 census: Preliminary Results Booklet, Wallchart, 3 volumes of tables, 10 thematic reports and 8 bulletins on Fertility, Nuptiality, Mortality, Housing and household amenities, Labour, Education, Gender, Population Projections, Youth, Agriculture; National Transfer Accounts Research bulletin; 5 Leaving No Youth Behind thematic reports; Census and DHS Infographic; SDGs Infographic; 4 DHS 2016 reports (Key Indicators, Main Report, Nutrition analysis, SDGs & Gender Comparison of DHD and Nabilan study on GBV); Births & Deaths statistics report, Teenage Pregnancy and Early Marriage Report.
O.5.2 Number of advocacy and policy dialogue initiatives using evidence and informed policies	Baseline: 2. Cumulative CP target: 2019: 7 (source UNFPA reports).	11 initiatives by Nov. 2019 – 157% (11/7) of total CP target achieved. (Source: UNFPA reports)	Advocacy and policy initiatives supported included: 1. National Transfer Accounts; 2. Timor-Leste Women Parliament Caucus or Grupo Mulher Parlamentares de Timor-Leste report; 3. SRHR Country Assessment Report; 4. Teenage Pregnancy Report; 5. CSE Assessment Report; 6. Leaving No-One-Behind programme report; 7. HIV/AIDS Research report; 8. Stigma and Discrimination Report in collaboration with MSI and Estrela+; 9. Transactional Sex with focus on young people; 10. Health Financing and Family Planning; 11. Youth Policy Briefs.
O.5.3 Number of biennial evaluations of strategies and intersectoral programmes of	Baseline: 0. Cumulative CP target: 2019: 3 (source UNFPA reports).	0 evaluations undertaken by Nov. 2019 0% of total CP target achieved (Source: UNFPA reports)	UNFPA helped develop the national Youth Policy, National Action Plan for Youth and its M&E plan. The National Action Plan for Youth has not yet been finalized and launched the by Timor-Leste Government (i.e., SSYS). Hence, no biennial evaluation has been conducted yet.

CP Output indicators	CP Targets	Level of achievement	Comments
national youth policy			

The analysis of the level of achievement of the output indicators shows that by November 2019, 2 out of 3 indicators had achieved their cumulative annual targets for the Country Programme.

The CP achievements are entirely in line with the CP Output “Strengthened national capacity for using data and evidence to develop, monitor and evaluate national policies and programmes in areas of population dynamics, sexual and reproductive health, youth and gender equality.”

The CP effectively supported capacity building of the GDS as the government central entity to coordinate and conduct key population surveys, including the Population & Housing Census of 2015 and Demographic and Health Survey in 2016. This enabled the GoTL to produce an impressive number of high quality reports and studies, enabling the government to collect important data on population and development issues. The CP also supported key sector ministries in the integration of population, SRHR and GBV issues into plans and policies.

The CP was furthermore effective in promoting the use of data in programming and policy development by government institutions at national and municipal levels, who have started to use and request data for decision making and planning.

The strategic partner of UNFPA in this programme area is the General Directorate of Statistics (GDS) of the Timor-Leste Ministry of Finance. Macro-ICF was an Implementing Partner for provision of technical support to GDS for the 2016 Demographic and Health Survey.

The CP supported the GDS and sector Ministries in the development of a number of national policy documents in cooperation with government and partners, including the National Population and Housing Census in 2015, including a large number of thematic reports and information bulletins using the census data¹³⁷; the Demographic and Health Survey in 2016, including several reports based on DHS data¹³⁸; a Research bulletin on Investing in Timor-Leste’s Youth: A Resource for the Future / National Transfer Accounts analytical report¹³⁹, and a Births and Deaths statistics report¹⁴⁰.

The CP support to the Census involves support to the coordination of the operation, as well as technical support to the technical and logistical preparations. The GoTL is committed to conducting regular population censuses and other population exercises. Therefore, after supporting the organisation a population census in 2015, the CP is currently supporting preparations for the next population census planned for 2020. As recommended in the CP MTR report, the 2020 Census will use the latest technology including tablets for enumeration and automatic sending data through mobile connection to GDS as well as mapping of buildings through GIS (GPS).¹⁴¹

Capacity strengthening of GDS supported by the CP covered the following areas: statistics through (international) trainings, ensuring that that the appropriate staff are selected and by being strategic about how many people are trained; preparing and conducting of nation-wide surveys; analysis of data and production by staff from various Ministries of studies and thematic reports; organisation of dissemination workshops at national and municipality level with presentation of district-level data.

¹³⁷ General Directorate of Statistics (GDS), UNFPA (2018): 2015 Timor-Leste Population and Housing Census.

¹³⁸ GDS, MoH and ICF (2016): Timor-Leste Demographic and Health Survey 2016.

¹³⁹ National Transfer Accounts / UN (2017): Research bulletin on Investing in Timor-Leste’s Youth: A Resource for the Future; National Transfer Accounts analytical report.

¹⁴⁰ GDS, UNFPA, UNESCAP Timor-Leste (2017): Timor-Leste Births and Deaths Statistics Report 2014–2015.

¹⁴¹ UNFPA (2017): Mid-Term Review; UNFPA Assisted Programme 2015-2019 Timor-Leste. Mid-Term Review of the UNFPA Country Programme, December 2017. Personal communication by GDS Director.

The capacity strengthening was provided through (international) trainings - ensuring that the right staff were selected and by being strategic about how many people are trained – in combination with on-the-job training within GDS to ensure that skills learned in workshops are used. The capacity strengthening and provision of technical support was coordinated and led by a full-time international Technical Adviser, seconded by UNFPA to GDS. Apart from providing support to GDS and UNFPA, the Technical Adviser also supported data provision and analysis for other UN agencies, a task which often takes up a considerable part of his working hours.

The CP output in terms of national policy documents, studies and population surveys developed is impressive, with many demonstrating inequalities in human rights and gender equality. A number of the studies produced not only generate important population and sectoral data, but also identify weaknesses and challenges in current systems which need to be addressed as if for example the case for the Births and Deaths report which describes the challenges of the current Civil Registration and Vital Statistics system).

GDS and UN agencies interviewed by the CPE team expressed their high satisfaction with the technical and financial support provided by UNFPA. They observed that the UNFPA CP has had an impact on the capacity and willingness of central level and municipal government authorities to use data for planning and decision making. Central level and municipal authorities have reportedly started using data and have started to contact GDS to request data for planning and implementation purposes.

The secondment of a full-time international Technical Adviser during the past five years of the CP was an expensive investment, but contributed to ensuring continuity of quality technical assistance provided not only to GDS to produce key data but also to development partners.

At the start of the CP, the technical capacity at GDS was still limited. Also, there were issues with census data quality resulting from questionnaire design, low quality enumeration and data processing and cleaning. Furthermore, there was a lack of sufficient CP resources to recruit technical expert consultants to analyse the 2015 Census.¹⁴² Other activities were also not implemented due to funding constraints, such as providing technical support to birth registration as the registration funding did not go ahead during 2018. However, UNFPA managed to coordinate with other development partners to ensure that some support was provided to the national Civil Registration and Vital Statistics (CRVS) system in 2019.¹⁴³

During the first years of the CP period, advocacy by UNFPA to high level government institutions and other stakeholders on the use of population data was minimal.¹⁴⁴ This weakness was addressed during the later years of the CP, as described above.

An external challenge for this programme area is the high level of demands by other UN agencies and partners for assistance by the UNFPA Technical Adviser to produce data on various topics. This leaves less work time available for the Adviser for key CP tasks. Other general challenges include the lack of data generation and analysis capacity and practice within government, and the lack of demographers and population specialists in Timor-Leste.

4.2.2 Added value

EQ 4) To what extent has UNFPA made good use of its comparative strengths to add value to the development results of Timor-Leste?

SUMMARY

UNFPA has demonstrated real added value in its programmatic areas. Its recognized technical expertise has allowed UNFPA to act as a facilitator, playing an effective intermediary role between national counterparts and partners, particularly in the areas of gender, reproductive health rights,

¹⁴² UNFPA TL (2016): Country Office Annual Report 2017.

¹⁴³ UNFPA TL (2016): Country Office Annual Report 2018.

¹⁴⁴ UNFPA TL (2016): Country Office Annual Report 2016.

HIV/AIDS, combating GBV and producing population data. UNFPA's comparative advantage in and contribution to strengthening institutional capacity of central level government in UNFPA's mandate areas are also recognised.

The Country Office also adds value in engaging actively and effectively in policy dialogue, and particularly in placing sensitive themes on the national agenda. In some cases, the added value of UNFPA lies in the fact that it is the only country-based development partner to intervene; this is particularly true for the support to HIV prevention and the support to the organisation of the Census.

Among the interviewed stakeholders, including government officials, civil society partners, UN agencies and donors, UNFPA's technical expertise and mandate are well recognised. This is particularly the case in the area of sexual and reproductive health - especially for adolescents and young people - including family planning, gender issues, the fight against gender-based violence and other harmful practices and the production of population data, where UNFPA often acts as intermediary and facilitator between government and partners. UNFPA is also seen as the leading agency in the procurement of contraceptive and reproductive health products. CP achievements and results in the thematic area of HIV/AIDS prevention in Timor-Leste have placed UNFPA and the programme at a comparative advantage with respect to the government and other organisations active in this thematic area.

UNFPA in Timor-Leste has had long standing presence and relatively well accepted interventions in the areas of SRH, Gender and combating GBV and has been able to bring these to the national agenda, despite the cultural sensitivities and taboos around these topics. Several partner agencies have used UNFPA expertise to develop their strategies, programmes and projects. This included receiving technical support from UNFPA staff in the development of their strategies or programme documents or using data produced by UNFPA or by government with technical assistance and resources provided by UNFPA.

UNFPA has developed an international collection of information, knowledge and lessons learned, which has been partially shared with the Government of Timor-Leste and regional authorities throughout the current programming cycle. Several examples cited in this report corroborate the use of the south-south cooperation strategy for various programming areas.

Whereas previously UNFPA was the only UN agency working on the response to and prevention of GBV, and on adolescent and youth health programming, since a few years more UN agencies and partners have started to implement programmes focussing on these subjects. Some UN agencies such as UNICEF have created units in their HQ and in country offices for GBV and adolescent development programming. This situation may affect UNFPA's comparative advantage and coordination mandate on these issues.

4.2.3 Equality and Human Rights principles

EQ 5) To what extent did the implementation of the UNFPA programme in Timor-Leste take into account gender equality and human rights principles?

SUMMARY

UNFPA CP components in Timor-Leste are responsive to gender, in that they promote gender inclusion principles for the development of young women and men, promoting opportunities and equal treatment for all young people, young women and men alike.

CP supported the rights-based approach of universal access of vulnerable populations, including young people and key populations, to primary health care, family planning and SHR/HIV information and services as well as response to GBV.

The CP furthermore promoted an inclusive approach by generating knowledge on how to include vulnerable groups such as young people without employment, LGBTI youth, migrant youth, People Living with HIV/AIDS, People With Disabilities in SRHR and GBV programming. The various assessments and studies supported by the CP generated knowledge on inequities in access to information and services by vulnerable groups, which influenced the policy agenda of the government and partners and assisted advocacy for greater focus on vulnerable groups such as adolescent girls, people with disabilities etc.

Gender equality

All UNFPA programme activities in Timor-Leste have a direct link to women and girls as they focus on reproductive health and family planning, GBV and other harmful practices and on population interventions, which are supposed to improve the health status of girls and women, decrease early marriage, early pregnancies and school drop-outs amongst girls, decrease violence against women and girls and thus all contribute to increasing girls' and women's empowerment and participation, which contributes to gender equality. To some degree, the CP also worked with the central and regional authorities to strengthen capacity of institutions spearheading efforts to further women's empowerment and gender equality in Timor-Leste and contributed to developing national policy documents to this effect.

Human rights

By supporting the provision of SRH knowledge and services to vulnerable women and girls and other vulnerable and marginalised populations, such as key populations, the CP supported the rights-based approach of universal access to primary health care and safe deliveries. Similarly, by supporting the provision of GBV and youth information and interventions for vulnerable and marginalised populations, the CP contributed to the right of populations to access such information and services, thus contributing to greater equity. By supporting various assessments and studies, the CP generated knowledge on inequities of access by vulnerable groups to SRH information and services and made this knowledge available to the GoTL and stakeholders in relevant sectors. This knowledge strengthened the advocacy capacity of various lobby groups, such as the Women Parliamentarians and later of the senior government officials, and contributed to changing the policy agenda of the GoTL. The CP furthermore strengthened the capacity of government to provide information and essential services to vulnerable groups such as People With Disabilities¹⁴⁵, LGBTI persons, People Living with HIV, etc. Thus, the CP supported the population as rightsholders to participate and access essential services, and supported the Government as duty-bearer to provide those essential services and to review, document and report on various human rights related commitments.

4.3 Efficiency

EQ 6) To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 3rd CP outcomes in a timely manner?

EQ 7) To what extent has the CO established, maintained and leveraged different types of partnerships to ensure good use of UNFPA's comparative strengths in the achievement of the Country Programme outcomes?

SUMMARY

The CP was negatively affected by a total budget cut of 52% from USD 15.5 million to 9 million. 47% of CP resources were spent on the Outcome 1 programme area (FP and SRHR) and 3% on Outcome 4 (Population Dynamics).

In spite of the budget cuts meaning that the CP only had about USD 1.5 million per year to fund CP activities and CO staff and operational costs, UNFPA and partners managed to implement a meaningful programme and achieve a large part of the planned results.

The CO performed well in CP financial management: the implementation rate of the CP budget was high (92%) and the office achieved corporate compliance.

CP implementation was affected by delays, many of which caused by political changes in the country's national government.

UNFPA has established strong working relations with government counterparts in key sectors. This has contributed to high-level commitment by these sectors to support - and in some cases champion - priority interventions promoted by the CP. Stakeholders trust UNFPA and appreciate the CP alignment

¹⁴⁵ The CP did this as part of the Empower for Change (E4C) project, a United Nations project focused on advancing the rights of persons with disabilities in Timor-Leste, particularly women and girls with disabilities, to live a life free from violence and discrimination. It is implemented by UNFPA, UNICEF, the UN Human Rights Adviser's Unit (HRAU), UN-Women and WHO. The project partners with Organizations of Persons with Disabilities (DPOs), State Institutions and civil society.

to government policies and priorities. The CO is also working closely with key national and international civil society organisations in CP focus areas. Working relationships with other UN agencies are strong.

4.3.1 Use of CP resources

The CP supports the demand for and the use of sexual and reproductive health and family planning interventions which are internationally recognised to be effective and to represent “*Value for Money*”: through the strengthening of provision of sexual and reproductive health and service and the promotion of family planning to vulnerable populations in Timor-Leste, UNFPA contributed to reducing maternal mortality and morbidity, decreasing fertility and increasing contraceptive coverage. This evaluation does not request the estimation of the exact *Value for Money* of CP results. Also, the CP Results Framework does not include any cost-effectiveness indicators, such as the cost per *Couple Years Protection* or beneficiary satisfaction of the provided support.

