



THE UNFPA SECOND COUNTRY PROGRAMME (2009 -2013) OF ASSISTANCE TO TIMOR LESTE

Evaluation Report

March 2013

United Nations Population Fund Timor Leste

SECOND COUNTRY PROGRAMME (2009-2013) OF
ASSISTANCE TO TIMOR LESTE

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LIST OF ABBREVIATIONS AND ACRONYMS

AMKV	Assosiasaun Mane Kontra Violensia
AWP	Annual Work Plan
BEmOC	Basic Emergency Obstetric Care
BCC	Behavioural and change communication
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CHC	Community Health Center
CPAP	Country Programme Action Plan
CP2	Country Programme Two
CPD	Country Programme Document
DHS	Demographic Health Survey
DNE	Direcção Nacional de Estatística
DPKO	Department of Peacekeeping Operations
DV	Domestic violence
EmOC	Emergency Obstetric Care
FGD	Focus Group Discussions
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IEC	Information, Education, and Communication
IPs	Implementing Partners

JPC	Justice and Peace Commission
JSMP	Judicial System Monitoring Programme
LADV	Law Against Domestic Violence
LMIS	Logistic Management Information System
MICS	Multi Indicator Cluster Survey
MOH	Ministry of Health
MSS	Ministry of Social Solidarity
NAP	National Action Plan
NGO	Non-government organization
NPO	National Programme Officer
NSRH	National Strategy on Reproductive Health
NSD	National Statistics Directorate
OBGY	Obstetric and Gynecology
OPE	Office for the Promotion of Gender Equality
OROLSI	Office of the Rule of Law and Security Institutions
PCM	Programme Component Manager
PD	Population and Development
PNTL	National Police of Timor-Leste
PO	Programme Officer
PSA	Population Situation Assessment
PSF	Family Health Promoters
RH	Reproductive Health
SCR	Security Council Resolution

SDP	Strategic Development Plan
SEPI	Secretariat of State for the Promotion of Equality
SGBV	Sexual and Gender-based Violence
SISCA	Sistema Integrado Saude Comunitaria or Integrated Community Health Services
SM	Safe Motherhood
SOPs	Standard Operating Procedures
TL DHS	Timor -Leste Demographic and Health Survey
TOR	Terms of Reference
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UNIFEM	United Nations
UNTL	Universidade Nasional Timor-Lorosa'e (Timor Leste National University)
VPU	Vulnerable Persons' Unit

EXECUTIVE SUMMARY

Evaluation Purpose

This report presents the results of the Timor Leste UNFPA Second Country Programme Evaluation (CPE2) conducted by an independent evaluation during July and August 2012. The current Country Programme Action Plan (CPAP) is a five-year framework defining cooperation between the Government of Timor Leste and UNFPA covering the period 2009 to 2013. This is the second country programme cycle (CP2) focusing on three components: Reproductive Health (RH), Population and Development (PD), and Gender. The programme is planned to contribute to three UNDAF outcomes which target improved national capacities for poverty reduction; increase access to and utilization of quality basic services; and improved governance through strengthening state based institutions.

The purpose of this evaluation is to assess the Country Programme (CP) progress and achievements to date to determine the appropriateness of the CP strategy, proposed outcomes and outputs. UNFPA programme management guidelines require that evaluation be conducted during year four of the CP so that lessons learned from the current CP and recommendations from the evaluation can be incorporated into the new programme cycle. Furthermore, as per UNFPA policy and procedures, the upcoming new CPD needs to be backed by the evaluation of preceding CP. The primary stakeholders in this evaluation are the UNFPA country office, and the relevant government and non-governmental implementing partners, UN agencies and bilateral and other donors who are supporting the CP2 UNFPA focus areas in Timor Leste. The evaluation will provide recommendations for further improvement in the remaining period of the CP2 and in the next CP (CP3) that UNFPA is developing.

Evaluation Objectives and Interventions

Objectives of this evaluation are to: assess the extent to which CP2 achieved its outputs and contributed to its intended outcomes; assess the extent to which CP2 helped to enhance government commitment to the ICPD programme of action, Millennium Development Goals (MDGs) and other national priorities; and to provide lessons learned and recommendations that can be applied to the next country programme strategies as well as to the remaining period of the current programme cycle.

This evaluation (CPE2) covers the period from 2009 to July 2012 to assess the ten outputs that are expected to contribute to achieving four key outcomes under the three programme components: Reproductive Health, Population and Development and Gender.¹ The TOR² specifies that outputs of each component to be evaluated in terms of their results based on the DAC criteria: Relevance, Effectiveness, Efficiency, and likely Sustainability.

Programme Interventions

Interventions under the RH component are focused on increasing access to and utilization of comprehensive RH services, including maternal health, family planning, STI, and HIV prevention services, especially for vulnerable groups; and enhanced life skills of young people including prevention of STI and

¹ Please refer to the TOR Annex1: Outcomes and outputs of three programme components.

² Annex 1: TOR

HIV and adolescent pregnancy. Increasing demand for and access to high-quality maternal health services, including emergency obstetric care; increasing access to and demand for high-quality family planning services; increasing availability of information, counseling and services for populations most at risk, to promote healthier and safer behaviour and increasing access to high-quality reproductive health information and services for young people.

Interventions planned under PD expect to ensure that data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS available, analysed and used at national and sub-national levels to develop and monitor policies and programme implementation. To achieve this outcome, PD has planned that policy makers and planners at national and sub-national levels are sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies; and that analytical capacity at national and sub-national levels are strengthened for utilizing data on population, reproductive health and gender in order to develop, implement and monitor policies and programmes. Also in the interventions are to improve the availability of disaggregated demographic and socio-economic data at national and sub-national levels. Two major activities were support to implementation and dissemination of Timor Leste DHS (2009-2010) and 2010 Population and Housing Census.

Interventions under the Gender component are to strengthen national capacity to promote gender equality and prevent gender-based violence (GBV) through improved policies, protection systems, and enforcement of legal and reproductive health services. Implementing the national domestic violence law which is part of this involves advocating the need to promulgate and implement the draft Law Against Domestic Violence among key line ministries, the National Parliament and civil society; produce information, education, and communication (IEC) materials to educate the population on its benefits. Increased access to emergency medical, shelter, counseling and legal services for survivors of domestic and GBV in Dili and as many districts as possible and contributing to the development of a national action plan on Security Council Resolution 1325 form expected outputs under this component.

Evaluation Methodology

To achieve the above broad evaluation objectives, a set of key evaluation questions were developed based on the TOR. The evaluation focused on the country programme design and management issues and the strategies that were used to achieve the outcomes under the three programme components (RH, Gender and PD) by employing the DAC evaluation criteria, namely, relevance, effectiveness, efficiency, and sustainability. Data to support the evaluation assessment were derived from primary and secondary sources representing both national and sub-national level stakeholders, UNFPA country office staff, donors, and other UN agency staff. Evaluation findings are based on a mix of quantitative and qualitative evidence bringing out viewpoints of the stakeholders by triangulating multiple sources of data obtained from face-to-face interviews with individuals, phone interviews, direct observations, focus group discussions, questionnaires, documents, and websites. Due to the limited availability of baseline data and the contribution of many other organizations in the same programme area, counterfactual analysis was a challenge. A one-shot evaluation design which measures results after the intervention was used to assess the outcome of the intervention where baseline values were absent for comparison.

Main Conclusions

The overall program design of CP2 is to a large extent in line with the government development needs, UNFPA mandate, ICPD programme goals, MDGs and stakeholders' needs. UNFPA is operating at an upstream level, using its comparative advantage notably in supporting the accessibility and availability of quality data for evidence-based planning in the three programmatic areas (RH, PD and Gender). UNFPA partners with key stakeholders, such as, Ministry of Finance, Ministry of Social Solidarity, Min. of Health, NGOs and CSOs.

The RH component, designed in accordance with national priorities, the local context, and the current situation of the health sector, has made an effective contribution to the improvement of service provision. However, there is room for further assistance in capacity development for the health sector in provision of BEmOC and ASRH. The RH component made great efforts in policy advocacy for changes. The interventions received valuable support from religious authorities and community, policymakers, and health managers. The new government was informed of the existing programmes in the areas of support from UNFPA under CP2. Consequently, policy documents and legal frameworks have been revised and newly developed so as to create a supportive policy environment for RH care. The Family Planning interventions have made remarkable contribution in strengthening capacity of the current system and staff members in provision of services and information. However, capacity of the physicians in providing FP clinical service was still limited because of lack of human resource. The LMIS system was well functioning yet capacity in collecting up-to-date data on the Average Monthly Consumption. This coupled with the lack of in-depth data, especially those on unmet needs of unmarried people and youth, could weaken the basis for long-term planning of interventions in family planning.