The evaluation will focus on various aspects of programme efficiency, as requested in the CPE ToRs.

Financial resources

A major challenge of the 3CP was the reduction of the CP resource envelope by 60% compared to the expected resources described in the CPD and CPAP. Table 6 above provides a comparative analysis of planned versus actually raised budgets for the CP programme cycle. The total planned budget defined in the CPD / CPAP amounted to USD 15.5 mln. for the 5 CP years, whereas the actual budget for this period amounted to USD 8.02 mln., 52% of the planned budget. The CP received USD 7.09 million in regular UNFPA resources, only 71% of the planned USD 10 mln. regular resource contribution. Similarly, the planned co-financing budget for 2015-2019 was USD 5.5 mln. but the actual budget was only USD 0.93 mln., 17% of the planned co-financing amount.

The reason for the decrease in CP regular resources was the reduction in donor contributions to UNFPA due to the budget cut by the US Government in combination with decreases in resources from other donors following the global financial crisis and the economic classification of Timor-Leste as lower-middle income country.

UNFPA financial records report that the total actual expenditure for the period January 2015 to December 2019 only amounted to USD 9.29. During the years 2015, 2016, 2017 and 2018, total CP expenditure was highest on Outcome 1 - related to procurement of FP commodities - followed by Outcome 4 - to support census organisation and analysis. In 2019 up until the end of November, expenditure for Outcome 4 was slightly higher as for Outcome 1.

Table 6: Planned CP budgets compared to actual budgets over 2015-2019 (in million USD)

Planned and actual CP budgets (in USD million)	Regular Resources: R Other resources: O in USD MILLION										TOTAL 2015 - 2019	
	2015		2016		2017		2018		2019			
	R	O	R	O	R	O	R	O	R	O	R	O
Planned CP budget per year	2.30	1.20	2.10	1.95	2.10	0.95	1.80	0.70	1.70	0.70	10.00	5.50
Total planned CP budget per year	3.50		4.05		3.05		2.50		2.40		15.50	
Actual CP budget per year	1.85	0.02	1.54	0.15	1.14	0.56	1.28	0.04	1.28	0.17	7.09	0.93
Proportion of actual compared to planned budget	80%	1%	73%	8%	54%	59%	71%	6%	75%	24%	71%	17%
Total actual CP budget per year	1.87		1.69		1.70		1.32		1.45		8.02	
Proportion of actual total budget compared to planned total budget	53%		42%		56%		53%		60%		52%	

Source: UNFPA Timor-Leste Country Office (2019)

The bulk of CP spending from regular UNFPA resources during 2015 - 2019 was spent by Outcome 1 (outputs 1 FP and output 2 SRHR) (46%) and Outcome 4 (Population Dynamics). The same spending pattern was observed for external resources: the CP spent 51% of total co-financing resources for Outcome 1 and 36% of co-financing resources for Outcome 4.

Table 7: Actual total CP expenditures by outcome area for the period 1 January 2015 to 10 December 2019 (in USD)

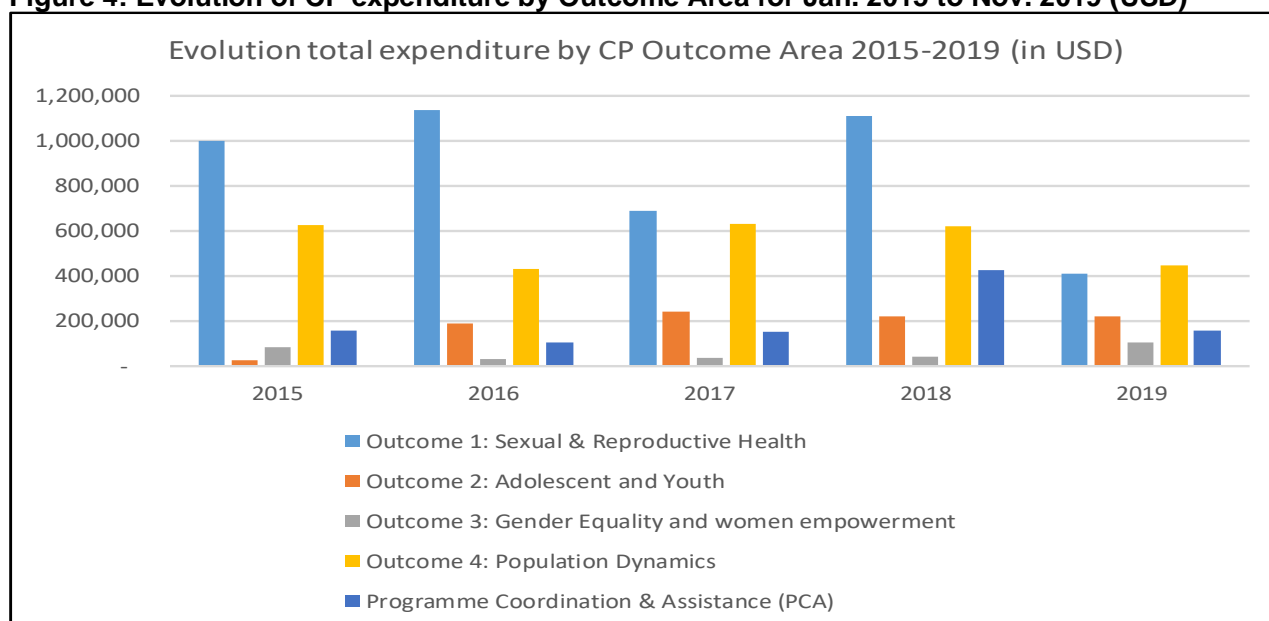
Expenditure per Strategic Plan Outcome Areas	Regular Resources	Other resources	Total CP expenditure over 2015-2018	
Outcome 1: Sexual & Reproductive Health	3,798,088	544,560	4,342,648	47%
Outcome 2: Adolescent and Youth	756,354	140,331	896,685	10%
Outcome 3: Gender Equality and women empowerment	296,786	-	296,786	3%
Outcome 4: Population Dynamics	2,365,307	390,965	2,756,272	30%
Programme Coordination & Assistance (PCA)	993,483	-	993,483	11%
Total USD million	8,210,017	1,075,856	9,285,873	100%

Source: UNFPA Timor-Leste Country Office (2019)

NOTE: figures up to 30 November 2019.

The CPE team is impressed with the level and variety of CP implementation achieved by UNFPA and its IPs on a budget of about USD 1.5 million per year.

Figure 4: Evolution of CP expenditure by Outcome Area for Jan. 2015 to Nov. 2019 (USD)



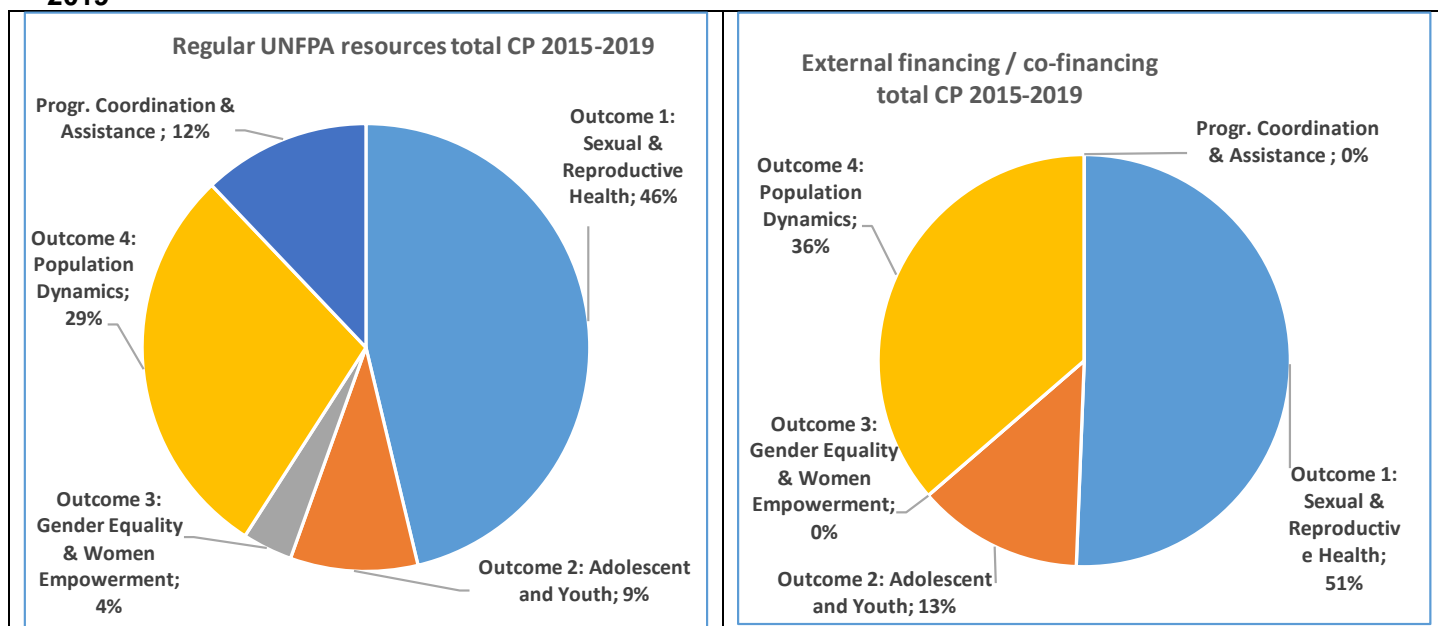
Source: UNFPA Timor-Leste Country Office (2019)

NOTE: figures up to 30 November 2019.

The government and UNFPA have so far managed to implement the programme for the budgeted costs in the work plan. Efforts were also made to economise programme costs by holding meetings and workshops in existing agency premises, and by compacting the number of meeting days and increase use of remote meeting technology (video calls). The CP also contributed to economies of scale through its involvement in the international procurement by UNFPA of reproductive health products (including

contraceptives), thus contributing to achieving low prices for reproductive health products in conformity with UNFPA quality standards.

Figure 5: CP spending of regular UNFPA resources and co-financing by programme area for 2015-2019



Source: UNFPA Timor-Leste Country Office (2019)
NOTE: figures up to 30 November 2019.

In terms fund implementation, the UNFPA Country Programme in Timor-Leste reached an average financial implementation rate of 92% over the period from January 2015 to December 2018, with programme area implementation rates ranging between 88% and 100%, as shown in table 8. This is above the standard required by UNFPA.

Table 8: Implementation rates of the 3rd UNFPA Timor-Leste Country Programme from January 2015 to December 2018

Country Programme Components	2015	2016	2017	2018	Total CP implementation rates per programme area
Sexual Reproductive Health	90%	96%	93%	96%	93%
Adolescent and Youth	89%	94%	91%	85%	91%
Gender Based Violence	90%	99%	102%	88%	85%
Population and Development	96%	92%	88%	90%	92%
Program Coordination and Monitoring	96%	98%	100%	84%	92%
All CP Components	93%	94%	91%	90%	92%

Source: UNFPA Timor-Leste Country Office (2019)

The implementation rates of the CP Implementing Partners (IPs) showed more variation. Table 9 in Annex 4 demonstrates that annual implementation rates varied from 0 or 35% for some IPs to 100% for other IPs in some years. An external challenge mentioned by stakeholders interviewed is that changes in policy priorities in the country resulted in IP funds not being utilised and therefore required IP funds to be reprogrammed.

Figure 6 shows that the total CP expenditure implemented by UNFPA during 2015-2018 was over USD 6.4 million, whereas GDS, MoH, Macro ICF and Alola Foundation managed to implement USD 218,000, 130,000, 185,000 and 247,000 respectively.

Figure 6: CP total Implementing Partner expenditure over 2015-2018 (in USD)

Implementing Partner	total CP expenditure
MoH	129,952
SEII	36,836
GDS (MoF)	218,347
MoEYS	-
SYSS	5,950
INS	68,206
PRADET	24,908
ALFELA	20,813
Alola Foundation	185,034
SHC	17,396
MACRO ICF	247,267
UNFPA implementation	6,366,842

Source: UNFPA Timor-Leste Country Office (2019)

NOTE: Nossal Institute, FOKUPERS, Estrela+ and Burnet Institute are not included in this table as they only became IPs in 2019.

Financial management

The UNFPA CO in Timor-Leste performed well in financial management of the CP. The implementation rate of the CP budget was generally high and UNFPA Timor-Leste achieved corporate compliance. Procurement targets were met. The UNFPA CO also volunteered to conduct an internal management audit in 2018 and is currently implementing the audit recommendations.

As shown in table 9, the majority of programme resources – 87% to 93% each year - were executed directly by UNFPA through the Direct Execution (DeX) modality. The remaining resources were executed through contracts with counterpart Implementing Partners through the National Execution (NeX) modality based on Annual Workplans. GDS, Macro ICF and Alola Foundation were the Implementing Partners with the largest budget and expenditure, mostly related to the organisation, analysis and publication of the census exercises and the implementation of the BPP programme.

Funds disbursements were processed on time, except for when they were delayed due to late signing of annual workplans or due to late submission by IPs of financial reports over the previous period. CO officials interviewed reported that programme financial monitoring by the CO through IP spot-checks was regular. UNFPA built capacity of IPs in monitoring and reporting, resulting in better quality IP financial reports (completeness, data quality and supporting documents) and less delays in report submission.

Weaknesses in the CP operations management include the fact that during the first CP years no management audits were conducted. The UNFPA operations team also reported that the team is not systematically informed and consulted by programme staff in the planning of programmes and in development of funding proposals. This represents the risk of programme proposals not including adequate budgets for staff, M&E, communication and operations.

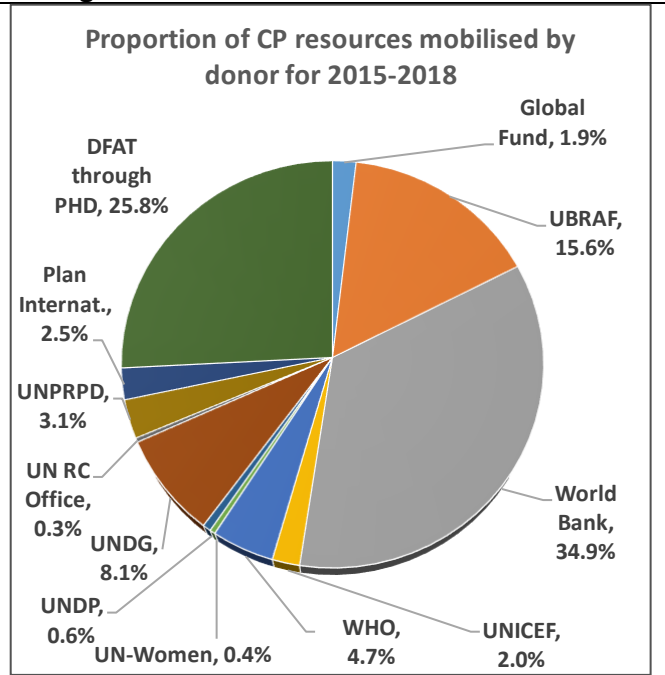
Resource mobilisation

The UNFPA Country Office succeeded in mobilising resources for the CP, particularly in the areas of SRHR/FP and Population Dynamics. From January 2015 to the end of 2018, UNFPA Timor-Leste managed to mobilise a total of USD 1.22 million from external donor sources (see table 10). The main external CP donors were the World Bank, Australia, UBRAF (UNAIDS) and UNDG, who together provided over USD 1.032 million or 84,5% of the total external resources mobilised.

In 2019, UNFPA contributed to successful efforts to mobilise new additional resources for large multi-agency GBV programmes starting 2020. This included USD 9,9 million from the European Union SPOTLIGHT programme for a 3-year UN Joint Programme on GBV starting in 2020. The UNFPA Country Programme will receive a part of this funding. An application by UNFPA and five other UN agencies for USD 7.9 from KOICA Korea for a 4-year joint UN programme on GBV is still pending.

Table 10 and Figure 7: Financial resources mobilised during Jan. 2015- Dec. 2018

CP Donor	Programme Area	Amount (USD)
Global Fund	HIV	22,679
UBRAF (UNAIDS)	HIV	191,496
World Bank	DHS	427,611
UNICEF	Census Thematic Education Report, youth NAP	25,000
WHO	RH (EmONC + MDSR), DHS, census, youth	57,020
UN-Women	Youth NAP	5,000
UNDP	Youth, Youth NAP	7,598
UNDG	Youth: Leaving No One Behind Project (Joint Programme)	99,424
UN Resident Coordinator Office	Youth: Support to Youth Result Group	4,112
UNPRPD	Gender: Empower for Change Project (Joint Project)	37,800
PLAN International	Youth: Teenage Pregnancy Early Marriage Research	30,650
DFAT through PHD	Emonc and Youth (Boys and Girls Circles)	316,205
TOTAL (USD)		1,224,595



Source: UNFPA Timor-Leste Country Office (2019)

Administrative resources

The evaluation does not have enough elements to assess if the level of CP administrative costs indicates efficiency. The specific context in Timor-Leste, with political instability and policy changes, a remote geographic location and an enclave located surrounded by a neighbouring country, is expected to generate additional operational costs.

Human resources

The UNFPA CO team is small and consists mainly of national staff (18 persons) with three international positions (Representative, International Operations Manager and Census Technical Adviser). Staff in Timor-Leste are hardworking and committed to their work. The UNFPA programme staff are working in integrated ways and can cover for each other during staff absences. A similar mechanism exists for the operations staff. Working relationships between the programme and operations team are excellent. Recently the workload of UNFPA programme staff has been very high, exacerbated by illness of some of the staff. Consequently, some UNFPA staff are overloaded, which likely effects staff efficiency.

Technical resources (expertise)

UNFPA managed to engage in-house and external expertise to provide technical support and assistance for the CP. The members of the UNFPA Country Office team are multidisciplinary and can cover for each other. However, frequent changes in policies within UNFPA means that sometimes UNFPA staff are not keeping up with changes and puts the burden of constant adjustments. The CO received useful support from the Asia and Pacific Regional Office (APRO) in Bangkok and from colleagues at UNFPA HQ and in Copenhagen.

The CO achieved quality assurance of CP interventions through close relationships with implementing partners, which provided frequent opportunities for engagement on technical issues. However, some government staff are overstretched and therefore not always available for UNFPA CP activities. Government partners interviewed mentioned that procedures for UNFPA to source national and international consultants were sometimes lengthy.

Innovation

The UNFPA CP in Timor-Leste supported a number of innovative approaches, including:

- Capacity strengthening of health workers on EmONC following a competency-based certification approach, which involved a combination of theoretical and practical teaching followed by supervision in the place of work before training certificates are provided.
- EmONC strengthening programme implemented jointly by UNFPA and WHO, co-funded by UNFPA, WHO, USAID and Australia DFAT, with WHO contributing funding to UNFPA for joint programme implementation.
- Integrated approach to capacity building of health workers and police officers on HIV / SRHR by a variety of trainers from government, UN, civil society and key populations (for example People Living with HIV).
- Online methodology planned for the 2020 Population Census, including using tables for enumeration and automatic sending data through mobile connection to GDS, as well as mapping of households through GIS.

Timeliness

The Timor-Leste Government and UNFPA are committed to implementing the programme and achieving all the goals in a timely manner. However, as explained earlier, political volatility and changes led to delays in implementation of a number of CP activities and required frequent reprogramming of activities and budgets. IP capacity to utilise funds was sometimes limited given competing priorities.

Stakeholders interviewed listed delays in the signing of Annual Work Plans with IPs as an inefficiency. Also delays in submission of reports by IPs at times resulted in delay of disbursement of funds. All IPs interviewed mentioned delays in signing annual workplans at the start of each calendar year as a challenge for their internal planning, recruitment and procurement systems.

Programme management, monitoring and evaluation

CP programme management generally functioned well. The CO programme teams generally collaborated in CP implementation which promoted integration of programme areas. However, at times integration between programmes was not sufficient. The CPE team observed that some health worker trainings focussed on a single topic rather than integrating topics from other UNFPA mandate areas within health or other programme areas.

An external challenge to the CP programme management was the turnover of government and NGO staff which resulted in loss in capacity and required UNFPA to continuously train newly appointed staff in programme and financial management and in reporting to UNFPA.

The CP was not based on any Theory of Change, nor did the CP Evaluation reconstruct a ToC. The CP Document includes a Results-Based Management tool in its CP Results and Resource Framework, which includes outcome indicators and output indicators, baselines for 2014 and final targets for 2019. Overall the CP outcome and output indicators, baselines and targets were developed well, and enable the capturing of CP achievements. Exceptions to this are the output indicators of Output 1, which do not sufficiently capture the capacity strengthening and policy development efforts supported by the CP towards MoH and SAMES, and instead only focus on changes in FP health facility performance and in FP knowledge by the population, areas to which the UNFPA CP only contributes partially.¹⁴⁶ Furthermore, in the CP results framework there is no consistency in the level of outcome and output indicators with

¹⁴⁶ For example, Output 1 indicators capture the proportion of health facilities in reporting no contraceptive stock-outs; health facilities providing at least three or more methods of FP; and the level of knowledge of FP amongst married women in UNFPA supported districts. Even if UNFPA procures 100% of contraceptives in the country, challenges within the national MoH supply chain may result in stockouts. Similarly, the degree to which facilities provide at least 3 FP methods depends on how many health workers were trained and on their personal convictions, whereas UNFPA did not train 100% of all health workers in the country in FP. Lastly, the level of FP knowledge amongst women in the priority municipalities depends on many factors, whereas UNFPA only trained a part of the health workers, and not all women will receive FP counselling during their health facility visit.

output indicators for Output 1 being formulated at a higher level - which to the CPE team seems more appropriate as a CP Outcome Indicator – and the indicators for other Outputs formulated at a lower level - which seems more appropriate for a CP focussing on systems strengthening.¹⁴⁷ Some output indicator targets seem high and unrealistic, and again do not reflect the CP focus on strengthening government capacity rather than supporting service provision.

A weakness in the CP monitoring practice is that CO staff do not use the CP and CPAP results framework as basis for monitoring CP performance in Timor-Leste. The CO team did not maintain the CPAP tracking tool (included in the CPAP) updated to monitor CP performance and take programmatic decisions to adjust CP performance. The M&E team trained UNFPA and IP staff on the CP M&E system. By using the UNFPA monitoring systems, the capacity of IP staff to report to the UNFPA CP monitoring system has increased.

The majority of reporting by UNFPA is targeted to UNFPA, the UN system and donors. UNFPA TL does produce external annual reports on the Timor-Leste CP or systematic programme updates for Government and partners. An exception are mandatory reports to government, such as financial spending reports submitted by UNFPA to the DPMU unit of the Ministry of Finance, which UNFPA does submit regularly and on time. The narrative sections in the internal UNFPA SIS reports are often short, meaning the SIS does not always adequately reflect the achievements of UNFPA TL programme areas. Also, UNFPA programme staff do not systematically produce reports on work in direct implementation. As a result, a (large) part of CP performance is not captured. In addition, there is little joint monitoring of CP implementation (with other UN agencies and partners) and no involvement of national government in CP monitoring visits.

An evaluation achievement was the CP mid-term evaluation carried out in 2017, which formulated a number of recommendations which the CO and partners are following up.¹⁴⁸

4.3.2 Partnerships

In terms of UNFPA's partnerships with government, UNFPA Timor-Leste maintained strong working relationships with a number of Ministries at central level. Staff from government institutions interviewed found UNFPA to be a trusted and responsive partner, always willing to provide assistance where possible. UNFPA partnerships with government focused on those government institutions and departments within them which are Implementing Partners of UNFPA. UNFPA also established working relationships with sectoral departments in a number of municipalities in which (pilot) interventions were supported by the CP. However, in some municipalities visited by the CPE team, these relationships with local authorities were not very strong and contact was not frequent.

Government partners appreciate that UNFPA support is highly aligned to government policies and strategies, and that UNFPA participated in and supported annual planning process of a number of government partners. However, the downside of the strong CP alignment to the GoTL's policies and procedures is that for a number of interventions CP implementation follows government processes which often take longer.

In terms of UNFPA's partnership with civil society organisations, UNFPA has good relations with a number of national and international NGOs and associations, some of which are its current or former implementing partners. During the past years, UNFPA's civil society Implementing Partners (IPs) have done a good job in running programmes and providing essential services. This is appreciated by UNFPA staff and other stakeholders.

IPs interviewed by the CPE team appreciate UNFPA as a cooperative, flexible and responsive partner, prepared to listen to technical suggestions and requests when IPs make them. IPs appreciate the flexibility of UNFPA in adjusting annual workplans when required. They also reported that UNFPA

¹⁴⁷ For example, for Output 3 – Youth, the outcome indicator (and not the output indicator) measures the level of knowledge of the target population.

¹⁴⁸ UNFPA (2017): Mid-Term Review of the UNFPA Country Programme 2015-2019 in Timor-Leste.

contributed to capacity building of IPs in the areas of policy development, programme planning and management, narrative and financial reporting, data collection and in the development of some level of documentation and communication products.

IP staff interviewed suggested that UNFPA could do more to promote links or exchange of experience between IPs working in the same programme area in Timor-Leste or with similar initiatives abroad. They also suggested that UNFPA staff could share more information on relevant developments in programme areas abroad. This would provide an opportunity for CP implementing partners for cross-fertilisation and learning from each other, to replicate best practice, form stronger links and also to motivate IP staff. Some IP staff felt that there is no clear system for information sharing by UNFPA with IPs and stakeholders, including with central and local government.

Within the UN family, UNFPA has developed excellent working relationship with WHO and UNWOMEN and recently strengthened working relationship and coordination with other UN agencies active in areas related to UNFPA's mandate areas, including UNICEF, IOM and ILO. UNFPA's working relationship with WHO is quite innovative, as it includes close cooperation, planning and joint implementation of health systems strengthening activities, such as the EmONC system strengthening. WHO even channels resources through UNFPA for UNFPA to implement activities in the name of both agencies.

Communication

As far as external communication is concerned, the UNFPA CP produced a number of communication products, including programme brochures and summaries, reports and audio-visual materials, which give a good representation of the interventions. Up until June 2019, when the Country Office had a communication officer, the UNFPA Timor-Leste website regularly published human interest stories and documents produced by UNFPA in Timor-Leste and at global level.¹⁴⁹ Engagement by UNFPA in social media has increased in recent years.

A weakness of the CP production of communication outputs is the gap in UNFPA communication officer between June 2019 and early 2020. A number of central level government officials interviewed stated that they do not receive regular written updates or reports from UNFPA on progress of CP implementation. Similarly, municipal authorities informed the CPE team that they have not received regular reports from civil society implementing partners active in their municipalities who are supported by the UNFPA CP. An exception here is the regular reporting by UNFPA to the Development Partnership Management Unit (DPMU) within the Ministry of Finance. Civil society implementing partners also stated that they appreciated the thematic meetings organised by the CO, but that UNFPA did not facilitate regular information exchange between IPs working in the same programme area nor shared information about best practices identified in Timor-Leste and abroad.

UNFPA staff report that internal communication and information exchange within the UNFPA Timor-Leste Country Office function well.

4.4 Sustainability

EQ 8) To what extent has UNFPA support helped to ensure that SRH and rights, and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in Timor-Leste?

EQ 9) To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership and durability of effects of the 3rd CP interventions?

¹⁴⁹ <https://timor-leste.unfpa.org/en/news>

SUMMARY

The CP was effective in integrating SRH and rights and concerns for young people, gender equality, gender-based violence and population dynamics into national policy frameworks such as sector development plans, policies and strategies and guidelines.

The CP was also effective in contributing to building systems and capacities of government authorities and civil society partners and increasing ownership and commitment to the CP interventions.

The CP was effective in integrating SRHR concerns into the health sector policy documents including the RMNCH Strategy, Youth Policy and National Action Plan for Youth and into the education curricula of primary and secondary schools. Issues of Gender and GBV were integrated into national guidelines and training materials for health workers and school teachers in the public sector. Thus, the CP has contributed to these issues having become part of the policy objectives and implementation of the government and its partners in Timor-Leste.

The CP contributed to strengthening the capacity of counterpart government institutions and civil society IPs to establish, manage, monitor and report on priority interventions in the area of SRH, adolescents & youth, GBV and population data. This increased capacity and visibility will assist these IPs to sustain their programmes and to mobilise resources. CP efforts also increased the capacity of some IPs to organise campaigns and advocate with local, regional and national government for increased political attention and domestic resource allocation to their areas of focus.

Capacity development was one of the main programme delivery mechanisms defined in the CPD and CPAP. During implementation, the CP supported individual level capacity building of service providers and government decision makers and technical staff at central level - as well as systems strengthening through procurement of equipment and supplies and development of national policies, procedures and tools. Lobbying and advocacy by UNFPA with government authorities contributed to building political buy-in of government for support priority interventions and procurement and to increasing commitment to support the scale up of these interventions using its own resources. This has contributed to the financial sustainability of some interventions. These efforts will need to be maintained to ensure that government will indeed adopt the supported interventions as key priorities and support their scale up.

IP capacity building focussed on strengthening technical capacity as well as management skills of Implementing Partners, including programme management, monitoring and reporting. This was done through national trainers, international trainers coming to Timor-Leste as well as by sending IP staff abroad. South-south cooperation was used and was much appreciated by Timor-Leste partners.

The CP efforts thus contributed in two ways to sustainability of interventions supported: they increased institutional sustainability by strengthening the capacity of counterpart organisations to plan, manage and monitor key interventions; and contributed to financial sustainability by strengthening the counterpart's capacity to manage their existing resources efficiently, to mobilise additional resources and to advocate for increased resources for priority interventions.

A weakness of the CP human resource capacity building efforts is that so far they have mainly focussed on individual capacity building of service providers (health workers, teachers) and less on service managers (health facility managers, school directors) and the environment (municipal authorities, parents of school children). In addition, EMONC and FP capacity building relies heavily on (a limited number of) national trainers, without many teaching aids having been produced so far. This represents a risk if the national / municipal trainers leave their positions. Stakeholders recommended that the CP increase the pool of national and municipal trainers and produce (audio-visual) training tools to enable the INS, INFORDEPE and the hospitals and schools to train additional trainers, health providers and teachers without the CP's direct support.