The ARH service and information provision was primarily establish and functioning under support of the CP2. Young people can initially have access to information about ARH through various channels including in-school and out-school. Nevertheless, there was still lack of National Core Trainers in ARH clinical services, lack of a system of ARH monitoring and supervision, and lack of service and information in sexual health. Even though reproductive health was within the national priorities of Timor-Leste, the lack of a regular budget from the government was a challenge for the health sector. Interventions related to capacity building and service provision were still reliant on international donors. This in fact hampered the health sector on being proactive in carrying out their strategies and action plans independently.

In Timor-Leste, like in most developing countries, the main sources of data are the population censuses and household based sample surveys. UNFPA provided technical, administrative and financial support to the census process and supported implementation of the DHS. The development of the Strategic Development Plan benefitted from DHS and census data which were used as baseline and for target setting.

Several monographs based on Census data will be published soon and these would contribute to better understanding the country situation for planning. Compared to the last Census, disaggregated data are available for planning and data projections were done and disseminated to relevant ministries. While it is still too early to assess the usage of the data and its full integration in sector planning, integration of population data into sectoral planning seem weak and needs strengthening of its monitoring system as well. The delay in the establishment of the National Population Commission also may have been a factor contributing to this. Currently, several ministries are collecting household data and some regulation would be necessary to ensure the reliability, validity and accuracy of national data bases and

to increase the efficiency of data collection exercises. Any kind of inventory is lacking for anyone needing to refer to data needs.

UNFPA engages successfully in a number of downstream activities in RH and Gender. Currently, support to PD is somewhat limited to national level and programme support in PD should review the needs at sub-national/district level.

With regards to Gender, Timor-Leste is clearly committed to gender equality as encapsulated in its national priorities and strategies. Ensuring that gender equality is attained in every dimension of life is clearly the country's goal. In this regard, efficient collaboration across the various stakeholders cannot be underestimated in addressing GBV and DV. Collaboration would also suggest that the different stakeholders cooperate in matters of monitoring as well as risk management.

Under the CP2, the promulgation of the LADV may be considered a significant step forward in addressing the problems of GBV and DV in the country. UNFPA has not only played a critical role in lobbying for this law but also is heavily committed to its implementation. While the support given by UNFPA has been important towards the furtherance of the cause towards eliminating GBV and DV, much more needs to be done on the part of the government to play a more proactive role in independently executing the interventions related to the implementation of the LADV and service provision towards GBV and DV victims. Looking forward in terms of addressing GBV and DV, equipping the various stakeholders with the relevant skills set and knowledge becomes essential so that efforts towards reducing GBV and DV can be maximized.

Recommendations

Continue to support the health sector in completion of capacity building in BEmOC focusing on three tasks. Firstly, continue to provide refresher training to midwives and nurses who have received training on BEmOC. Secondly, support the development of a team of National Core Trainers in EmOC. The trainers could be selected midwives and nurses who have trained and are competent to provide BEmOC services. Thirdly, support to development of teams of national and sub-national technical supervisors for BEmOC.

Continue to support family planning system with strengthening capacities of LMIS in collecting data on AMC for better projection, especially that of the sub-national levels; support capacity building for new Timorese doctors on vasectomy and tubectomy; support the health sector to collect, analyze, and utilize data of unmet needs of young people and the unmarried in Family Planning and RH care. This provides crucial evidence for further policy advocacy and community mobilization in providing sexual education and family planning services to young unmarried people. Support the MoH to develop capacity for National Core Trainers and Supervisors on ASRH. Support the implementing partners of different sectors to advocate for a budget line from the government for RH care. Achievements, experiences, and lessons learnt from the previous interventions should be documented to facilitate this effort. The advocacy should focus on a budget line for FP, BEmOC first since these intervention has obtained considerable achievements over years.

For PD, Continue to work on establishment of the National Population Commission (and/or Secretariat) to coordinate population issues and to formulate a National Population Policy that ensures population, reproductive health and gender concerns are integrated into all sectoral programmes. Indicators for this may be qualitative and/or quantitative in nature and will be useful to establish both process and output indicators to ensure achievement of expected outcome.

Given UNFPA mandate to support credible data, UNFPA should support the government, specifically NSD, in streamlining data collection efforts in the country. Assist preparation of an inventory of data bases (research, surveys, and studies) specifically related to UNFPA mandated areas.

Continue with targeted capacity building in PD. This may entail conducting an organizational capacity assessment and a needs assessment prior to targeting capacity development programmes and should be done at district /sub-national level as well, to identify the areas needing specific capacity development interventions at that level. Integrated to this plan, there should be an exit-strategy on capacity development for long-term sustainability of the UNFPA programme.

UNFPA should continue to support in the preparation and implementation of Census and DHS until the national capacity is established. Preparation for the next census would happen during the next CP cycle as the country's desire to repeat the census exercise in five years instead of ten years. Lessons learned from the past census exercise (for example, need to strengthen capacity at sub-national level and creating awareness on census procedure and the sensitizing the importance of reliable data at the the initial stages of planning) should be taken into consideration.

In general, common to all programme components in the CP, UNFPA CO should pay more attention to establishing a workable/managable M&E system. This entails establishing baseline data, measurable indicators and regular feedback to the M&E officer to update the RRF, via systematic meetings/communication. The current CP lacks evaluability assessments. Although the M&E results framework is fairly complete and has established baseline values and targets with a monitoring system including indicators for outputs, some were found to be missing. The updating of the M&E framework was limited due to the inconsistency in the way feedback reports/ progress reports measured progress.

Although it may not be required by UNFPA M&E guidelines to conduct evaluability assessments during planning stage, involving IPs in evaluability assessments would be helpful to set up and agree on baseline values and targets. This would also help in developing an integrated and comprehensive M&E plan, as planning an intervention and designing an M&E strategy are inseparable activities.

For Gender, capacity building in GBV should be made a priority. Training in all areas related to the prevention, intervention, and advocacy at the national, district, and suco levels should be stepped up. There should be a joint monitoring mechanism in place—a mechanism which is systematic and formalized. Coordination across all the key players in addressing GBV is critical in addressing GBV and should be strengthened. In particular, the role of the health sector has to be reinforced as this sector appears not to be as actively engaged in addressing GBV issues unlike the NGOs engaged in service provision. The relevant NGOs should be consulted as to the appropriate timing for such a study, and conclusions and recommendations from the assessment should help the respective government departments in programming, more specifically how these services can be built up, what is needed where, and what would be feasible.

Strengthening the monitoring and evaluation capability of CSOs in population, gender and RH should be an explicit part of UNFPA's strategic plan for capacity building of CSOs. For capacity building activities, there is a need to develop a strategic approach and expand partnerships with training and research institutions to ensure effectiveness, efficiency and sustainability. These groups are supported by consultants and it is necessary to build capacity to monitor/maintain progress reports.

1.0 INTRODUCTION

1.1 Background

Introduction

UNFPA has been supporting the Government of Timor-Leste since 1999 in the areas of reproductive health (RH), population and development, and gender. After its restoration of independence, UNFPA signed the first country programme of support to the Democratic Republic of Timor-Leste (2003-2005). In the year 2005, in order to harmonize its planning cycle with the National Development Plan, UNFPA first country programme was extended until the year 2007. Due to the security situation following the events on May 2006, a further year of extension was required till the end of December 2008.

UNFPA is currently providing assistance to the Ministries of Health (MOH), the National Statistics Directorate (NSD) and the Secretary of the State for the Promotion of Equality (SEPI) through the three programme components. Besides these major counterparts such as MOH, Ministry of Finance (MoF) through (NSD) and SEPI, UNFPA also works with other partners such as Ministry of Social Solidarity (MSS), Ministry of Education (MoE) and number of local and international Non-Government Organizations to assist the Government of Timor-Leste via the second five year country programme-CP2 (2009 to 2013).

Three major components of the CP2 include Sexual and Reproductive Health, Population and Development, and Gender equality. The Reproductive Health component is formed of 2 major outcomes that are (i) *“Increased access to and utilization of comprehensive reproductive health services, including those focusing on maternal health, family planning, and the prevention of sexually transmitted infections and HIV, especially for vulnerable groups and (ii) Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies.”* These two outcomes are to be reached by achieving four outputs which will be described in detail later.

The PD component has one comprehensive outcome to ensure that *“data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS are available, analyzed and used at national and sub national levels to develop, implement and monitor policies and programmes.”* Three outputs are expected to lead to this outcome.

The Gender component has one outcome that is *“Strengthened national capacity to promote gender equality and prevent gender-based violence through improved policies, protection systems, the enforcement of laws and the provision of reproductive health services.”* Again, three outputs are expected to lead to this outcome.

The Evaluation Team (ET) comprised three international consultants - a Reproductive Health consultant; a Gender consultant; and a Population and Development consultant who is also the team leader.

Table 1: UNFPA Resource Allocation for CP2* (USD, in million)

Area	Regular resources*	Other sources	Total
Reproductive health	5,458,336.00	1,496,801.24	6,955,137.24
Gender	1,613,260.00	1,218,282.49	2,831,542.49
Population and development	4,391,497.00	2,250,750.00	6,642,247.00
Programme coordination and assistance	203,000.00	-	203,000.00
Total	11,666,093.00	4,965,833.73	16, 631,926.73

*NB: The figures here are only from 2009 to September 2012.

Figure 1: District Map of the country



1.2 Evaluation Purpose

UNFPA programme management guidelines advise that the end-of-programme evaluation be conducted during year four of the CP so that lessons learned from the current CP and recommendations from the evaluation can be incorporated into the new programme cycle. Furthermore, as per UNFPA policy and procedures, the upcoming new CPD needs to be backed by the evaluation of preceding CP. As such the purpose of this end-point evaluation is to assess the Country Programme (CP) progress and achievements to date and to determine the appropriateness of the CP strategy, proposed outcomes and outputs as well as if the counterparts identified are the most suited ones in the current and changing context of Timor-Leste.

This evaluation is expected to identify when and under what circumstances the CP2 adds values to the country's action plan implementation via its achievement and its alignment with the national efforts to

overcome its issues under the programme components in Reproductive Health, Population Development, and Gender. The evaluation will provide recommendations for further improvement in the remaining period of the CP2 and in the next CP (CP3) that UNFPA is developing.

The intended users of this evaluation include Government implementing partners and co-implementing partners, and non-Governmental Organizations (NGOs) who are working on the areas of RH, PD, and Gender; and those UN agencies and bilateral and other donors who are supporting the CP2 UNFPA focus areas in Timor Leste. In addition, this evaluation could serve as a reference for future evaluation exercises in related areas.

1.2.1 Evaluation Objectives and Scope

The second CPE covers several outcomes and outputs from the three programme components: Reproductive Health, Population and Development and Gender.³ The TOR⁴ specifies that outputs of each component to be evaluated in terms of their results based on the DAC criteria: Relevance, Effectiveness, Efficiency, and likely Sustainability. CPE2 covers the period from 2009 to July 2012.

As per TOR, the specific objectives of the evaluation are:

- To assess the relevance of the country programme specifically to assess if the outcomes are in line with the government's priorities, policies, and UNFPA's mandate and if they are considered useful by the target population.
- To assess the effectiveness of the country programme in terms of if the expected outputs of the CPAP are achieved or likely to be achieved; extent to which population data are taken into account in planning poverty reduction strategies, policies, plans and programmes; the extent to which the CP contributed to improving and affordability of SRH services, interventions under gender contributed to raising awareness on GBV, and how the positioning of this theme in the national agenda, and implementation of LADV functioned. Finally, how well the programmes are targeted to reach the intended beneficiaries via UNFPA support.
- To assess the efficiency of the programme: justification of actual or expected outputs to the cost incurred, if any duplication of interventions, and if resources are used efficiently.
- To assess the sustainability of the country programme, specifically when and under what circumstances they are owned, continued or maintained by local counterparts if supports from UNFPA are phased out.

1.2.2 Key Evaluation Questions

These are broad questions that are common to all three areas. Specific questions are attached as an Annex.

³ Please refer to Annex 2: outcomes and outputs of three programme components.

⁴ Annex 1: TOR

1. Are three key focus areas (programme components) designed according to national priorities, UNFPA mandate, and within the country context?
2. Do the programme components add value and are considered useful by the target populations?
3. Is the programme design logically sound?
4. Do the programme management and partnerships contribute to an effective, efficient and sustainable development programme intervention?
5. What are the factors that facilitate or limit the effectiveness of the interventions under CP2?

The strategies used to achieve the CP2 programme component outcomes were assessed by employing DAC evaluation criteria, namely, relevance, effectiveness, efficiency, and sustainability. The evaluation did not undertake any cost-benefit assessment of the interventions to measure efficiency.

1.3 Evaluation Methodology

Based on the programme's logic as stated in the CPAP, the three member independent evaluation team agreed on an evaluation design that guides the overall strategy for selecting appropriate data sources, methods and analyses to answer the evaluation questions outlined in the TOR. Under each component, the relevant team member reviewed the design and implementation of the programme, the outputs, and the programme management with the intent of assessing the achievements of each and every output up to the time of the evaluation. It was decided to assess the programme relevance at the outcome level and the analyses of programme effectiveness, efficiency, and sustainability to be performed for each output. An evaluation design matrix was prepared which included key evaluation questions under the three programmatic areas. Moreover, sub-questions were developed to ensure that data can be collected to answer those questions. It must be noted that the methods were participatory in nature and sufficient space for the stakeholders at different levels were ensured.

Data Collection:

Both secondary and primary data were employed in this evaluation.⁵ The type of data were based on a mix of quantitative and qualitative, derived from multiple sources. The evaluation also triangulated the data sources, data types, data collection methods and investigators. To strengthen the evidence base and the participation of stakeholders, data collection used triangulation approach through application of perceptions, validation, and documentation. Perceptions were elicited through interviews with internal and external stakeholders and key respondents. For example for the gender component, primary data based on interviews were collected with key stakeholders including officials from SEPI, MSS, and implementing partners. The rationale for interviewing officials from SEPI and MSS was to ascertain whether UNFPA's CP was in alignment with national priorities and that the Timorese government would like to see other changes by way of how UNFPA may be able to provide assistance to SEPI and MSS. Similarly, key stakeholders identified for RH and PD components were interviewed in-depth. Primary data collection was critical to the evaluation exercise for a number of reasons. These interviews verified that CP2 was relevant to the target population. In addition, the primary data were important for ascertaining the extent to which the outputs of the CPAP have been achieved as well as for investigating the extent to which the interventions have contributed to the outcomes of each programme component. These interviews were also critical to shed light on how UNFPA was able to support its partners and beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects. Validation was achieved through stakeholder meetings, such as debriefing

⁵ primary data will mainly be qualitative in nature

meetings with UNFPA staff and ERG. In addition, direct observation during field visits; and discussions with non-beneficiaries were valuable in the evaluation exercise.

Documentation included CP-related documents such as relevant national policies, strategies and action plans, national statistics, midterm analyses, external reviews, AWP, CPAP, CPD, UNDAF, UNFPA annual review reports and other external documents. A list of the documents reviewed is in the annex 7. A detailed examination of these secondary sources helped to guide the design of the interview schedule for primary data collection.

Selection of sites for visits:

Selection of sites was based on discussions with POs and IPs and by document review to understand where and how the interventions were implemented. ET's initial suggestions were discussed in detail, to clarify the basis for selection during the CPE inception report presentation made to the EMC members.

RH sites:

Timor-Leste comprises thirteen districts. UNFPA's activities under RH include programmes on EmOC/midwifery, FP (Family Planning) including LMIS (Logistic Management Information System), ARH (adolescent reproductive health), general RH (Obstetric Fistula, cervical cancer and MISP), and BCC (Behavioural Change and Communication). While these activities were implemented in all thirteen districts, ARH (adolescent reproductive health) activities have only been piloted in the capital of the country. Because of the presence of all UNFPA's activities in Dili, the RH consultant decided to conduct interviews among the various stakeholders based in the capital, in addition to the other areas in the country. For example, the pilot YFS (Youth Friendly Services) resource centre is located in Becora and is implemented by a local NGO. Moreover, there is a CHC (Community Health Centre) in Becora providing YFS/ARH services. Data collection was also extended to areas outside Dili where UNFPA had implemented activities. The ET selected Maliana, the capital of the district, Bobonaro, for a fieldtrip since RH and SM (safe motherhood) activities have already been established in this capital. Moreover, the RH consultant visited the UNV OB specialist based in the Maliana Referral Hospital which supports the provision of CEmOC in the district.

A field trip was also made to Oecusse by the RH consultant. UNFPA interventions similar to that of Maliana have been made available in Oecusse since August 2010 (although there is no OBGYN specialist placed there), during which UNFPA as part of a UN joint programming strengthened its interventions in the district. In addition COMPASIS has been piloted in this district. Moreover, the ET decided to select the enclave as a field site because interventions in this district have been fairly comprehensive. The RH consultant also visited Oecusse because of its geographical isolation from the rest of the country since it is situated in West Timor. This is in contrast to other districts which are within the mainland and are closer to Dili.