In the current system for capacity building of health workers and teachers, national trainers were selected from various municipalities and supported to train health workers and teachers in other municipalities. This system is quite expensive as it requires providing support to national trainers for transport and time spent (overnight) in other municipalities. Stakeholders interviewed suggested that it would be cheaper to use municipal trainers to train service providers in their own municipality. Civil society partners

interviewed mentioned as a weakness and risk the approach by UN agencies to pay incentives to government staff to work as national or municipal trainers in their own location of work. Partners feel that this creates a wrong precedent and contributes to government staff not being motivated to act as trainers of their colleagues during the rest of the year when no incentives are paid. The CPE believes that this situation represents a real risk of undermining the sustainability of training initiatives established and supported by the CP. So far most capacity building of service providers has focussed on in-service training. While this has reached excellent results in some areas such as EmONC training of health workers, it is important that the CP also support pre-service capacity building of human resources as this will generate more sustainable results.

Since over 15 years, UNFPA has been paying 100% of the Census Technical Adviser's salary, a costly investment. However, after lobbying with other UN agencies, UNFPA managed to convince UNICEF to co-share the Adviser salary payments starting from 2021. Seconding a full-time UNFPA Technical Adviser to GDS over a number of years represents a risk as it may lead to the Adviser being used more as staff (substitution) and less in a capacity strengthening role. Interviews with the GDS Director and the UNFPA Technical Adviser indicated they are aware of this risk and that the Adviser is only used for institutional development tasks. However, it is important that UNFPA remains vigilant on this point. UNFPA also demonstrated its commitment to avoiding parallel implementation mechanisms as much as possible, for example by successfully lobbying GDS to integrate the census project staff previously employed by UNFPA into GDS contract under state budget.

The relatively abrupt stop in CP support to the BPP programme by Alola Foundation in late 2018 did not allow for an adequate period of phase-out and hand-over to the local authorities. This contributed to the suspension of service provision to vulnerable populations and to the loss of capable Alola Foundation programme staff in Oé-cusse and Baucau municipalities.

The CP could explore options to benefit from existing resources for strengthening of institutional capacity of CP partners in Timor-Leste. For example, the Australia Department for Foreign Affairs and Trade (DFAT) has a framework contract with the British NGO RedR and may be able to fund provision of technical assistance, training and mentoring to UNFPA staff and IP staff through this mechanism.¹⁵⁰

Documentation of programme interventions for advocacy and policy development is one of the mechanisms to share information and lessons learned from the CP and promote the replication and scale-up of CP best practices. By strengthening documentation of CP best practices and lessons learned, UNFPA will have better tools for advocacy, better contribute to the development of national policies and guidelines on important issues and build the knowledge base that will allow UNFPA to demonstrate impact and guide the replicability and expansion of good practices. Furthermore, documentation of successes, best practices and development of policy briefs is important to guide CP implementation and ensure quality and standardisation of implementation between the various Implementing partners. We know from other evaluations that piloting / testing of new approaches without documentation does not generate any lasting impact.

The CP is undertaking efforts to document the support to the EmONC strengthening through a mid-term review of the EmONC Improvement Plan of Action for Timor-Leste. However, while UNFPA has supported a number of important situation assessments of the CP working environment, documentation by UNFPA, GoTL and IPs of interventions supported through the CP has generally been limited. This is a lost opportunity as a number of interventions supported by UNFPA in Timor-Leste were mentioned by stakeholders interviewed as examples of best practice. For example, it would be useful to document the Birth Preparedness Planning programme, as well as the various CSE approaches (and a comparison between them), etc.

¹⁵⁰ RedR conducts cap building of staff on programme management, project cycle management, M&E, developing coaching and mentoring programmes, management and leadership, information management, HR management, security management, humanitarian principles. RedR organizes courses in various locations around the world. <https://www.redr.org.uk>.

4.5 Coordination

EQ 10) To what extent did the CO contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities / seeking synergies) within the United Nations system and in the national development sectors of Timor-Leste?

SUMMARY

The Country Office co-chaired and contributed actively to the mechanisms supporting the implementation of the UNDAF, such as the UN Gender Technical Group and the UN Results Group on Youth, and chairs the UN Office Management Team. These UN coordination mechanisms contribute to a better division of tasks and coordination of priority interventions within the UN family.

UNFPA has furthermore supported and strengthened a number of national (multi-)sector coordination mechanisms, such as the health sector Maternal and Child Health Technical Working Group and the Inter-Ministerial Commission responsible for coordination, monitoring and evaluation of the implementation of the NAP-GBV.

UNFPA is the co-chair of the UN Gender Technical Working Group (GTG), which coordinates UN programmes on gender equality and gender-based-violence, and is chaired by UN-Women.¹⁵¹ The GTG also coordinates the efforts of UN agencies to prevent and respond to GBV within their own agencies, employees and their dependents. The GTG is guided by its annual workplans and meets every three months. Stakeholders interviewed appreciated the expertise and commitment of UNFPA to this area and the technical contributions made by UNFPA to activities of the sector. UNFPA also co-chairs the UN Results Group on Youth in close cooperation with UNICEF which is the chair. In 2016, the group developed a concept note on joint programming and mapped UN Agencies and other development partners active in the youth sector. It also drafted a UN Position Paper on youth.¹⁵² In 2017 the Group produced 2 useful quarterly newsletters called “United Nations and Youth in Timor-Leste” outlining interventions supported by individual UN agencies.¹⁵³ Unfortunately it seems that since 2018 no further newsletters were produced. Unfortunately, not all UN agencies are as focussed and committed to furthering youth causes in Timor-Leste, and participation in the UN Results Group is often limited to a few agencies only. UNFPA has also contributed to the functioning of the UN Country Team (UNCT) coordination mechanisms through its attendance of meetings and contributions to data collection and development of reports etc. This includes the monitoring of the current UNDAF and the development of the new UNDAF.

UN agencies have expressed their willingness to partner with UNFPA for joint programming, as directed in the common chapters of the respective global strategic plans of various agencies. Partnerships with UN agencies will also be useful to leverage the expected results in the government commitments, through the provision of technical assistance to the designated sectors under the premise of multi-sectoral coordination. The GBV project financed by the EU Spotlight Initiative (and that by KOICA if approved) will likely strengthen joint programming and collaboration between the UN agencies funded.

In terms of operations cooperation with other UN agencies, UNFPA reactivated the UN Office Management Team (OMT) by chairing it. UNFPA also participates in the UN procurement working group, which developed common rosters for service providers and consultants. The UNFPA CO currently uses UNICEF and UNDP procurement contracts with providers, which is an example of advanced harmonisation of management procedures between agencies. UNFPA also participates in the HACT working group which deals with common IP payment procedures used by UNICEF, UNFPA and UNDP.

UNFPA contributes to strengthening of national (multi-)sector coordination mechanisms. The CP supported the Mother and Child Health Working Group led by the MoH MCH Department, where all

¹⁵¹ UN Gender Theme Group (2018): UN GTG update, December 2018.

UN Gender Theme Group (2019): UN GTG consolidated workplan, 12 February 2019.

¹⁵² SSYS / UNFPA (2016): Quarterly Annual Workplan Progress Reports over Q1, Q2 and Q3.

¹⁵³ UN Timor-Leste (2017): United Nations and Youth in Timor-Leste; April-July 2017. Newsletter.

UN Timor-Leste (2017): United Nations and Youth in Timor-Leste; Newsletter issue 2, December 2017.

partners working in the area exchanged information on activities carried out and planned.¹⁵⁴ UNFPA also attended national coordination mechanisms in the education sector, including the technical working group on school health. Stakeholders interviewed suggest that UNFPA's attendance of key health sector meetings contributed to better information exchange on and harmonisation of initiatives supported, which resulted in sharing of resources and contributed to better CP results. They also suggested that UNFPA can more frequently attend high-level education meetings such as the "*Acção Conjunta para a Educação em Timor-Leste*" (ACETL) meetings, led by the Minister of Education. In the GBV response, UNFPA supported SEII to chair the Inter-Ministerial Commission responsible for coordination, monitoring and evaluation of the implementation of the NAP-GBV.

Strengthening and working through national coordination mechanisms and their respective technical working groups is an excellent way for UNFPA and CP partners to lobby for and promote government ownership on priority issues, while at the same time strengthening national capacity for roll-out of priority interventions. Strong coordination with MoH and other government institutions will also facilitate the development of further policies and guidelines to guide effective programme implementation. A challenge is the fact that coordination by government of the implementation of sector strategic plans and annual work plans is still not strong.

Relations with the main bilateral CP donor Australia through the Australia-Timor-Leste Partnership for Human Development (PhD) office in Dili are excellent and UNFPA senior management and programme officials meet frequently with PhD officials.

¹⁵⁴ MoH Timor-Leste (2018): Annual Work Plan Progress Report over Q3 of 2018.

5 CONCLUSIONS

5.1 Strategic level

CONCLUSION 1 (C1) - RELEVANCE

The 3rd UNFPA Country Programme (CP) in Timor-Leste for 2015-2019 is relevant with its interventions addressing population needs identified in national development plans and through participatory needs assessments and consultations with partners.

Origin: EQ1

Associated recommendations: none

UNFPA Country Programme interventions addressed information and service needs of vulnerable groups, particularly young women (15 to 24 years old) who experience the highest maternal mortality, greatest percentage of mistimed births and highest rate of gender-based violence, as well as young men as supporters of family planning and maternal health and acknowledging their role in reducing gender-based violence. Interventions also targeted younger adolescents and key populations such as uniformed personnel, People Living with HIV, female sex workers and MSM.

CONCLUSION 2 (C2) – RESPONSIVENESS TO EMERGING NEEDS

The UNFPA Country Office (CO) was responsive to changes in government policies and managed to reorient programme interventions to optimise buy-in and cooperation from government authorities. The CO also reoriented the CP geographic focus to respond to requests from central government and to changes in intervention requirements.

Origin: EQ2

Associated recommendations: none

The CO was able to adapt CP approaches and speed of implementation to developments in the sectors relevant to UNFPA's mandate, such as changes in sector priorities and policies, changes in high-level Ministerial staff, and to implement the recommendations from the CP Mid-Term Evaluation.

CONCLUSION 3 (C3) – ADDED VALUE

UNFPA Timor-Leste has demonstrated real added value in its programmatic areas. Its technical expertise is recognised and appreciated by partners. The Country Office also adds value in engaging actively and effectively in policy dialogue, including in placing sensitive themes on the national policy agenda.

Origin: EQ4

Associated recommendations: R3

UNFPA has demonstrated added value in its programmatic areas. Its recognised technical expertise has allowed UNFPA to act as a facilitator, playing an effective intermediary role between national counterparts and partners, particularly in the areas of gender, reproductive health rights, HIV/AIDS, combating GBV and producing population data. UNFPA's comparative advantage in and contribution to strengthening institutional capacity of central level government in UNFPA's mandate areas are also recognised. Furthermore, the CO adds value in engaging in policy dialogue, particularly regarding sensitive themes such as right of adolescents and young people and unmarried persons to SRHR information and services. In some cases, the added value of UNFPA lies in the fact that it is the only country-based development partner to intervene; this is particularly true for the support to HIV prevention and the support to the Census.

Since a few years, more UN agencies and partners have started to implement programmes on adolescent and youth health and on gender-based violence response and prevention. Some UN agencies such as UNICEF have created units in their HQ and in field offices for GBV and adolescent development programming.

CONCLUSION 4 (C4) – GENDER EQUALITY AND HUMAN RIGHTS PRINCIPLES

The CP effectively takes into account gender equality and human rights principles. It promotes gender inclusion principles for the development of young women and men, promoting opportunities and equal treatment for all young people. The CP supported the rights-based approach of universal access to essential health and GBV response services and information by vulnerable populations. It also supported various assessments and studies which generated knowledge on inequities in access to information and services by vulnerable groups, which influenced the policy agenda of the government and partners and assisted advocacy for greater focus on vulnerable groups such as adolescent girls, people with disabilities etc.

Origin: EQ5

Associated recommendations: none

The UNFPA CP components in Timor-Leste are responsive to gender, in that they promote gender inclusion principles for the development of young women and men, promoting opportunities and equal treatment for all young people, young women and men alike. The CP supported the rights-based approach of universal access of vulnerable populations, including young people and key populations, to primary health care, family planning and SHR/HIV information and services as well as response to GBV. The CP furthermore promoted an inclusive approach by generating knowledge on how include vulnerable groups such as young people without employment, LGBTI youth, migrant youth, People Living with HIV/AIDS, People With Disabilities in SRHR and GBV programming.

5.2 Programme level

CONCLUSION 5 (C5) – EFFECTIVENESS - SRHR AND FP

The UNFPA CP was effective in contributing towards capacity strengthening of central level government for the coordination of service provision in areas such as Family Planning (FP), emergency obstetric care (EmONC) and the health sector response to Gender-Based Violence (GBV). The CP furthermore made a significant contributing to ensuring the availability of contraceptives in the country during the programme period. CP advocacy led to the GoTL's commitment to gradually take over contraceptive procurement funding from domestic resources during the coming years. However, contraceptive stockouts in health facilities are continuing, a situation which MoH, UNFPA and partners are working to address.

Capacity strengthening of health service providers has started, particularly on FP, EmONC, MDSR, HIV/AIDS and on the health sector response to GBV. The capacity strengthening is highly appreciated by stakeholders interviewed. Training participants and stakeholders expressed the opinion that the training had greatly increased the participants' knowledge and ability, and had an impact on their performance. However, so far increases in participants' knowledge and ability has not been documented by the CP. CP training has not covered all relevant health workers due to lack of CP resources. Capacity strengthening was also not always carried out in a way that optimised integration of various subjects and key programme areas. Furthermore, capacity strengthening focused on training of service providers, without much involvement of service managers and municipal coordinators.

Origin: EQ3

Associated recommendations: R5, R6, R7

The UNFPA CP was effective in contributing towards capacity strengthening of central level government for the coordination of service provision for Family Planning (FP), Sexual and Reproductive Health, emergency obstetric care (EmONC), and the health sector response to Gender-Based Violence (GBV). The CP also strengthened capacity of MoH to coordinate and support the provision of HIV prevention services, particularly for professionals at risk such as police officers, health workers groups and key populations in border areas.

CP support provided 100% of all contraceptives consumed in the country's public sector over the past 5 years, and was thus able to ensure that contraceptive availability was maintained in the country. CP advocacy also has led to the GoTL's commitment to gradually take over contraceptive procurement funding from domestic resources. However, contraceptive stockouts in health facilities are continuing,

mainly due to lack of capacity and systems in the supply chain management system. MoH, UNFPA and partners are working to address.