PD sites:

Similar to that of RH, PD activities have been carried out in all thirteen districts at the national, district, subdistrict, and suco levels. Since PD activities are national-level activities, they have been carried out across the country. Interviews were conducted in Dili, and the PD consultant made fieldtrips to the

same areas as the RH consultant. In Oecusse and Maliana, the PD consultant met with the district statistical officers as well as the district administrative officers who were involved in carrying out the recent Census. Because Oecusse has been chosen as a pilot district, the team decided to observe the comprehensive programme implemented by UNFPA jointly with other agencies in this district to understand the exit strategies and lessons learned for future planning and programming of the interventions implemented.

Gender sites:

For gender, UNFPA has implemented activities in four districts: Dili, Bobonaro, Covalima, and Oecusse, although it must be noted that substantial support has also been provided at the national/central level under the programme. Further more, the gender consultant reviewed the extent to which gender has been effectively mainstreamed in the RH and PD programme components. In addition to collecting data in Dili, the gender consultant undertook a fieldtrip to Suai in the district of Covalima because the capital has a court of justice dealing with GBV cases, in addition to a shelter run by an implementing partner in Salele. In addition, the court based in Suai oversees GBV cases not only from Covalima but also Bobonaro, Lospalos, Baucau and Viqueque. The gender consultant of the ET also visited Maliana in Bobonaro district because the implementing partner, FOKUPERS runs a transit house in the capital. Interviews with the staff of Fokupers were valuable since the NGO has been aggressively implementing several communication strategies to raise awareness on GBV. A field trip was also made to Oecusse because PRADET/MoH operates a Fatin Hakmatek for GBV victims on the grounds of the regional hospital. The gender consultant also spoke with the Director of the referral hospital to investigate the quality and relevance of the health services provided to GBV victims.

Owing to the difficulties in reaching Oecusse, the ET combined their fieldtrips to the field sites selected for this evaluation exercise in order to facilitate logistical arrangements. Observations of the field sites were also made, especially of health facilities and GBV shelters. Interviews were conducted in Tetum or Indonesian through translators identified from the local community who were not staff of UNFPA. The gender consultant conducted most of the interviews in Indonesian because the familiarity with the spoken language.

The evidence gathered in this study include data collected from the field, document review, direct observations, rating tools, interviews, focus group discussions, questionnaires, and secondary sources. A convenient sample of beneficiaries was also used for focus group discussions to gather information on service quality and its accessibility and utility. Efforts were also made to obtain feedback from non-beneficiaries of UNFPA interventions. The evaluation also reviewed and made use of the monitoring reports (quarterly reports, standard progress reports, annual reports, trip reports by programme staff) submitted by IPs and UNFPA staff. The triangulation of data collection had the purpose of minimizing the weaknesses of one method, and offsetting the strengths of another and, in turn, enhancing the validity of the data.

Key Informant Interviews:

Interviews were conducted with key informants who included: officials from key ministries, implementing agencies, donor agencies and district programmes, heads of UN agencies, Task Teams, UNFPA CO staff, and M&E persons in the UN system, and NGO representatives. At the field level, community group leaders were interviewed for their views on how UNFPA activities have influenced the planned objectives and vice versa. Key respondents were identified at the national and district levels. A

consent form was developed and introduced to the respondent before the interview procedure for confidentiality purposes, where feasible and applicable. A questionnaire protocol was developed as a guide for in-depth interviews and was modified to suit the specific context and activities under each programme component.

The key informants of this evaluation were finalized after meeting the POs and the evaluation manager/evaluation focal point. Prior to the field visits, POs were provide an overview of the UNFPA interventions and detailed discussions were requested on individual programmatic areas (RH, PD, and Gender).

1.3.1 Ethical Considerations

Ethics and maintaining the quality of evaluation:

The team examined the “*Standards for Evaluation in the UN System*” and “*UNFPA Evaluation Quality Standards*” documents that were provided to the team (with the TOR). A brief M&E orientation on the terminology and methods used in the evaluation was also held so as to ensure that the CO and ET members understood the aims and assumptions made in the evaluation process. The ET followed the UNEG guidelines and standards in carrying out the evaluation to maintain the quality of the evaluation. Reliable data sources were identified, and key respondents and other interviewee selection were made in a representative manner so as to ensure credibility and impartiality.

The CO prepared letters informing the interviewees and requesting the participants’ agreement and cooperation in providing information. Where written consent was not applicable or feasible, verbal agreement was sought. The interview respondents were informed of the evaluation purpose, rights, and obligations of participating in the evaluation. Target groups were also given the right to refuse the interview and, as such, the evaluation involved only those who agreed to participate. Moreover, the evaluation team adhered to measures to ensure that the evaluation process conforms to relevant ethical standards observing privacy and confidentiality considerations.

The evaluation team made every effort to ensure that evaluation findings are credible based on reliable data and observations. Conclusions and recommendations were discussed with EMC for clarification and to explain the how judgements were made based on evidence. The evaluation team made a presentation to the key stakeholders the methodology, procedures, and analysis that were used to collect and interpret the data to arrive at the conclusions and recommendations. Confidentiality and anonymity were preserved if and when sensitive information was reported and interpreted.

1.3.2 Challenges and Limitations to Evaluation

Firstly, given that the implementation of the country programme has covered only three and a half years out of its five-year cycle, the desired outcomes may not have been realized for the ET to compare with the expected outcome indicators. As such, while this evaluation was not able to cover the long-term impacts of the interventions under the current CP, the evaluation team assessed the processes and strategies that are in place, and the achievement of outputs to date that are contributing to the expected outcomes.

Secondly, because of the limited programme baseline and endline surveys, the ET was not able to make before and after comparisons in most of the interventions. However, effort was made to take into

account the available secondary sources (such as DHS 2004, CPA) which would aid in understanding the situation prior to the implementation of the interventions. It must be noted that the limited timeframe of this evaluation exercise did not allow the team to collect primary quantitative data of related areas. Because of the constraints in identifying sound bases for comparison, the evaluation is based mainly on the results of secondary quantitative data and qualitative data that were collected during the evaluation process. In addition to that, key stakeholder interviews, site visits and identified key documents support evaluation findings.

Because of the difficult geographic conditions of the project sites coupled with time limitations, the ET was not able to visit several project sites at lower administrative level. Instead, the ET selected a sample of three districts (including Dili) to visit. It must be noted that the time factor (duration in each place and the distance to villages) might have challenged the team from gaining a more accurate picture of what has been happening on the ground.

The lack of counterfactuals, constraints in identifying sound bases for comparison, and possible biases due to subjectiveness in the interview responses, the evaluators sought to mitigate these limitations and minimize possible biases through triangulation of data collection methods, sources and investigators.

A detailed cost-benefit analysis was not undertaken but efficiency issues were addressed through document review, Atlas reports and interviews with relevant stakeholders.

1.3.3 Evaluation Team

The three member team comprised persons with technical expertise⁶ on reproductive health, gender, and population studies. The sections on RH, PD and Gender were prepared by each of the respective experts and the entire team contributed to the overall report while the team leader was responsible for putting the report together. The final report is based on the comments and feedback received from the country office staff, the ERG members, Regional Office (APRO) and other stakeholders.

1.3.4 Structure of the Report

With a brief background to the evaluation, its scope, objectives and evaluation methodology, the report provides the context within which the country programme operates. With a general section on the programme design and the programme management which include capacity building, partnerships and gender mainstreaming, that are common to the overall country programme, the report discusses the evaluation findings under each programme component, namely Reproductive Health; Population and Development; and Gender. The strategies employed to achieve the results (as given in the TOR and the CPAP) are assessed using DAC criteria – relevance, effectiveness, efficiency, and sustainability.

The three programme components have specific characteristics, and managed by POs with relevant IPs. The facilitating and hindering factors in achieving results, and program design issues and management issues that are relevant to that particular component are discussed separately under each programme component. Although this may be repetitive, it was unavoidable given the nature of the interventions under each programme component (RH, PD and Gender). As such, it was decided to have the aforementioned issues discussed under each individual programme component while general issues

⁶ Composition of the team: Reproductive health team member with MD, M.Sc., gender person with Ph.D. in Anthropology and women studies, and population & development person with a PhD in Rural Sociology and Demography.

relevant to the overall programme design (2.1) and management and partnerships (2.2) were discussed in the beginning under the evaluation findings of the country programme. Conclusions and recommendations for the three focus areas are discussed in section 3.

Appendices include TOR, CP2 programme components, evaluation questions, capacity development outputs under PD, additional recommendations, list of persons interviewed, and documents reviewed.

2.0 EVALUATION FINDINGS

The second country programme (CP2) has ten outputs that are expected to contribute to achieving four outcomes under the three key programme components (RH, PD and Gender). These are presented in figure 1 as well as in Annex 2. Several strategic interventions are employed to achieve these outcomes.