The CP was effective in contributing to capacity strengthening of the public system for maternal health services, with focus on emergency obstetric and newborn care (EmONC) and maternal death surveillance, through strengthening of national policies, guidelines and tools and central level capacity in these areas. Capacity building of health care providers has contributed to improve the availability and accessibility of quality family planning services. Survey results show that the proportion of married women who know at least one modern contraceptive method is increasing. The CP did not have sufficient resources to support any large-scale SRHR behaviour change communication interventions. Capacity building of health workers in emergency obstetrics has also reportedly contributed to greater capacity of CEmONC facilities to deal with emergencies themselves and decreased the need for referrals to hospitals. With limited resources, the CP was able to highlight the stigma experienced by PLHIV in Timor-Leste and provide the impetus to develop a training package for health workers on HIV prevention and stigma reduction, which has been accepted by MoH and is being rolled out.

Community-based approaches supported by the CP such as the Birth Preparedness Plan contributed to increasing deliveries assisted by qualified personnel, whereas capacity building of health workers reportedly contributed to decreasing maternal morbidity and mortality in the CEmONC facilities supported. However, most CP capacity strengthening efforts and their results were not monitored or documented.

The training of health sector staff on EmONC and FP so far focussed on training service providers, without much involvement of health service managers and municipal coordinators. This is a missed opportunity, as involving municipal coordinators ensures greater commitment to promoting modern contraceptives and ensuring strong supply chain management. The CPE team observed that a number of UNFPA supported trainings of health workers tended to focus on one single topic and did not always maximise opportunities to include other key UNFPA mandate areas.

UNFPA supported emergency preparedness by ensuring that Reproductive Health needs are included in the National Emergency Plan. In addition, UNFPA developed a minimum preparedness plan for the CP and regularly trained CO staff on the Minimum Initial Service Package (MISP). UNFPA also oriented relevant Ministerial staff and stakeholders on MISP.

Community-based approaches supported by the CP such as the Birth Preparedness Plan contributed to increasing deliveries assisted by qualified personnel, whereas capacity building of health workers contributed to decreasing maternal morbidity and mortality in the CEmONC facilities supported.

CONCLUSION 6 (C6) – ADOLESCENTS AND YOUTH

Advocacy by UNFPA with MoEYS and SSYS was highly effective and allowed them to develop ownership of and commitment to CSE interventions and become champions for raising awareness of adolescents and youth on SHRH/gender/GBV.

The CP supported the roll-out of CSE programmes and training of teachers. However, this roll-out has not been monitored and CSE results have not yet been documented. Assessments suggest that many teachers do not yet feel comfortable to teach CSE subjects to students. The approval and roll-out of CSE materials developed for out-of-school youth has not yet started.

The programme area of adolescents and youth is strategic as it focusses on an important vulnerable group within UNFPA's mandate area. Achieving results amongst adolescents and youth can greatly increase the impact of the UNFPA CP on the population of Timor-Leste and its future.

Origin: EQ3

Associated recommendations: R1, R8, R9

The CP was highly effective in conducting advocacy with high-level officials of the MoEYS and the Youth Secretariat, who have developed ownership of and commitment to CSE interventions and have become champions for raising awareness of adolescents and youth on SHRH/gender/GBV. This is an impressive result in a country such as Timor-Leste with its traditional cultural values. The CP supported the development of key national strategic policies and plans, and the development of associated tools, particularly for CSE interventions.

The CP supported the roll-out of CSE programmes in all schools in the country, followed by training of teachers in one municipality in the use of CSE teaching aids. However, the roll-out has not been monitored by central government and the CSE results not yet documented. Assessments and

interviews suggest that many teachers do not yet feel comfortable to teach CSE subjects to students. The approval and roll-out of CSE materials developed for out-of-school youth was delayed due to cultural sensitivities amongst government staff.

The CP contributed to building capacity and empowering youth-led organisations, who have since become recognised partners of government. Partnering with local organisations for the development of the out-of-school CSE manual was important to ensure that cultural sensitivities were addressed and for the CSE materials to be accepted.

Government and civil society partners requested that the current and next UNFPA CP have a general focus on adolescents and youth, with a particular focus on addressing teenage pregnancy. Partners in Timor-Leste could benefit from learning from successful multi-sectoral youth programmes implemented by UNFPA in Sub-Saharan Africa. These programmes achieved impressive results in reducing teenage pregnancy and HIV transmission amongst young people through multi-sectoral SRHR information and service provision programmes implemented jointly by municipal authorities from Ministries of Health, Education and Youth and Sports in cooperation with civil society partners. In view of the commitment of the education and youth sectors in Timor-Leste, such multisectoral programmes could work in Timor-Leste and contribute to increasing buy-in from the Ministry of Health, which contains some elements who so far have opposed the provision of SRH information and services to unmarried young people.

CONCLUSION 7 (C7) – EFFECTIVENESS - GENDER EQUALITY AND WOMEN'S EMPOWERMENT

CP advocacy has contributed to GBV having become a topic that government and partners feel comfortable discussing and are committed to tackle. With CP support, SEII has become committed and proactive in the coordination of the implementation of the National Action Plan for GBV, and the government has tools to respond to GBV in the health sector in an inclusive manner.

CP supported capacity building efforts produced and strengthened relevant policies and tools for the implementation of the National Action Plan on GBV (NAP-GBV), particularly in the health sector and for provision of information on GBV prevention amongst adolescents and youth reached through CSE interventions.

Origin: EQ3

Associated recommendations: R9, R10

CP advocacy efforts have resulted in GBV having become a topic that government and partners in Timor-Leste feel comfortable discussing and are committed to address. Advocacy efforts such as the organisations of thematic meetings for Women Parliamentarians on GBV were very effective in mobilising decision makers and giving visibility to the issue. The meeting resulted in a number of follow up events and the generation of strategic knowledge on teenage pregnancy and SRH information in school curricula which the CP and partners used for further advocacy with government and partners. With CP support, SEII capacity has been strengthened and supported to become a committed and proactive coordinator of the implementation of the National Action Plan for GBV.

CP supported capacity building efforts produced and strengthened relevant policies and tools for the implementation of the NAP-GBV, particularly in the health sector and for provision of information on GBV prevention amongst adolescents and youth reached through CSE interventions. During the initial years, the CP also supported the capacity of civil society partners to provide GBV response services to survivors.

CONCLUSION 8 (C8) – EFFECTIVENESS - POPULATION DYNAMICS

The CP effectively supported capacity building of the GDS and enabled the government to produce an impressive number of high-quality surveys and studies to collect data on population and development issues. The CP was furthermore effective in promoting the use of data in programming and policy development by government institutions at national and municipal levels, who have started to use and request data for decision making and planning.

Origin: EQ3

Associated recommendations: R11

The CP effectively supported capacity building of the GDS as the government central entity to coordinate and conduct key population surveys, including the Population & Housing Census of 2015 and Demographic and Health Survey in 2016. This enabled the GoTL to produce high-quality surveys and studies, enabling the government to collect important data on population and development issues. The CP supported key sector ministries in the integration of population, SRHR and GBV issues into plans and policies. The CP also promoted the use of the population and sector data produced for decision making and planning processes by central level ministries and agencies and by municipal management teams. These efforts have been successful as central and municipal authorities and partners have started requesting data from GDS.

CONCLUSION 9 (C9) – EFFICIENCY

In spite of budget cuts resulting in the CP having only about USD 1.5 million per year to fund activities, UNFPA and IP staff and operational costs, UNFPA and partners managed to implement a meaningful programme and achieve a large part of the planned CP results.

The CO performed well in terms of CP financial management and corporate compliance. CP implementation suffered from delays due to political volatility and policy changes, which required frequent reprogramming of CP activities and budgets.

Origin: EQ6

Associated recommendations: none

The CP was negatively affected by a total budget cut of 52% from USD 15.5 million to 9 million for the period 2015-2019. 47% of CP resources were spent on the Outcome 1 programme area (FP and SRHR) and 30% on Outcome 4 (Population Dynamics).

Impressively, UNFPA and partners managed to implement a meaningful programme and achieve a large part of the planned results in spite of budget cuts meaning that the CP only had about USD 1.5 million per year to fund CP activities and CO staff and operational costs.

The CO performed well in CP financial management: the implementation rate of the CP budget was high (92%) and the CO achieved corporate compliance.

The CO managed to mobilise USD 1.2 million from donors for CP implementation during 2015-2019, in addition to USD 18 million in new resources for joint UN GBV programming starting 2020.

Political instability and frequent changes in central level government officials and policies resulted in delays in CP implementation and the need for reprogramming of CP interventions and resources.

CONCLUSION 10 (C10) – EFFICIENCY - PROGRAMME MANAGEMENT

CP programme management, monitoring and evaluation was carried out well. The CO programme teams generally work in an integrated manner, although there is room for improvement.

The M&E team trained UNFPA and IP staff on the CP M&E system. By using the UNFPA monitoring systems, the capacity of IP staff to report to the UNFPA CP monitoring system increased.

The CP supported a number of assessments and evaluations in key CP programmes areas. However, the CP did not establish systems for assessing or monitoring the increase in capacity of staff trained and of systems strengthened, which makes it difficult to demonstrate the impact of the CP contributions to systems strengthening. Furthermore, CO staff do not use the CP and CPAP results framework as basis for monitoring CP performance in Timor-Leste.

Origin: EQ6

Associated recommendations: R12

In general, CP programme management, monitoring and evaluation was carried out correctly. The CO programme teams worked well together and often in an integrated manner. There were some instances where integration between programmes was not optimal, for example when some trainings of health service providers focussed on a single topic without integrating related health or GBV topics. Overall, the CP outcome and output indicators, baselines and targets were well developed and enable the capturing of CP achievements. However, a few output indicators were not easy to monitor while targets for a few indicators were unrealistically high. Also, data collection was mostly not disaggregated by sex.

CO staff do not use the CP and CPAP results framework as basis for monitoring CP performance in Timor-Leste. The CO team also did not maintain the CPAP tracking tool (included in the CPAP) updated to monitor CP performance and take programmatic decisions to adjust CP performance.

UNFPA supported a number of important situation assessments of the CP working environment, such as the Health Sector Commodity Assessment, the EmONC Assessment and CSE Assessment. However, documentation by UNFPA, GoTL and IPs of interventions supported through the CP has generally been limited. As a consequence, it is not easy for the CP to demonstrate the results of its capacity strengthening efforts. This is a lost opportunity as a number of interventions supported by UNFPA in Timor-Leste were mentioned by stakeholders interviewed as examples of best practice. If these interventions are not documented they cannot feed into policy dialogue on potential replication and scaling up and to contribute to facilitate mobilisation.

The M&E team trained UNFPA and IP staff on the CP M&E system. By using the UNFPA monitoring systems, the capacity of IP staff to report to the UNFPA CP monitoring system increased. However, opportunities for involving civil society partners in the monitoring of policy implementation – for example in FP forecasting - were not maximised.

An evaluation achievement was the CP mid-term evaluation carried out in 2017, which formulated a number of recommendations which the CO and partners are currently implementing.

CONCLUSION 11 (C11) – PARTNERSHIPS

UNFPA has established strong working relations with government counterparts in key sectors, which contributed to high-level commitment by these sectors to support - and in some cases champion - priority CP interventions. The CO is also working closely with key national and international civil society organisations and UN agencies.

Origin: EQ7

Associated recommendations: none

UNFPA has established strong working relations with government partners in its principal mandate areas. This has contributed to high-level commitment by these sectors to support - and in some cases champion - priority interventions promoted by the CP. The CO is also working closely with key national and international civil society organisations in CP focus areas. Working relationships with other UN agencies are strong.

The CP IPs generally appreciate UNFPA as a cooperative, flexible and responsive partner, prepared to listen to technical suggestions and requests when IPs make them. Stakeholders trust UNFPA and appreciate the CP alignment to government policies and priorities.

IPs observed that they appreciated the thematic meetings organised by the CO, but that outside of these meetings, the UNFPA CO did not always actively promote links or experience exchange between IPs working in the same programme area in Timor-Leste or with similar initiatives abroad.

CONCLUSION 12 (C12) – SUSTAINABILITY

The CP was effective in integrating SRH and rights and concerns for young people, gender equality, gender-based violence and population dynamics into national policy frameworks such as sector development plans, policies and strategies and guidelines.

Origin: EQ8

Associated recommendations: none

UNFPA and partners were effective in integrating SRHR concerns into the health sector policy documents including the RMNCH Strategy, into the Youth Policy and National Action Plan for Youth and into the education curricula of primary and secondary schools. The CP also contributed to issues of Gender and GBV being integrated into national guidelines and training materials for health workers and schoolteachers in the public sector.

CONCLUSION 13 (C13) – SUSTAINABILITY

The CP was effective in contributing to building systems and capacities of central level government authorities and civil society partners and to increasing ownership and commitment to CP interventions.

Origin: EQ9

Associated recommendations: R4, R6

The CP contributed to strengthening the capacity of counterpart government institutions and civil society IPs to establish, manage, monitor and report on priority interventions in the area of SRH, young people, GBV and population data. This increased capacity and visibility will assist these IPs to sustain their programmes and to mobilise resources. CP efforts also increased the capacity of IPs to organise campaigns and advocate with government for increased political attention and domestic resource allocation to their areas of focus.

So far, the majority of capacity building of service providers focussed on in-service training. While this has achieved results in some areas, it is important for the CP to also strengthen pre-service capacity building of human resources as this will generate more sustainable results.

Lobbying and advocacy by UNFPA with government authorities contributed to building political buy-in of government for support priority interventions and procurement and to increasing commitment to support the scale up of these interventions using domestic resources. This has contributed to the financial sustainability of some interventions.

CONCLUSION 14 (C14) – COORDINATION

The CO has co-chaired and contributed actively to UN coordination mechanisms, and has supported and strengthened national (multi-)sector coordination mechanisms.

Origin: EQ10

Associated recommendations: R13

The CO co-chaired and contributed actively to the mechanisms supporting the implementation of the UNDAF, such as the UN Gender Technical Group and the UN Results Group on Youth, and chairs the UN Office Management Team. These UN coordination mechanisms contribute to a better division of tasks and coordination of priority interventions within the UN family.

UNFPA has furthermore supported and strengthened a number of national (multi-)sector coordination mechanisms, such as the health sector Maternal and Child Health Technical Working Group and the Inter-Ministerial Commission responsible for coordination, monitoring and evaluation of the implementation of the NAP-GBV.

Coordination between some Ministries - such as SEII and MOH and other relevant ministries - on implementation of NAP GBV is reportedly still weak. Joint annual monitoring of the NAP GBV implementation had been put on hold in 2017-2018 following political changes. This affected the speed of implementation of CP activities supported by UNFPA. The slow process of the establishment of the NAP-GBV Coordination Entity also represented a challenge to the CP.

6 RECOMMENDATIONS

This chapter presents the recommendations for the last year of the UNFPA current Country Programme in Timor-Leste during 2020 and for the next Country Programme for 2021-2025.

6.1 Strategic level

RECOMMENDATION 1: The next UNFPA Country Programme 2021-2025 should have an overall focus on SRHR programming for adolescents and youth, including through multisectoral programmes with strong advocacy and engagement with government authorities and partners on key issues.

Priority: High

Target level: Country Office

Based on conclusions: C4, C6

Operational implications

For the new CP, UNFPA should increase focus on reaching adolescents and youth in all its programme components, with the objective of increasing the access to SRH/HIV, FP and GBV information and services for unmarried adolescents and young people. Thus, UNFPA will continue to build on its comparative advantage and continue its strong presence in these areas going forward into the new programme.

To achieve this, UNFPA should prioritise multisectoral approaches and programmes, involving priority sectors of education, youth & sports, health and gender, with strong advocacy and engagement with government authorities (central and municipal) and partners on key issues. Programmes should where possible be implemented through inter-agency cooperation with UN agencies and in close cooperation with civil society partners.

RECOMMENDATION 2: UNFPA should continue to promote cohesion between the CP programme areas.

Priority: High

Target level: Country Office

Based on conclusions: C10

Operational implications

In the current and new Country Programme, UNFPA Timor-Leste should continue to promote cohesion of CP implementation between programme areas. UNFPA should encourage integrated CP implementation across teams on key issues to enhance cooperation across programme areas. This can be achieved by encouraging joint planning by UNFPA programme teams and implementing partners of UNFPA and of IP workplans, as well as regular monitoring meetings throughout the year. Regular monitoring and thematic meetings will also contribute to facilitating exchange of information and experiences between IPs and partners working in the same field through meetings. The CP could also facilitate exchange / site visits between IPs and relevant partners within the country and where appropriate abroad through south-south cooperation. This would contribute to strengthening programme quality and promote standardised delivery of services and interventions, as well as documentation of achievements and best practices.

RECOMMENDATION 4: UNFPA should accelerate documentation of best practices and lessons learned of key interventions supported during the current CP, as well as documentation, knowledge generation, collection and dissemination in the new CP, to enable the CO and partners to use evidence for advocacy with government in order to influence policy development and promote replication where appropriate, and other countries can learn from Timor-Leste's example.

Priority: High

Target level: Country Office

Based on conclusion: C5, C6, C13

Operational implications

The current and new CP should increase emphasis on knowledge generation, collection and dissemination, including innovation, with the objective of influencing policy development and national programme implementation. Knowledge generation will facilitate UNFPA ability to fulfil its UN role of influencing policy development and implementation by contributing to Getting Research Into Policy and Practice (GRIPP). Better knowledge products will also facilitate resource mobilisation. This should include the production of policy briefs and materials for advocacy with government and engaging in national coordination mechanism to promote policy development and replication of best practices.

This implies that the CP should plan for and ensure adequate CP budgets to support documentation of best practices and intervention models, knowledge generation and communication.

Best practices which should be documented include the Birth Preparedness Planning programme, strengthening of health worker and system capacity in areas such as FP and MDSR, as well as the various CSE approaches which were supported by the CP. Documentation should be carried out rapidly, while the actors involved in the implementation and monitoring of these interventions are still around.

6.2 Programme Level

RECOMMENDATION 5: UNFPA should continue to advocate with MoH and sector partners on the need for domestic financing of FP commodities, while maintaining contingency funding for contraceptive procurement and/or maintaining emergency supplies to avoid stockouts.

Priority: High

Target level: Country Office

Based on conclusions: C5

Operations implications:

UNFPA should continue to engage and advocate with GoTL to ensure that it delivers upon its commitment to gradually take over the funding for the procurement of contraceptives and reproductive health products. At the same time, the CP should plan for contingency funding for the procurement of contraceptives and supplies in case domestic funding is delayed or suspended. Alternatively, UNFPA could maintain an emergency stock.

RECOMMENDATION 6: UNFPA should continue to support capacity building of the health system in family planning, maternal health, emergency obstetric care, HIV/AIDS and GBV including by supporting supportive supervision and mentoring of in-service trainees and by reviewing and strengthening pre-service training.

Priority: High

Target level: Country Office

Based on conclusions: C5, C6, C7

Operations implications:

The CP should support capacity building of service providers using the best practice example of the competency-based certification used in the EmONC trainings of health workers. Capacity building should include mentoring of service providers in their workplace, plus support to supportive supervision and monitoring by municipal and central authorities.

Where possible, UNFPA should consider using civil society actors for supportive supervision and monitoring of implementation of the FP guidelines. The CP should also continue to the current best practice of using beneficiary groups (youth / youth-led organisations, people living with HIV, etc.) as trainers.

In its capacity strengthening efforts, UNFPA should strengthen coordination, information exchange and collaboration with other health sector organisations / actors who are building capacity of health professionals in areas of maternal health, SRHR / HIV, GBV, etc.

Also, decision makers at central and municipal level as well as managers and community leaders should be included in awareness raising on FP, EmONC and the health sector GBV guideline.

Furthermore, it is important for the CP to also support in-service training of service providers through the review and strengthening of pre-service curricula and where required through the strengthening of training institutions.

RECOMMENDATION 7: UNFPA should advocate with Government for greater focus on HIV prevention in upcoming country funding applications to international funding mechanisms.

Priority: Medium

Target level: Country Office

Based on conclusions: C5

Operations implications:

UNFPA should ensure that additional funding is mobilised to support scaling up of HIV prevention efforts in Timor-Leste. This can be done by lobbying GoTL and partners to include a greater focus on HIV prevention in upcoming country funding applications to the Global Fund and other international funding mechanisms and global health initiatives (such as the GFF). Additional resources would allow for the GoTL, UNFPA and partners to scale up HIV prevention in high transmission areas such as border areas and amongst vulnerable groups and key populations.

RECOMMENDATION 8: UNFPA should continue to support to MoEYS and SSYS in the roll-out of existing SRHR / gender / GBV interventions targeting young people, while supporting relevant municipal and central authorities to conduct supportive supervision and monitoring of implementation and documenting results and lessons learned to continuously improve the approaches followed.

Priority: High

Target level: Country Office

Based on conclusions: C6, C7

Operations implications:

The CP should continue to support MoEYS and SSYS in the roll-out of existing SRH / gender / GBV interventions, including:

- ensuring that HIV prevention is well covered by the CSE materials for in-school and out-of-school adolescents and youth. Support SSYS in the roll-out of out-of-school CSE teaching once materials are approved,
- rolling-out to schoolteachers not yet reached,
- awareness raising of school managers, boards, parents and communities on the CSE programme,
- supporting on-the-job mentoring and supportive monitoring by MoEYS and INFORDEPE of the in-school CSE roll-out,
- conducting a rapid assessment of the results of in-school CSE teaching to students to identify lessons learned and adjust approaches and materials for further roll-out and scaling up,
- further improving the CSE teaching aids and tools (including improving their wording, the size of some of the tools, such as posters and providing posters to complement audio-visual tools for schools who have no access to projectors or electricity),
- supporting SRHR / gender / GBV teaching for reaching other in-school age groups (secondary schools), incl. development of specific tools,
- inserting CSE topics into existing publications for the education sector such as Lafaek Magazine which is distributed to teachers and parents in all municipalities.

The CP should furthermore strengthen coordination and information exchange between CSE actors and explore opportunities for synergies with approaches supported by other actors supporting education and/or SRHR (e.g. student councils supported by UNICEF; School Councils supported by UNESCO, etc.). This will include UNFPA regularly attending coordination meetings of the education sector and on school health, including the high-level forum “Acção Conjunta para a Educação em Timor-Leste” (ACETL) meetings, led by the Minister of Education.

UNFPA should also continue advocacy with National Parliament on providing SRHR for in-school youth, including in primary schools.

RECOMMENDATION 9: To take advantage of current momentum amongst government and partners for tackling teenage pregnancy, UNFPA should promote and support multisectoral SRHR/HIV/CSE interventions and programmes targeting adolescents and young people which have demonstrated results in Timor-Leste and other countries.

Priority: High

Target level: Country Office

Based on conclusions: C6, C7

Operations implications:

In view of the commitment of the education and youth sectors in Timor-Leste to providing SRHR information to young people and the interest of these government ministries to tackle teenage pregnancy, UNFPA should explore options for replicating successful multisectoral UNFPA Adolescents & Youth SRHR Programmes implemented by Ministries of Health, Education and Youth & Sports in other countries, such as the *Geração Biz* programme in Mozambique and the regional *Safeguard Young People* (SYP) programme coordinated by ESARO and implemented in several countries in Southern Africa.

With the increase of the use by young people of mobile telephones with internet, it would be worthwhile for the CP to also explore options for the use of social media applications to reach adolescents and young people. Here UNFPA Timor-Leste could again learn from experience by successful UNFPA programmes in other countries and continents, including the SYP.

To prevent girls dropping out from school, UNFPA should continue to advocate with MoEYS for the implementation of the inclusive education policy. UNFPA should also consider supporting other interventions to prevent girl school dropouts, such as menstrual hygiene interventions (procuring menstrual caps; producing menstrual pads from local materials, etc.).

It will be important to ensure the participation and involvement of youth-led organisations in the CP youth programming. To make this more effective, the CP should continue to support capacity strengthening of these organisations in technical and programmatic areas (such as on SRHR, GBV, empowerment and participation) and in organisational skills (programme planning, management, M&E, reporting).

UNFPA could consider contracting youth-led organisations as (sub-)IPs to provide SRHR/HIV/gender/GBV information for in-school and out-of-school adolescents and youth.

Government and civil society partners interviewed suggested CP youth programmes should address teenage pregnancy. In view of the commitment of the education and youth sectors in Timor-Leste, partners could benefit from learning from successful multi-sectoral youth programmes implemented by UNFPA in Sub-Saharan Africa, such as the *Geração Biz* programme in Mozambique and the regional *Safeguard Young People* (SYP) programme coordinated by ESARO and implemented in several countries in Southern Africa. These programmes achieved impressive results in reducing teenage pregnancy and HIV transmission amongst young people through SRHR information and service provision programmes implemented jointly by Ministries of Health, Education and Youth and Sports, in close cooperation with civil society organisations. When during the CPE validation meeting the CPE team leader briefly described these initiatives, a number of government officials expressed their interest in learning more about them.

RECOMMENDATION 10: To maintain momentum, UNFPA should continue to support and guide the government in the implementation of the NAP GBV 2017-2021, while ensuring that it follows an inclusive approach.

Priority: High

Target level: Country Office

Based on conclusions: C7

Operations implications:

UNFPA should continue to provide technical support to SEII and other government authorities for the implementation of the NAP GBV 2017-2021. To this purpose, the CP should continue to support capacity strengthening of SEII staff in areas of annual planning and budgeting for government sectors, monitoring of the implementation of the NAP GBV, etc.

Furthermore, UNFPA should provide adequate technical support to the implementation of the NAP GBV through joint UN programme interventions funded through EU/SPOTLIGHT and KOICA initiatives. This may include hiring additional UNFPA staff to ensure coordination of these programmes.

UNFPA should also promote the inclusive approach of the NAP GBV by encouraging increased focus on GBV prevention and access to GBV services for vulnerable groups such as People with Disabilities (PWD), including by working with Disabled People's Organisations (DPO) and to advocate with MoH, MSSJ, SEII, SYSS and other government authorities for the inclusion of PWD into sectoral policies and strategies.

RECOMMENDATION 11: UNFPA should continue to support the production of population data by the government while promoting the developing of data literacy within government at central and municipal level and across the development community.

Priority: High

Target level: Country Office

Based on conclusions: C8

Operations implications:

The CP should strengthen the analysis of data and generation of knowledge within the UNFPA CP, while at the same time continuing to strengthen the national system of monitoring of the progress on the SDGs and ICPD Programme of Action. In the spirit of leaving no one behind, it is important to know as much as possible about key vulnerable groups, to understand which groups have benefited from certain interventions, and which has not and to identify key problems. The disaggregation of data should not just apply to Census and DHS surveys, but to all national surveys.

It should furthermore strengthen the national capacity for knowledge generation and data analysis, while increasing focus on developing data literacy within Government and across the development community. The CP should also increase the breadth and depth of data dissemination, so that data is more accessible and used more for policies and programming by Government and partners.

RECOMMENDATION 12: UNFPA should continue to strengthen CP management and monitoring & evaluation. The CO should promote the systematic cooperation between programmes areas and their integration, including when planning trainings of service providers or managers. Civil society partners should be encouraged to participate in the monitoring of policy implementation. The CP should also strengthen its efforts to promote the exchange of experience and information between IPs.

Priority: High

Target level: Country Office

Based on conclusion: C10

Operational implications

The CO should base CP monitoring on the CPD Results Framework and regularly update its CP Tracking Tool.

It will be important to for UNFPA to facilitate and encourage the participation of civil society partners in the monitoring of policy implementation, such as the national FP quantification committee and key (multi)sector coordination mechanisms.

The CP should promote links and exchange of information and experience between IPs working in the same programme area in Timor-Leste and with similar initiatives abroad. UNFPA could also share more information on relevant developments in programme areas abroad. This would facilitate cross-fertilisation and learning from each other, replication of best practice, forming of stronger links and potentially contribute to greater motivation of IP staff.

UNFPA could also explore options to benefit from existing resources for strengthening of institutional capacity of CP partners in Timor-Leste. For example, the Australia Department for Foreign Affairs and

Trade (DFAT) has a framework contract with the British NGO RedR and may be able to fund provision of technical assistance, training and mentoring to UNFPA staff and IP staff through this mechanism.¹⁵⁵

RECOMMENDATION 13: UNFPA should continue to strengthen the capacity of key central government organisations to coordinate priority strategies, such as the NAP-GBV and CSE.

Priority: High

Target level: Country Office

Based on conclusion: C14

Operational implications

UNFPA should continue to support coordination of programme areas at national/central and municipal levels including with civil society, academic institutions and other partners. In the area of GBV, the UNFPA should continue to actively promote and support the coordination of key government sector in the implementation of the NAP-GBV. This will be particularly important with the start of the Spotlight initiative. UNFPA and other UN agencies can support the relevant government agencies to improve their capacity to coordinate through these opportunities. In the area of CSE it will also be important for the CP to support coordination of priority interventions between the MoEYS, SSYS and other key institutions.

¹⁵⁵ RedR conducts cap building of staff on programme management, project cycle management, M&E, developing coaching and mentoring programmes, management and leadership, information management, HR management, security management, humanitarian principles. RedR organizes courses in various locations around the world. <https://www.redr.org.uk>.

ANNEXES

Annex 1 – Bibliography

Annex 2 – Terms of Reference of the Evaluation

Annex 3 – Mapping of partners consulted

Annex 4 – IP implementation rates

Annex 5 – Evaluation matrix

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ANNEX 2 – EVALUATION TERMS OF REFERENCE

TERMS OF REFERENCE FOR THE EVALUATION OF THE UNFPA 3RD COUNTY PROGRAMME OF ASSISTANCE TO THE GOVERNMENT OF TIMOR LESTE (2015-2020)

JULY, 2019

1. INTRODUCTION

UNFPA Timor Leste is planning to conduct an independent evaluation of its 3rd Country Programme of Assistance to the Government of Timor Leste (2015-2020) [original period was 2015-2019 and extended by a year to 2020] as part of its 2019 annual work plan, and in accordance with the UNFPA evaluation policy 2019. The Third Country Programme aims to assist GOTL's efforts to improve the sexual and reproductive health in the country, through strengthening relevant capacities to address inequalities and address the needs of the underserved.