The following section discusses the programme design and the management issues in general. While these are common to the overall CP2, each separate programme component will also provide a brief on program design and management that are specific to the individual programme under the relevant section.

The evaluation of the program design and program management is based on the contextual analyses of the CP2 document, CP Action Plan (CPAP), Standard Progress Reports, Annual Work Plans, interviews and discussions held during the evaluation.

2.1 Program Design

The Country Program Action Plan (CPAP), based on the Country Program Document (CPD), is designed in line with the Government strategic priorities, UNDAF, UNFPA strategic priorities, ICPD, MDGs, and business plan. Indicators and targets provided in the results and resources framework in the CPD and CPAP were followed to assess the programme results achievement.

As part of the overall programme design, issues related to national ownership, capacity building and gender mainstreaming are discussed here.

The following schematic presentation of CP2 shows the relationship between the proposed outcomes, and the associated outputs. The design, as indicated in the CPAP follows clear program logic with identified strategies and partners to implement the interventions. In general, viewed from a results-based management (RBM) perspective, the program design, as illustrated in the CPAP, has laid out the targets, indicators and measures to follow performance. However, while some outputs are sufficiently specific and are measurable by the available information, some components have ambitious indicators which are not able to capture easily. These specific examples will be discussed under the individual programme components. Some of the indicators are too general and baseline data are incomplete. Also, some important indicators are missing or limited, for example, those for assessing the extent to which services, policies and programs are rights-based and gender-sensitive. Qualitative indicators to measure processes are limited in the design.

National Ownership: UNFPA strategic direction focuses on supporting national ownership, national leadership and capacity development as well as advocacy and multi-sectoral partnership development. The strategic direction also guides UNFPA with regard to results-based management, UN reform,

knowledge sharing, and resource mobilization. Line ministry involvement in the planning and designing of the CP has enabled the ownership, however, heavy dependency on external human resources may have impeded the ownership to a certain extent as the short-term consultants complete the assignments on behalf of the line ministries without much input and participation of the national counterparts. This depends on the management as well as the individual consultant and the national counterpart. It was observed some partnerships to be productive and empowering.

Capacity development: Building in capacity development component into the CP is at the heart of CP design. How and what program aspects can be absorbed into the main government mechanism is part of the design that needs to be clear from the programme inception. However, interventions supported by UNFPA, CPAP and AWP do not spell out an explicit exit strategy which indicates that UNFPA support will be continuing without an end date. Although UNFPA designs the programme in close consultation with the government and works alongside government institutions to ensure capacity development of human resources for institutions to pave the way to sustainability of the different programme components, the design needs to take into consideration the heavy dependency on international consultants in the implementation of CP2.

Gender Mainstreaming: A strong, continued commitment to gender mainstreaming is one of the most effective means for the United Nations to support promotion of gender equality at all levels - in research, legislation, policy development and in activities on the ground, and to ensure that women as well as men can influence, participate in and benefit from development efforts. There is a continued need, however, to complement the gender mainstreaming strategy with targeted interventions to promote gender equality and women's empowerment, particularly where there are glaring instances of persistent discrimination of women and inequality between women and men.

Where relevant, evaluation assessed the extent to which data disaggregated by sex were used for planning and assessing programme/project and extent to which programme/project promoted gender mainstreaming.

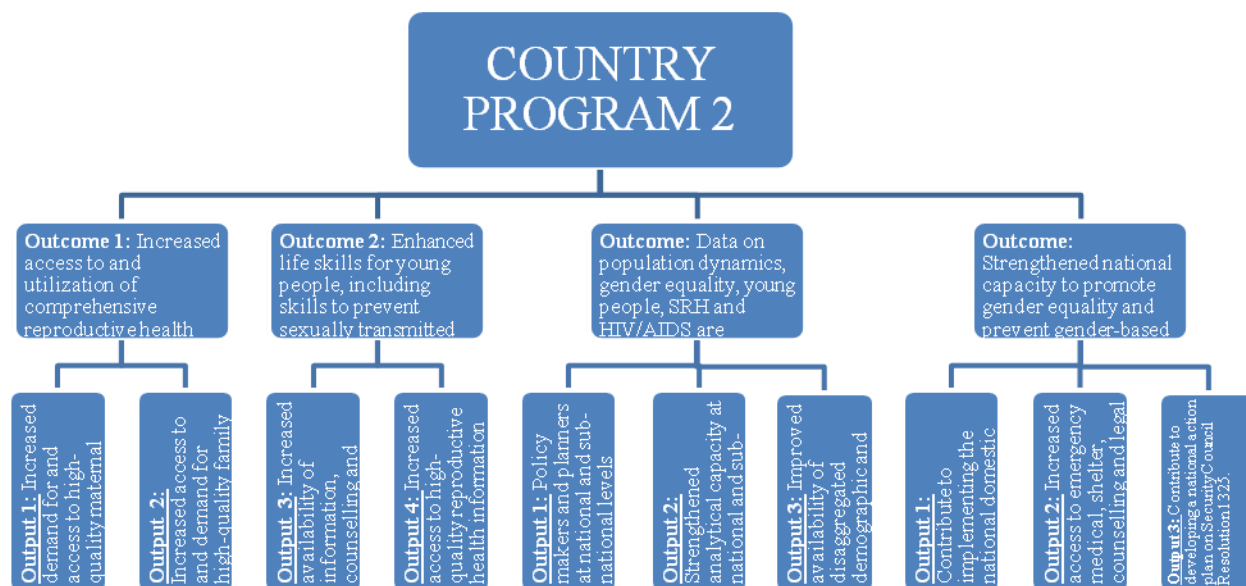
The country programme design has considered gender mainstreaming at the planning stage of large surveys which provide key data for national planning. DHS and Census made an effort to collect and analyse sex-disaggregated data to enable gender analysis and interpretation. The DHS provides a detailed gender analysis on large portions of the raw data collected. These are useful towards policymaking. In addition, there was sensitivity for the gender biases in data collection and enumerators of the survey consisted both male and female.⁷ For example, in the area of education and literacy, gender-disaggregated data on gender parity index in school attendance ratios, educational attainment, repetition and dropout rates, as well as literacy rates were collected providing gender specific data for planning. The DHS also includes data on knowledge of HIV (*human immunodeficiency virus*) prevention methods disaggregated by sex. DHS, for the first time, includes a separate chapter on Domestic Violence, including information on prevalence rates by age, marriage, types of violence, district, as well as attitudes of men and women towards violence.

In general, CP2 program design is based on a well thought out programme logic with specific outputs that are logically linked to planned outcomes and long-term impacts. Qualitative indicators to measure processes are somehow not well presented in the design. There was no mention of any evaluability assessment at the programme design stage.

⁷ Forty percent enumerators were females.

Based on the ICPD framework on integration of RH, PD and Gender Equality, the linkages between the RH, Gender and PD components appeared to be well in place in the plans. However, may be due to the limited human resources, cross fertilization and dialogue among those who implement the programmes are seemingly weak and this is discussed further in the programme management section.

Figure 2. Overall Schematic Representation of the Second Country Programme (CP2)



Source: UNFPA Country Office, Timor Leste

2.2 Programme Management and Partnerships

The success of the UNFPA country programme depends on the national partners as the implementation lies with them. At the apex level UNFPA is guided by the Ministry of Finance with regard to policies and financial procedures and operations of UNFPA support to the country. UNFPA operating modality is direct budget support to the Government and other IPs. Some activities like DHS were by pooled financial facilities and direct funding of NGOs who are IPs on agreed activities in AWP.

In the UNFPA CP, commitment and support of the implementing partners contributed positively in achieving anticipated results. However, some delays in getting the AWP approved were reported by programme officers (POs). According to their feedback, these delays have not impacted the programme negatively, but they would prefer that the AWP are approved on time so the planning can be done according to schedule.

Lack of a systematized opportunity to meet face-to-face, such as a monthly meeting, to discuss and share information among UNFPA POs limits the cross-fertilization of RH, Gender and PD components. Current mechanisms of sharing information via email and progress reports were inadequate according to POs' feedback. Quarterly meetings are held to discuss special activities, such as preparation of DHS, Census, special seminars etc., but do not provide a forum to discuss the routine work on a regular basis.

All the POs felt that more frequent meetings, rather than quarterly, would be beneficial to the programme.