As per the evaluation policy, evaluation at UNFPA serves three main purposes: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; (iii) contribute important lessons learned to the formulation of the 4th Country Programme in Timor Leste.

The evaluation will be an external, independent exercise conducted by an independent team of evaluators, in accordance with [UNFPA guidance on Country Programme Evaluations](#), ethical norms and UNEG standards. The evaluation will be managed by the CO in close collaboration with the Regional M&E Adviser in APRO and with oversight from the Independent Evaluation Office of UNFPA in New York.

These Terms of Reference (ToR) set out the details of the evaluation process, methodology, outputs and management arrangements, including quality assurance mechanisms.

2. CONTEXT

Some Key Facts about Timor-Leste:

- Estimated population 2018: 1,261,400.¹⁵⁶
- Population growth rate 2018: 1.6% per annum.¹
- Total fertility rate 2017: 3.7 live births per woman.¹
- Maternal mortality ratio: 215 per 100,000 live births.¹⁵⁷
- Infant mortality rate 2018: 54 deaths per 1,000 live births.¹
- Births attended by skilled birth personnel: 56.7%.¹⁵⁸
- Proportion of married women of reproductive age (aged 15-49) currently using modern methods of contraception: 24.1%.³
- Proportion of women reproductive age (aged 15-49) who have their needs for family planning satisfied through modern methods: 46.6%.³
- 25% of married women have unmet need for family planning.³

¹⁵⁶ General Directorate of Statistics (GDS), 2017. Volume 8: Thematic Report on Population Projections, Dili, Timor-Leste.

² WHO et al. 2014. *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Geneva: World Health Organization.

³ General Directorate of Statistics (GDS), Ministry of Health and the DHS Program, ICF, 2017. *Timor-Leste Demographic and Health Survey 2016—Key Indicators Report*. GDS: Dili.

² WHO et al. 2014. *Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. Geneva: World Health Organization.

- One-third of the population is between ages 10 and 24.¹
- 7% of 15-19 year-old women have begun childbearing.³
- One in five women aged 20-24 have given birth by exact age 20.³
- Young people are at risk of HIV/AIDS – less than 8% of women aged 15-24 has a comprehensive knowledge about it.³
- 34% of women aged 15-49 have experienced physical or sexual violence in their lifetime.³

Reproductive Health: Timor-Leste is one of nine countries worldwide estimated to have reduced maternal mortality ratio by over 75% since 1990. Since 2003 UNFPA has been working with the Government of Timor-Leste to maintain, and further enhance this trend. Standards of care and protocols have been developed for antepartum, intra-partum and postpartum care at secondary and tertiary care facilities, and a maternal death surveillance and response system established.

UNFPA started working in Timor-Leste in 2003. The number-and rate of women dying from complications of pregnancy or childbirth has been reduced, families are smaller and healthier, Young people are more connected and empowered than ever before.

Yet, maternal mortality in Timor-Leste is still among the highest in Asia. This reflects insufficient care for mothers during pregnancy and delivery and poor access to health care: seven out of 13 districts in the country have no functional emergency obstetric and newborn care. UNFPA's focus is now on continuing support to the Emergency Obstetric and Newborn Care National Technical Committee (EmONC-NTC), tasked to provide technical oversight to implementation of the EmONC improvement plan.

A great deal remains to be done to ensure that every mother can safely give birth in Timor-Leste, Young people bear have comprehensive knowledge of HIV/AIDS and contraceptives to prevent unintended pregnancies.

Young People: 59% percent of the population in Timor-Leste is under 25, and lack information about sex and contraception, UNFPA places high priority on supporting the country's efforts to empower young people through imparting necessary knowledge. It does this through advocacy and technical support to the government in the field of sexual and reproductive health and rights, which are recognized by the recently approved National Youth Policy.

Specifically, the UNFPA Youth Programme works to increase access of young people to comprehensive sexuality education (CSE) both in school (through integration into the national curriculum) and out-of-school (through the development of a manual to be used by Youth Centers). UNFPA also strives to increase young women's agency in preventing teenage pregnancy. In this, UNFPA collaborated with the Secretariat of State for Youth and Sports and the Ministry of Education, and other development partners.

Women & Girls tackling endemic gender-based violence: Gender-based violence is endemic in Timor-Leste: 29 percent of women aged 15-49 in Timor-Leste have experienced physical violence in the past 12 months and 33% in their lifetime. UNFPA supported the GOTL to promulgate the Law Against Domestic Violence (LADV) in 2010, and continues to provide support under the 3rd CP through its support to develop the 2nd National Action Plan on Gender-Based Violence 2017-2021 aligned with the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence as well as the National Guideline for Health Care Providers developed to address gender-based violence, including intimate partner violence.

Sexual and reproductive health and rights: Despite progress in improving access to family planning, unmet need is still very high: only 47% of the demand for family planning among currently married women is being met. UNFPA aims to address this, and the widespread lack of knowledge about fertility and contraception, as well as addressing the harmful gender norms that undermine women's ability to take control of their own bodies and their fertility.

Population and Development: For every person to count, every person must be counted. UNFPA continues to provide technical and financial support to the National Statistics Office (NSO) of the GOTL to undertake population and housing censuses as it did in 2004, 2010 and 2015. UNFPA supports the analysis of census data and broad dissemination of its implications to facilitate the use of evidence in development planning including in the Timor-Leste National Strategic Plan 2011-2030. UNFPA also continues to support the NSO and Ministry of Health to undertake the Demographic and Health Surveys (DHS) as it did in 2009-10 and 2016 where tablets were used for the first time to collect data. Under the

3rd CPD, UNFPA is also providing technical and financial support to develop sampling frame for future surveys based on the 2015 population and housing census.

3. OBJECTIVES AND SCOPE OF THE EVALUATION

The objectives of the independent evaluation of the UNFPA 3rd country programme for Timor Leste are:

- to provide an independent assessment of the relevance and progress towards the outputs and outcomes set forth in the results framework of the 3rd country programme; including its contribution to the 3rd Country Programme is aligned with the UNFPA Strategic Plan (2018-2021) and the Timor-Leste National Development Strategic Plan 2011-2030.
- to provide an analysis of how UNFPA has positioned itself within the development community and national partners with a view to adding value to the country's development results;
- to draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the 4th country programme (2021-2025);
- to assess UNFPA's comparative advantage in the four programme areas.

This CPE will also build on the result from UNDAF 2015-2019 final evaluation.

The CPE will cover the time period 2015-2019 and include all activities planned and implemented under the 3rd CPD covering the full geographic scope of these interventions. Besides the assessment of the intended effects of the programme, the evaluation also will identify unintended effects

4. EVALUATION CRITERIA AND PRELIMINARY EVALUATION QUESTIONS

In accordance with the methodology for CPEs as set out in the UNFPA Evaluation Handbook (2019)¹⁵⁹, the evaluation will be based on a number of evaluation questions (limited to a maximum of eight) covering the following OECD DAC and other UNFPA-specific evaluation criteria.

Relevance

- a. To what extent has UNFPA ensured that the sexual and reproductive health and other needs of young people (including adolescents) are integrated in the planning and implementation of all UNFPA supported interventions under the country programme?
- b. To what extent has the CO been able to respond to changes or shifts caused by political changes in the country? What was the quality of the response?

Effectiveness

- a. To what extent have the 3rd CPD outputs been achieved, and to what extent have these outputs contributed to the achievement of the 3rd CPD outcomes?
- b. To what extent has UNFPA made good use of its comparative strengths to add value to the development results of Timor-Leste?

¹⁵⁹ <https://www.unfpa.org/EvaluationHandbook>

Efficiency

- a. To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 3rd CP outcomes in a timely manner?
- b. To what extent has the CO established, maintained and leveraged different types of partnerships to ensure that UNFPA can make use of its comparative strengths to achieve all country programme outcomes?

Sustainability

- a. To what extent has UNFPA support helped to ensure that SRH and rights, and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country?
- b. To what extent has UNFPA been able to support its partners and target populations in developing capacities and establishing mechanisms to ensure ownership and durability of effects of the 3rd CP interventions?

Coordination

- a. To what extent did the CO contribute to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities / seeking synergies) within the United Nations system?

The generic questions listed above are only indicative; the final set of evaluation questions will be determined during the design phase, after a discussion with the evaluation reference group and key stakeholders.

5. METHODOLOGY AND APPROACH

Evaluation Approach

The Evaluation will utilize a mixed method approach, using qualitative and quantitative methods as necessary. The theory of change (TOC) used to design the 3rd Country Programme Action Plan will be reviewed and revised as necessary, based on stakeholder consultations to provide the basis for this evaluation. If a valid TOC does not exist, the Evaluator will reconstruct the theory in consultation with all key stakeholders.

The evaluation will pay special attention to ensure equity, gender and human rights based approaches are embedded into the data collection and analysis. It will be also guided by the UNEG ethical guidelines for evaluation, as well as UNEG Norms and Standards. The evaluation will be transparent, inclusive and participatory as well as gender and human rights responsive. It will seek and utilize data disaggregated by age, gender, vulnerable groups, etc. to ensure findings are gender reflective and targeted.

Sampling Strategy

The team will identify suitable sampling strategy to select, interventions to scrutinize, field visits as well as stakeholders to interview. Sampled sites and stakeholders should reflect the full range of interventions under CP3 in terms of themes and contexts across priority geographic areas of work as well as target groups.

Data Collection

Primary data will be collected at the national and sub-national levels through semi-structured interviews, focus group discussions and direct observation during field site visits as appropriate.

Secondary data will be collected through desk review of existing literature (evaluations, research and assessments conducted by CO and other partners in the country), annual reviews/progress reports, and other monitored data.

Validation mechanisms

The Evaluation will use a variety of methods to ensure the validity of the data collected, including systematic triangulation of data sources and data collection methods. Further, the team will validate findings with key stakeholders and ensure that there are no factual or interpretive errors or missing evidence that could materially change findings.

Stakeholder participation

An inclusive approach, involving a broad range of partners and stakeholders, will be taken. Communication with stakeholders with respect to its purpose, the criteria applied, and the intended use of the findings will be ensured at all stages of the evaluation. The evaluation team will perform a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders include representatives from the Government, civil-society organisations, the private-sector, sister UN organisations, other multilateral organisations, bilateral donors, and most importantly, the beneficiaries of the programme. Every effort will be made to include key stakeholders as part of the evaluation process either as sources of data (primary/secondary) or through their representation in the Evaluation Reference Group.

Evaluation audience

Findings, lessons learned and recommendations of the CPE shall be used to assess the achievements of the 3rd CPD and to inform the development of the 4th Country Programme. For transparency and accountability purposes, the CPE report shall be communicated to all stakeholders including but not limited to UNFPA Country Office:

Representative, Assistance Representative, all programme managers, and the Executive Board, Implementing partners such as the Ministry of Health (MoH), Ministry Finance (MoF) through General Directorate of Statistics (GDS), Ministry of Education, Youth, and Sports (MoEYS), Secretary of State for the Gender Equality and Inclusion (SEII), Secretary of State for Youth and Sports (SSYS) key government counterparts. Additionally, partners among donors (Partnership for Human Development –PHD, international and national NGOs and other civil society, as well as other sister UN agencies (e.g. UNICEF, WHO, UN WOMEN, UNDP, Mari-Stopes International, Alola Foundation).

6. EVALUATION PROCESS

This third CPE will involve the following phases:

The evaluation will unfold in five phases, each of them including several steps.

Preparation phase

This phase will include:

- Drafting the evaluation Terms of Reference;
- Approval of the ToR by IEO;
- Recruitment of a team of evaluators;
- Set up the Evaluation Reference Group;
- Orientation of key national government counterparts to the evaluation process.

Design Phase

This phase will include:

- The Evaluation Team will conduct *desk review* of all relevant documents available at UNFPA regarding the country programme for the period being covered (2015-2019);
- *Stakeholder map*– the evaluation consultant will prepare a map of stakeholders relevant to the evaluation and the strength of relationship to the programme. The map will cover Government units/officials, IPs, major civil society and other development actors relevant to UNFPA's work, sister UN agencies, and key bilateral donors;
- Reconstruct the intervention logic/*theory of change* of the programme – revisit the theory of change and results and resources framework meant to lead from planned activities to the intended results of the programme;

- Develop the *Evaluation Matrix*: Finalize the list of evaluation questions, identify related assumptions and indicators to be assessed, and data sources (using the template and example provided in the UNFPA Country Programme Evaluation Handbook);
- Develop a concrete *work plan* for the field phase along with clear delineation of the roles and responsibilities of team members; and
- Develop a data collection and analysis strategy as well as a concrete work plan for the field phase, including division of labour;
- Specify limitations and challenges expected to conduct the evaluation and any mitigation efforts to be taken to overcome these.
- Share with ERG for review, discussion and finalization of the report addressing all comments received.
- Clearance of the design report by the Regional M&E Advisor and CO Approval of the design report.

Field Phase

The evaluation team will be deployed to the field for at least, two weeks to conduct interviews and desk review to answer the evaluation questions. At the end of the field phase, the consultant will conduct a validation workshop to present to all key stakeholders the analysis and emerging findings of the evaluation in an effort to validate it.

Synthesis and Reporting Phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a first draft of the final evaluation report, taking into account comments made by the CO at the field phase debriefing meeting. This **first draft final report** will be submitted to the evaluation reference group for comments (in writing). The evaluation team will submit a **second draft** of the report addressing the comments made by the reference group.

This second draft report will form the basis for an **in-country dissemination workshop**, which will be attended by the CO as well as all the key programme stakeholders (including key national counterparts). The **final report** will be drafted taking into account comments received from the participants of the workshop.

The Report will be cleared by the CO and submitted with an EQA to the Regional M&E Advisor for **approval**. The quality of the report will be assessed based on the criteria set out in the CPE Guidance (see Annex 6 for details). Once approved, the Regional M&E Advisor will submit EQA (along with the Report) to IEO for validation and finalization of the quality assessment of the CPE.

Management Response, Dissemination and Follow Up

The management of the CO will provide management response to each evaluation recommendation. APRO will quality assure the response. The final response will be uploaded in the corporate tracking system within six weeks of CPE submission. The CO will be responsible for periodically updating the status of implementing the management response. The CO senior management will be responsible for ensuring that the lessons and evidence emerging from the CPE fully informs the design of the 3rd CP.

A dissemination strategy will be in place to share findings and lessons internally within UNFPA and externally. The evaluation and the management response will be posted on the CO website within six weeks of CPE submission.

7. EXPECTED OUTPUTS

The evaluation team will produce the following deliverables:

- An approved design report including (as a minimum): a) a stakeholder map ; b) the evaluation matrix (including the final list of evaluation questions and the corresponding judgement criteria and indicators) ; c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase;
- A debriefing presentation document (*Power Point*) synthesizing the main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the CO during the debriefing meeting foreseen at the end of the field phase;
- A draft final evaluation report (potentially followed by a second draft, taking into account potential comments from the evaluation reference group);
- A power point presentation of the results of the evaluation for the in-country stakeholder workshop;
- An approved final evaluation report, with annexes, based on comments expressed during the in-country stakeholder workshop.
- An evaluation brief, a 2-3 page summary of the key evaluation findings, conclusions and recommendations.

All deliverables will be drafted in English and shall follow the structure and detailed outlines in the Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA.

8. EVALUATION WORK PLAN

Workplan covers the period June 2019 to January 2020.

9. COMPOSITION OF EVALUATION TEAM

The evaluation will be conducted by an independent two-member evaluation team composed of an International Consultant/Evaluation Team Leader and a National Consultant.

The Evaluation Team Leader will have the overall responsibility during all phases of the evaluation to ensure the timely completion and high quality of the evaluation processes, methodologies, and outputs.

Qualifications, Experience and Competencies of the Evaluation Team Leader (International Consultant)

A. Team Leader (International Consultant) :

1. The candidates should have minimum a Master degree with 10 years of evaluation experience in one of the following areas (Health, Gender and Development, Demography, International Development Studies or Sociology).
2. Demonstrable experience in leading complex or country level evaluations, preferably in areas related to the ICPD agenda and UNFPA mandate.
3. Experience and knowledge of Timor-Leste cultural and political context will be an asset.
4. Strong technical and analytical capacities and demonstrated knowledge of evaluation methods and techniques for data collection and analysis,
5. Ability to work with and lead a multi-cultural team.
6. Excellent leadership, communication ability and excellent writing skills in English are required.

B. Team Members (National Consultant):

1. The candidates should have minimum a Master degree with 5 year of relevant experience or Bachelor Degree with 7 years of relevant experience in one of the above mentioned areas (Health, Gender and Development, Demography, International Development Studies or Sociology).
2. Working experience in programme management in related areas, and experience in conducting evaluations will be an advantage.
3. Familiarity with the UNFPA mandate and programming is highly desirable.

4. Proven ability to communicate clearly and fluently (verbal and written) in English, required.
5. Strong interpersonal skills and ability to work in a multi-cultural team.

10. MANAGEMENT OF EVALUATION

The team will comprise between 2-3 independent evaluators, each being an expert in one or more of the programme components: Reproductive Health, Population and Development, Gender Equality, and Youth areas. The evaluators will be selected by UNFPA Timor-Leste CO in consultation with the Asia and Pacific Regional Office (APRO). The selected team must be approved by IEO.

Team Leader will be responsible for the following:

- Provide overall leadership to the independent evaluation of the UNFPA CP relying on the inputs and insights of the National Consultant;
- Will cover at least one of the outcome area of the CPE;
- Lead the design of the evaluation and prepare the design report including the evaluation matrix, stakeholder map and the work plan;
- Lead the desk review;
- Guide the methodology and application of the data collection instruments, and lead the data collection;
- Lead consultations with stakeholders;
- Responsible for putting together the draft evaluation report, based on inputs from the national consultant;
- Finalizing the report in time and ensure that it meets UNFPA quality standards and addresses all inputs from the ERG and stakeholders and;
- Prepare the evaluation brief.

Team members (national consultants), will take part in the data collection and analysis work during the design and field phases. The evaluator will be responsible for drafting key parts of the design report and of the draft final and final evaluation reports, including (but not limited to) sections relating to her/his area of expertise.

Team Member: will assist the TL in all phases of the CPE, including but not limited to:

- o Drafting the design report;
- o Conducting the desk review;
- o Data collection;
- o Synthesis of evidence;
- o Report writing, particularly sections related to his/her areas of expertise;
- o Addressing feedback received from ERG;
- o Preparing the evaluation brief.

Evaluation manager (the CO Monitoring and Evaluation Officer) will be assigned to interact on a day-to-day basis with the evaluation team and who, together with the ERG, will ensure that all the necessary aspects of CPE are well taken into account by the evaluation team.

The evaluation manager under the supervision of the Representative and in close collaboration with an Assistant Representative will manage the evaluation and will carry out the following functions:

- To ensure consistency throughout the evaluation process (from ToR to dissemination of results and follow-up of recommendations) and assumes day-to-day responsibility for managing the evaluation;
- To coordinate the development of the ToR for the Country Programme Evaluation, with support from APRO and EO;
- To correspond with the reference group members at strategic points throughout the evaluation;
- To provide/facilitate the provision of documents and other resources available in the country office;
- To support the evaluation team in the development of the design report;
- To support all phases of the evaluation and assesses the quality of related deliverables (inception report, draft and final evaluation reports)

- To be the first point of contact and bridge the communication between CO staff, senior management, APRO, EO and evaluation team throughout the evaluation.

In order to ensure a smooth evaluation and involvement of relevant stakeholders in the management and implementation of the CP evaluation, the CO will establish Evaluation Reference Group. The composition of this task force is as follows:

Evaluation Reference Group (ERG) will have the following tasks:

- Provides input to the ToR of the evaluation and to the selection of team of evaluators;
- Contribute to the selection of evaluation questions;
- Provide overall comments to the design report of the CPE,
- Facilitate access of evaluation team to information sources (documents and interviewees) to support data collection;
- Provide comments on the main deliverables of the evaluation, including the draft final report.

The ERG composes of (one representative from each of the following units):

- Former Dean of School of Medicine, National University of Timor-Leste (UNTL);
- Director of Mari-Stopes International, Timor-Leste;
- Director of John Snow Inc. (JSI);
- Team Leader from Partnership for Human Development (PHD); and
- APRO M&E Adviser.

The ERG is chaired by a senior government official with the UNFPA Representative as the Co-Chair.

The CO relevant programme staff and operations will provide support if needed throughout the process by sharing relevant documents and information and any other logistical support the consultants may require.

APRO M&E Advisor: Will be responsible for Clearing the team selection for IEO approval, Clearing the ToR for IEO approval, and approving the design report and the final evaluation report, with EQA.

IEO: Will be responsible for approving the ToR, the evaluation team, and validating the final EQA.

11. AUDIENCE

The main audience and primary users of the evaluation are the decision makers and programme managers in UNFPA Timor Leste (CO), UNFPA Asia and the Pacific Regional Office (APRO) and UNFPA Headquarter divisions, as well as counterparts in the Government of Timor Leste (GOTL), particularly the Ministry of Health (MoH), Ministry Finance (MoF) through General Directorate of Statistics (GDS), Ministry of Education, Youth, and Sports (MoEYS), Secretary of State for the Gender Equality and Inclusion (SEII), Secretary of State for Youth and Sports (SSYS). Additionally, partners among donors (Partnership for Human Development –PHD), international and national NGOs and other civil society, as well as other sister UN agencies (e.g. UNICEF, WHO, UN WOMEN, UNDP, Mari-Stopes International, Aloia Foundation)

12. BIBLIOGRAPHY

- [Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA](#) (Independent Evaluation Office, Feb 2019) <https://www.unfpa.org/EvaluationHandbook>
- 2012-2013 New Business Plan and UNFPA Strategic Plan 2014-2017 and SP 2018-2021
- Country Office Annual Reports (2015-2018)
- UNDAF document (2015-2019)
- Timor-Leste National Strategic Plan 2011-2030
- 2015 Population and Housing Census
- <http://www.unfpa.org.ph/index.php>
- 2016 Demographic and Health Survey
- Results of 2015-2019 CPAP Mid Term Review

- 2015-2019 Country Programme Action Plan

12. ANNEXES

- A. UNEG/UNFPA Ethical Code of Conduct for Evaluations
- B. A list of stakeholders by areas of intervention
- C. A short outline of the Design Report and final Evaluation Reports
- D. A Template for the Evaluation Matrix
- E. Evaluation Quality Assessment (EQA) Template and explanatory note
- F. Management response template
- G. 3rd Country Programme Document (2015-2019 CPD)
- H. List of Atlas Projects for the period under evaluation

ANNEX 3 – MAPPING OF CONSULTED PARTNERS

Below is a list of all the partners consulted during the UNFPA Country Programme evaluation in Timor-Leste.

UNFPA COUNTRY PROGRAMME

UNFPA Timor-Leste programme and operational staff, including:

- Representative,
- Assistant Representative,
- International Operations Manager,
- Operations staff,
- Programme staff for the teams of Reproductive Health, Gender, Youth and Population,
- M&E team,
- Coordinator of the EmONC training (consultant),
- Census consultant.

UNFPA regional team in Bangkok:

- Coordinator of regional support team.

OTHER UN AGENCIES

- UNICEF – Deputy Representative.
- WHO - Representative and MCH Officer.
- UNWomen – Representative.

GOVERNMENT

- Ministry of Health – head and staff of Mother and Child Health Department; Head of HIV/AIDS Department,
- National Institute of Health (INS) – Executive Director and Technical Directors,
- SAMES Medical Stores Department – Executive Director and staff,
- Ministry of Education, Youth and Sports – National Director for Partnerships Directorate and Officer; Director for Continuing Education,
- Secretariat of Youth and Sports (SSYS) - National Director for Youth,
- National teacher trainers institute (INFORDEPE) – General Director and Technical Directors,
- Secretariat of Gender Equality and Inclusion (SEII) – Director General,
- General Department of Statistics (GDS) of the Ministry of Finance – Director General,
- Development Partnership Management Unit (DPMU) of the Ministry of Finance – Director General and Technical Adviser,
- National Police of Timor-Leste (PNTL) – HIV Focal Point.

CIVIL SOCIETY ORGANISATIONS – Implementing Partners

- Alola Foundation – Director and former Oecusse Programme Officer,
- FOKUPERS – Deputy Director,
- Estrela + - Director and Programme Manager,
- Youth-led organisations, including SHC, DMUN, Youth Leadership Development Program (YLDP) and Youth Alumni Parliament (YAP) – Directors and members.

CIVIL SOCIETY ORGANISATIONS – other partners

- PRADET - Director,
- AIFeLa – Director,
- Health Alliance International (HAI) – health programme coordinator,
- John Snow International (JSI) – Chief of Party, Deputy Chief of Party,

- Marie Stopes Timor-Leste – director, health systems manager, clinical quality manager,
- Plan International – acting Director.

ACADEMIC AND TECHNICAL PARTNERS

- Nossal Institute for Global Health, Melbourne University – disability expert.

DEVELOPMENT PARTNERS

- PhD, implementing partner of the Australia Government Department for International Development (DFAT) – health officer.

MUNICIPAL AUTHORITIES

- Dili Municipality - municipal director of health,
- Oécusse Municipality – municipal director of health and MCH officer,
- Liquiça Municipality – municipal director of health,
- Liquiça Municipality – municipal director of education.

BENEFICIARIES

- Directors and management staff of Dili National Hospital (HNGV); of Regional Hospital of Oécusse.
- Trainers and health service providers of HNGV and Vera Cruz clinic in Dili, of Oécusse Hospital and Baucasse health post in Oécusse, and of Community Health Centre in Liquiça trained in EmONC and/or in Family Planning.
- INFORDEPE staff trained in in-school Comprehensive Sexuality Education (CSE).
- Managers and teachers of ESTV – ECC Becora school in Dili and Encino Basico Central Casait and 3 other schools in Liquiça trained in in-school Comprehensive Sexuality Education (CSE).
- Students who benefitted from in-school CSE in schools,
- Communities in Baucasse and Usapi Bela beneficiaries of the Birth Planning Programme.
- Young people associations who participated in the pilot testing of out-of-school CSE materials.

ANNEX 4 – IP IMPLEMENTATION RATES

Table 9: Implementation rate per UNFPA Timor-Leste Implementing Partner between January 2015 and December 2018

CP Implementing Partner	2015				2016				2017				2018				CP PERIOD 2015-2018			
	Annual CP Budget per IP in USD	Proportion of CP Budget	Expenditure in USD	Implementation Rate	Annual CP Budget per IP in USD	Proportion of CP Budget	Expenditure in USD	Implementation Rate	Annual CP Budget per IP in USD	Proportion of CP Budget	Expenditure in USD	Implementation Rate	Annual CP Budget per IP in USD	Proportion of CP Budget	Expenditure in USD	Implementation Rate	TOTAL CP BUDGET PER IP in USD	PROPORTION OF CP BUDGET	TOTAL EXPENDITURE PER IP in USD	Implementation Rate
SEII	19,006	0.9%	18,356	97%	15,001	0.7%	15,001	100%	-	-	-	-	10,000	0.5%	3,478.90	35%	44,007	0.5%	36,836	84%
GDS (MoF)	117,000	5.5%	116,965	100%	61,796	3.0%	60,251	98%	30,530	1.6%	30,530	100%	10,600	0.6%	10,600.00	100%	219,926	2.7%	218,347	99%
MoEYS	-	-	-	n/a	-	-	-	n/a	1,000	0.1%	-	-	-	-	-	-	1,000	0.0%	-	0%
MoH	18,546	0.9%	14,200	77%	64,605	3.2%	62,751	97%	45,301	2.3%	35,983	79%	47,009	2.5%	17,019.00	36%	175,461	2.2%	129,952	74%
SYSS	-	-	-	n/a	4,433	0.2%	4,158	94%	1,792	0.1%	1,792	100%	-	-	-	-	6,225	0.4%	5,950	96%
INS	-	-	-	n/a	9,234	0.5%	-	0%	7,579	0.4%	6,629	87%	73,092	3.8%	61,576.55	84%	89,905	1.1%	68,206	76%
PRADET	35,325	1.7%	24,908	71%	-	-	-	n/a	-	-	-	-	-	-	-	-	35,325	0.4%	24,908	71%
ALFELA	20,059	0.9%	17,265	86%	4,001	0.2%	3,548	89%	-	-	-	-	-	-	-	-	24,060	0.3%	20,813	87%
Alola Foundation	53,812	2.5%	40,325	75%	38,226	1.9%	32,057	84%	28,405	1.5%	23,512	83%	92,927	4.9%	89,139.60	96%	213,370	2.7%	185,034	87%
SHC	-	-	-	n/a	11,204	0.6%	-	0%	17,406	0.9%	17,396	100%	-	-	-	n/a	28,610	0.4%	17,396	61%
MACRO ICF	-	-	-	n/a	-	-	-	n/a	247,267	12.7%	247,267	100%	-	-	-	n/a	247,267	3.1%	247,267	100%
Nossal Institute	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a
Fokupers	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a
Estrella+	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a
Burnet Institute	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a	-	-	-	n/a
UNFPA Implementation	1,875,205	87.7%	1,741,837	93%	1,823,514	89.7%	1,713,978	94%	1,575,008	80.6%	1,463,493	93%	1,667,031	87.7%	1,447,533.06	87%	6,940,757	86.5%	6,366,842	92%
COUNTRY	2,138,953		1,973,857	92%	2,032,013		1,891,744	93%	1,954,288		1,826,603	93%	1,900,659		1,629,347.11	86%	8,025,913		7,321,550	91%
PROGRAMME TOTAL (USD)																				

Source: UNFPA Timor-Leste Country Office (2019)

NOTE: Nossal Institute, FOKUPERS, Estrella+ and Burnet Institute only became IPs in 2019. Therefore they show no budget and expenditure in this table.

ANNEX 5 – EVALUATION MATRIX

See separate attachment