The UNFPA strategic direction focuses on supporting national ownership, national leadership and capacity development as well as advocacy and multi-sectoral partnership development. UNFPA is operating at an upstream level, using its comparative advantage, notably in supporting the accessibility and availability of quality data for evidence-based planning in the three programmatic areas (RH, Gender and P&D). UNFPA partners with key stakeholders, such as MOF, MOH, WHO, UNICEF and MOE, and donors to provide much needed data base for the country. UNFPA has the mandate to support countries in using population data for policies and programmes to reduce poverty and to ensure safe motherhood and that every young person is free of HIV, and every girl and woman is treated with dignity and respect. Under this CP2, support is provided by placing an international technical advisor and trained national staff and other input to enhance capacity to conduct national surveys, analyses, and dissemination of results. An area that need attention is targeted technical input and sustainable capacity building, upon careful capacity gap assessments, in relevant sectors to ensure that population data are well integrated and reflected in planning documents. Although data are available, technical capacity and skills to integrate the data for sector planning and monitoring still need attention and guidance.

While the above discussion was on the overall programme design and management issues, the following section presents the evaluation findings under the three programme components separately, namely Reproductive Health, Population and Development, and Gender. First, the program design issues and programme management and partnership issues that are specific to the programme component will be discussed very briefly, and then the strategies for achieving results/outputs will be assessed using DAC evaluation criteria, namely relevance, efficiency, effectiveness and sustainability.

2.3 Reproductive Health

2.3.1 Context

Timor-Leste is a young country, having survived a political conflict spanning over two decades. In the area of reproductive health, there were issues to be addressed. According to the DHS 2009-10, the maternal mortality ratio estimated at 557 deaths per 100,000 births⁸. Approximately two-third of maternal deaths was a result of complications arising from pregnancy, delivery and post-delivery, and the other one-third was a result of indirect causes such as anemia, malaria or malnutrition. The 2009-2010 DHS showed a declining trend in infant mortality at 83 per 1,000 live births, and neonatal mortality was at 36 per 1,000 live births⁹. Peri-natal mortality, which is an important indicator of care during pregnancy and delivery, was estimated at 18 per 1,000 pregnancies¹⁰, a decline from 43 per 1,000¹¹ ten years earlier.

Timor's healthcare system was facing a number of challenges, of which one was the dire lack of human resource at all levels (e.g. doctors, midwives, specialist doctors, etc.). Currently, the government is addressing this issue by various national policies and strategies to improve the health care services including SRH. More than one thousand medical students have been sent to Cuba for MD training.

⁸ Timor Leste Demographic and Health Survey, 2009-10, page 112

⁹ Timor Leste Demographic and Health Survey, 2009-10, page 101

¹⁰ Timor Leste Demographic and Health Survey, 2009-10, page 105

¹¹ Source: Country Program Action Plan, Timor Leste 2009-2013, page 4, cited from DHS 2003

Midwifery training program was developed and has been conducted in the University of Timor Leste. Health workers have been sent for graduate training in other countries including Malaysia, Philippines, Indonesia, and Papua New Guinea.

2.3.2 Programme Design (RH)

According to the CPAP, two outcomes and four outputs were planned as mentioned above.

The outcome 1 indicators have been identified as follows:

- Maternal mortality ratio
- Total fertility rate
- Increased contraceptive prevalence rate
- Increased % of births by skilled attendants

The outcome 2 indicators have been identified as follows:

- Decreased adolescent fertility rate (15-19 years)
- Percentage of youth with comprehensive knowledge on HIV/AIDS

In keeping with the above, the 04 outputs included under the RH component are as follows:

Output 1: Increased demand for and access to high-quality maternal health services, including emergency obstetric care.

Output 2: Increased access to and demand for high-quality family planning services.

Output 3: Increased availability of information, counselling and services for populations most at risk, to promote healthier and safer behaviour.

Output 4: Increased access to high-quality reproductive health information and services for young people.

Comments for the RH program design would be about the indicators at outcome and output levels and some statements. The four indicators of outcome 1 were not of the same level. The indicator “maternal mortality ratio” is a big indicator that could be achieved by improvement of series of proxy indicators, of which “increased % of birth by skilled attendants” is just one. This is the case for the rest two indicators of outcome 1. At CP output level, some indicators were not developed as “SMART”¹². For instance, an indicator was stated “Caesarean sections as a percentage of all live births”, which was not measurable. In addition, these indicators did not reflect high quality services as stated.

2.3.3 Programme Management and Partnership (RH)

The RH component was implemented in partnership with the Government sectors including the Ministry of Health, Ministry of Education, and Secretariat State for Youth and Sport, Faith Based Organizations,

¹² SMART: Specific, Measurable, Assesible, Relistic, and Timebound.

women's groups and youth organizations. South-South collaboration with other UN agencies was conducted through joint programming and the Thematic Groups. For those who are the implementing partners, a Memorandum of Understanding was signed between each and every of them with the UNFPA CO on the program implementation and coordination. For civil society organizations, Funding Agreements (FA) with the UNFPA CO was the documents signed prior to execution of projects.

The budget was managed directly by UNFPA CO under Direct Execution mechanism. Annual workplans were developed by the implementing partners in consultative workshops involving concerned stakeholders. Budget was transferred to the implementing partners based on the requested activities. The UNFPA CO kept all original financial documents for recording and reporting purposes.

2.3.4 Outcome One (Programme Relevance - RH)

Increased access to and utilization of comprehensive reproductive health services, including those focusing on maternal health, family planning, and the prevention of sexually transmitted infections and HIV, especially for vulnerable groups.

Relevance

CP2 was designed taking into account that Timor-Leste is a young country characterised by specific challenges in the areas of reproductive health and family planning. After independence, the newly-installed Government developed a number of policies and strategies to address these shortfalls. In particular, Outcome 1 was formulated to be aligned with key priorities of the major policies and strategies in the National Reproductive Health Strategy 2004-2015, the Health Sector Strategic Plan 2008-2012, and the National Family Planning Policy. The interventions under output 1 was assessed to be aligned with the national priorities that were identified in the core areas of the Strategies 3 and 9 of the HSSP 2008-2012 and four components of the NRHS 2004-2015. The output 2 (Family Planning) was fully aligned with all three components of the NFPP (see appendix 8 for more details).

Outcome 1 was relevant in another respect since it falls within the UNFPA mandate as reflected in the design of the country programme documents which were built on specific strategic plans and frameworks of the UN, in general and UNFPA, in specific. Firstly, the SRH and FP interventions of Outcome 1, which have been built on UNDAF 2009-2013 and guided by the goals and targets of the Millennium Declaration, clearly reflected and responded to the national situations as outlined in the MDGs with 12 key challenges identified at the point of time in which the CPAP was formulated¹³. Secondly, the activities are strongly in line with Outcomes 1, 2, and 3 of the UNFPA's strategic plan 2008-2011. This, in turn, has been important for accelerating the process and promoting national ownership of the ICPD PoA. The RH interventions support all the outcomes of the Strategic Plan under the overarching goal of universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life. Finally, the RH component reflected the UNFPA SRH Framework that was developed in May 2008. Hence, the RH component was found to be highly relevant to UNFPA's mandate.

In summary, Outcome 1 was designed with appropriate consideration of the national healthcare system. Hence the interventions matched the actual needs of the healthcare system in terms of improving SRH and FP services provision as well as raising the demands for and utilization of services among people.

¹³ Country Program Action Plan, UNFPA in Timor Leste

Moreover, the issues prioritized by the Timorese government and health sector during the period of 2005-2015 have received crucial financial and technical support. The mandate of UNFPA has also been taken into account in the design of CP2 in the areas of SRH and FP and, therefore, technical support from UNFPA has been maximized in the actual implementation.

2.3.4.1 Output One

Increased demand for and access to high-quality maternal health services, including emergency obstetric care.

The output was designed with the aim of improving maternal health service provision and enhancing the utilization on both supply and demand sides. Given the situation of SRH care in a country characterised by a number of challenges in resources for healthcare including SRH, the maternal health interventions of CP2 focused on supporting the healthcare system in six areas: human resource development via pre-service training, in-service training, graduate training of health service providers on SM and EmOC, support to provide high-quality BEmOC and Comprehensive EmOC services in health facilities nationwide, and increase access to and demand for skilled birth attendance and delivery at healthcare facilities. After three and a half years of implementation, progress has been made with obvious achievements although there was room for improvement in terms of effectiveness, efficiency and sustainability in all the interventions undertaken under this output.

Effectiveness:

The effectiveness of SRH implementation is assessed in light of its achievements in the areas of capacity building in the healthcare system and in the provision of services and advocacy for changes among policymakers, and access of services by the community.

Capacity building:

Capacity building for the healthcare sector in service provision was reflected in the implementation of CP2 through the training of health service providers on EmOC, supplied medical equipment for EmOC at all levels of health care facilities with more focus on the Community Health Centers, technical assistance by International OBGYN specialists at national and district referral hospitals and midwives at lower levels, and technically supportive supervision to health facilities. Because of time constraints in this evaluation, quantitative data collected with the aid of structured questionnaires could not be gathered. In addition, the lack of CP2 baseline and endline surveys was an obstacle as it prevented the team from examining the quality of these capacity building activities in greater depth. For example, it was not possible for the team to discuss the changes in technical skills of health service providers as well as utilization of the supply that interventions of CP2 provided, or any other impact made over the short period of time in which CP2 was implemented. Instead the evaluation is based on data collected via qualitative methods and a review of the secondary data gleaned from programme reports and records.

Over the past 3 and a half years in which CP2 was implemented, UNFPA supported the health sector in conducting a series of in-service training of health staff on BEmOC at all levels based on the actual staffing situation of the different levels and absorbability of these staff. The training programme conducted by CP2 was based on international standards outlined in “Managing EmOC” which was generated by WHO. A Needs Assessment on EmOC conducted in 2008 provided inputs to the development of the EMOC programme. As such, the training modules were adapted to fit with the learning capacities of the local trainees. Accordingly, a five-week training course was conducted, consisting of a “theory” component which lasted for three weeks and a “practice” component which lasted for two weeks. The trainer was a Nepalese Obstetrician contracted by MoH and paid by UNFPA.

Because of the lack of medical doctors especially at the district and sub-district levels, the organization of training courses was planned aiming at maximizing the resources on midwifery training on BEmOC.

Technical training was provided to health staff of all levels. At the national level, all medical doctors and midwives of the Maternity department at the Dili hospital were trained on BEmOC. For the district referral hospitals and sub-district CHCs, at least two health staff members from each facility received training on BEmOC. Up to August 2012, all 65 CHCs and five referral hospitals have already had their staff receive in-service training in Dili Hospital. A total of 332 out of 420 midwives nationwide have undergone training on BEmOC. As a result of this training, a medical doctor from Dili hospital now could work together with the International Trainer as a co-trainer while a midwife served as a facilitator at these training courses. Refresher training courses on BEmOC were also conducted to review and reaffirm technical knowledge and skills of those who had undergone previous training. Nevertheless, in 2008, despite a plan to develop a pool of local EmOC trainers, MoH expressed their concerns that it was too early to identify local EmOC trainers at that time as there was a lack of qualified health staff¹⁴. Hence, all the training courses were conducted by international trainers. As a result, the plan for a Training of Trainers on EmOC was delayed.

Other types of training were supported by the CP2 in an effort to address issues of lack of high quality human resources in the OBGYN areas and the poor status of health facility-based delivery. Training on safe and clean delivery for nurses were conducted so as these people would be able to help with home deliveries. To strengthen the midwifery training in the country, support was given to the establishment and equipping of the skills lab at the midwifery school and development of the clinical training materials. In response to the lack of high-quality health service providers in CEmOC, fellowships were given to Timorese general practitioners for graduate training abroad under CP2. Likewise, fellowships were also granted to a number of students for in-country undergraduate managerial training on public health. Despite these efforts on capacity development, two technical areas which continue to lack local clinical practitioners were Fistula treatment and cervical cancer screening. According to feedback received from POs, the issue here was that although there was a General RH national staff (MOH midwife) in charge for this programme, policy and strategies, protocols and guidelines are still not in place for the midwife to actively work and would need technical assistance to function better.

It is noted that the training for nurses on Safe and Clean delivery aligned the CP2 activities with the factual condition of the health sector in terms of availability of the human resource. Nevertheless, it could be only a quick response to the situation as the main functions of nurses do not include birth attendance. Besides, the nurses were not provided with pre-service midwifery specialty training, a five-week in-service training course is never enough to equip them with sufficient knowledge and skills for management of obstetrical complications. In the mean time, complications may happen regardless where the delivery takes place. Another issue could be the referral sometime might be delayed due to some over-confident nurses because they have received BemOC training. Apparently, midwives were still essential at Suco or village level and there was still room for further support.

Technical assistance provided to lower-level health facilities under the CP2 included supportive supervision and making comprehensive obstetrics and gynecology services available by an on-spot International Technical Specialist in OBGYN. The supportive supervision system was initially developed with a checklist for EmOC supervision developed and ready for use. Thirteen qualified staff members

¹⁴ IDI with Department of Human Resource, MoH, Timor Leste

who received EmOC training were selected and trained on EmOC technical supervision. Supportive supervision missions have been conducted since early 2011 to the health facilities in six districts providing valuable technical assistance such as the correction of technical skills to health service providers. Regarding the on-spot international obstetricians, a pilot model were launched under CP2 in 4 hospitals, including the Dili hospital, and 3 other district referral hospitals notably in Suai, Maliana, and Maubisse. This pilot mostly a crucial source of technical expertise as it ensures immediate response to cases and, more importantly, coaches the local staff on their daily technical tasks.

Finally, an essential part of building capacity for the health sector was the supply of EmOC medical equipment, maternity packs, and ambulances to relevant health facilities. It was reported that half of the CHCs nationwide, 4 piloted referral hospitals, and the OBGYN department of Dili hospital had been provided with BEmOC medical equipment and simultaneously the staff at these facilities were trained on how to use the equipment. At the health facilities visited by the ET, EmOC instruments were available and in use. Maternity packs were procured and provided to all health facilities at all levels which enabled the health facilities to make deliveries safer. Ambulances and multi-purpose cars were also provided to CHC and referral hospitals so as to make it possible for more people especially in the rural areas to access the health facilities since the infrastructure tends to be generally poor in the country.

Because of the above-mentioned interventions, we may come to a conclusion that CP2 has contributed considerably in improving comprehensive capacities especially in EmOC. Technical knowledge and skills of healthservice providers have been raised, essential equipment and drugs were available at all levels in the health facilities, ambulances were provided and in use. Consequently, it was reported that fewer cases were referred to higher levels, contributing to shortening the time taken to access services. These efforts helped the health sector improve two delays in utilization of EmOC services that are delay in having access to care due to bad transportation and delay in service provision due to lack of resources.

Advocacy

Advocacy was the backbone of CP2 with the aim of creating changes in the policy environment as well as raising awareness of policymakers, health managers, and community people in regards to SRH care. Steps toward advocacy undertaken in this output include collecting and utilizing data, reviewing and revision of the related national policies and the development of new policies and strategies, raising capacities and awareness of policy makers and managers through attendance at related international events, and organizing advocacy campaigns at national and grassroot levels.

Data related to SRH were collected through various channels including official national surveys health studies conducted under the CP2 implementation. Information about men and women of different reproductive ages, maternal mortality, and morbidity were included in the census survey variables. Indicators of the SRH were integrated in the Demographic and Health Survey. Besides, the HMIS and Family Health Registry systems were important sources of routine data collection. Thematic studies on the topics of SRH were also conducted. Data collected via these channels were analyzed and distributed to relevant stakeholders for planning and monitoring. UNFPA's CP2 has provided enormous financial and technical support to these channels of data mining. Results were disseminated to concerned stakeholders via series of dissemination workshops and events

Together with support on data mining, the output provided support to advocacy, review, and revision of the national SRH-related policies and strategies. During the first three and a half years of implementation of CP2, the programme obtained a number of achievements in incorporating SRH into national policies. Firstly, the National Priorities Outlines developed in 2010 by the new Timorese

Government placed importance in SRH care as one of the major components to be strengthened. Secondly, SRH issues were well integrated into Timor-Leste's Strategic Development Plan for the period of 20 years from 2011 to 2030. Thirdly, taking into account the mandate of UNFPA, CP2 played a convening role in SRH technical assistance to the Government in preparation of the annual MDG report. Next, the CP2 provided support to MoH in terms of advocacy for and development of the Timor-Leste National HIV and STI Strategy for the period of 2011- 2016. Last but not least, in order to inform the new Government about what UNFPA has been doing to support Timor-Leste, a Development Partner Handover Report was prepared by UNFPA in close coordination with the National Directorate for Aid Effectiveness and in the South-South collaboration with other international development partners. This assisted the new Government to be better aware about reproductive health issues and the role of UNFPA. To this end, it could be expected that further action plans would continue from what had been already achieved.

One of the important advocacy efforts under CP2 targeted at the policymakers and health managers involved exposing them to international standards and best practices. Parliamentarians, Ministers, and Directors General of concerned departments, as well as high-ranking officials received support from UNFPA to attend international events such as training workshops on SRH, FP, international conferences on Safe Motherhood, and so forth. These paved the way for greater collaboration and cooperation among various stakeholders to create better changes. Advocacy campaigns to advocate for EmOC care, STI/HIV prevention were conducted targeting community leaders, religion leaders, and community people.

In summing up, Output 1 under the SRH outcome of the CP2 made great progress on advocacy for changes in the areas of SRH care. The advocacy efforts were made via various channels including technical assistance in evidence-based advocacy with greater utilization of academic data, global experience and best practice exposure through international related events, and community outreach advocacy. The efforts have resulted in achievements such that SRH issues are now well reflected in important national policies. Moreover, SRH specific policies and strategies have been developed and used as the backbone for further actions. Despite the challenges in securing high-quality professional human resources on EmOC, and government budget limitations for SRH service provision, Output 1 has provided effective support towards the healthcare sector in strengthening services in order to ensure immediate and appropriate responses to needs. Effective advocacy has also contributed in creating a convenient legal framework for facilitating similar interventions and for further development of related programmes.

Efficiency

The efficiency of Output 1 was assessed in relation to the utilization of the programme budget, management of the supplies, management of human resource and international technical assistance, and management of potential duplication and overlaps with other development partners' interventions. A total budget of US\$4 million was approved for the all RH components throughout the programme cycle. Each output under this component was allocated US\$1 million over the five-year implementation period.¹⁵ Ninety percent of the budget comes from UNFPA's regular resource and the rest comes from other resources. The Government's contribution was counted based on personnel, office space, logistics, and regular meetings on programme review and planning. The AWP's were developed and allocated with separate budgets based upon the ceiling approved by UNFPA HQ for each particular year. UNFPA's Timor-Leste CO in Timor-Leste was responsible for managing the budget under Direct

¹⁵ Country Program Action Plan, UNFPA in Timor Leste

Execution modality which entailed that budget was transferred to the relevant counterparts on activity basis as per request.

Donor's contribution projects:

Donors/government	Amount of funds	Projects
Australia	\$449,258.95	PD/RH
New Zealand	\$27,859.65	Gender
Irish Aid	\$50,000.00	PD
Unicef	\$132,000.00	PD
UNDP	\$100,000.00	PD
WHO	\$15,000.00	PD
Finlandia	\$100,297.94	RH
MDG/Spain	\$1,032,513.20	Gender
Compassis/UN	\$285,863.00	RH
UNMIT/DPKO	\$85,600.00	RH
Total	\$2,278,392.74	

Source: Atlas records and reports provided by UNFPA CO

Up until the time of the evaluation, the RH component in general and SRH output in specific achieved positive results in fund raising with the aim of mobilizing funds from other resources as reflected in the above table. Clearly, the RH component in general and the SRH output in specific have demonstrated efficiency in terms of its capacity in budget mobilization.

The AWP's that were developed in full participation of the concerned stakeholders allowed for the budget allocation to match the priorities of the year and absorbability of the counterparts. By reviewing the AWP's, a major proportion of the annual budget was allocated for strengthening capacities of the healthcare sector in EmOC including training, equipment supply, international technical assistance, and training material development. The budgeting was appropriate since the outputs were found to meet the actual needs of clients. Moreover, the budget management modality matched the capacity of the concerned counterparts in financial management that was found limited by the Micro Assessment conducted by the UNCT. Direct Execution mechanism was applied and UNFPA CO was accountable for the programme budget. High implementation rates were made in each year throughout the project implementation period.¹⁶

The supplies including EmOC medical equipment, maternity packs, and transportation provided under the CP2 were planned based upon the results of the EmOC Needs Assessment conducted by UNFPA and MoH in 2008 and on the actual inventories from each health facility. The supplies were procured by UNFPA HQ and distributed by the UNFPA CO and MOH. Training on equipment use was conducted for all relevant staff members so that they would be able to put the equipment to use immediately. In fact, the supplies were assessed to be adequate to meet the demands of the specific hospitals, CHCs, Suco Health Posts, and mobile teams. Nevertheless, on the visits to the selected health facilities, it was found that because of the lack of patients at the sub-district levels, the provided items were not usually used nor sterilized unless there was a patient who needed the relevant services.

In an effort to respond to the EmOC care system in Timor-Leste, UNFPA CO recruited a number of international OBGY specialists from abroad to provide daily technical support to the health care sector at different levels. These include an EmOC trainer was working under a contract with the MoH while being paid by UNFPA, a team of surgeons to conduct Fistula operations in Dili hospital, three UNV international specialists to work at three referral hospitals, and two international consultants employed directly by UNFPA's CO. These people provided remarkable assistance to technical capacity building for the local health service providers through training, technical supervision and on-spot technical coaching,

¹⁶ Source: Atlas records and reports of UNFPA provided by UNFPA CO

making services available and accessible, and strengthening the SRH programme management and implementation.

As a new country marked by numerous challenges, the efforts of various development partners and international donors were critical in improving the health sector. Duplication and overlaps, therefore, would be inevitable. The implementation of activities under CP2 was not an exemption. Nevertheless, these duplications and overlaps were well managed among the partners from both the UNFPA and Government sides. This management was effectively done via South-South collaboration among international donors and development partners, agreement among agencies working on the same areas such as WHO, UNICEF and UNFPA, and the active coordinating roles of the MCH department.

In summary, Output 1 contributed much on maximizing the resources to ensure the efficient utilization of the budget. Budget mobilization, allocation, and management were carried out based on the actual needs and capacity of the counterparts. The supplies were provided appropriately to meet the demands of the situation together with raising capacity of equipment utilization. Overlaps were well managed by both UN agencies and Government counterparts. Generally, it may be said that the funded provided under CP2 were utilized efficiently.

Sustainability:

The assessment of the sustainability of the intervention examines three aspects over the period of implementation. These include the current policy environment of the country, capacities of the health sector to take over the interventions, and the budget from the Government regular resource for further maintenance of what have been done. A note was also made on the points of exit mechanism of the interventions once the CP2 phases out.

Policy environment:

Over the last 5 years with support from UNFPA and other international donors and development partners, the Timorese Government created a remarkable policy environment for SRH care system to flourish. The key issues of SRH including EmOC, SM, and RH in general were well reflected and integrated into the National Priorities and the National Development Strategy as discussed in the advocacy section as above. This would ensure that the health sector and other organizations working in the same areas would prioritize these areas for action in the future. Moreover, a Handover Report of UNFPA was developed and presented to the new Timorese Government so that the latter would be well informed about what areas of SRH, UNFPA has been working on since UNFPA has been recognized to be a key player in RH/FP areas, their interventions would certainly be recognized in the next period of development. In addition, South-South collaboration and national coordination resulted in greater opportunities for SRH interventions by both the national health sector and international organizations. Apparently, the policy environment is convenient for further SRH care interventions in the future.

Capacities of the health sector

The technical and managerial capacities of the health sector would indicate the readiesses to handle the tasks once supports from UNFPA and other donors are withdrawn. In this evaluation, capacities are reflected through the technical knowledge and skills of health service providers in the provision of EmOC services, inittitives asorbeb and managed by MoH, and the presence of high quality technical experts.

Regarding the technical knowledge and skills of service providers in EmOC, midwives at all levels went through at least a five-week in-service training while some received refresher training. It was assumed that the training has equipped them to handle the jobs at midwifery level with a degree of technical supervision. Moreover MoH established a pre-service midwifery training programme under the Faculty of Medicine and all health Sciences at the UNTL focusing on long-term midwifery human resource development with support from CP2 in the development and printing of training materials. Because of this programme, the availability of skilled midwives could be ensured.

Several achievements and human resource in the SRH areas were handed over to Timor Leste by UNFPA. The initiatives on EmOC program supported by UNFPA are being taken on board by the Timor Leste Institute for Health Sciences and other stakeholders, a good opportunity for the interventions to be replicated and sustained. Among staff members recruited and trained by UNFPA over the two country programs, one person has been absorbed by the MOH and now working as the MCH Assistant Coordinator. This could be assessed as a sustainable contribution of UNFPA to the MOH in terms of human resource development.

In order to continue the enhancement of technical skills of trained midwives on EmOC, it is essential that technical supportive supervision be provided regularly. CP2 took this into account and as a result developed tools for technical supervision, provided training to supervisors, and provided support to ensure that the supervision system is in place. Nevertheless, the practicing started since late 2011 as discussed was not long enough to secure technical skills of the supervisors and well functioning of the system.

In contrast, the knowledge and skills at the doctor level were still limited because of the lack of local medical doctors in general and OBGYN specialists in specific. The limited supply of medical doctors was beyond the control of CP2 efforts; in spite of this obstacle, capacity building continues to be important in the areas of professional human resource and technical supervision. It must be noted that there were also no local trainers on EmOC to build the capacities of their colleagues. For this reason, high quality human resource for EmOC tend to be filled by expertise from abroad. Moreover, an OBGYN specialty doctor training programme was also not in place challenging the long-term human resource development for EmOC. In addition, supervisors at the doctor level were still lacking. These constraints limit the sustainability of the EmOC intervention.

Financial resource:

The most important aspect of sustaining the interventions is a regular budget from the Government for EmOC full program. Currently, as a newly independent country marked by poor infrastructure, the Government is facing a burden of building new facilities and roads. Moreover, in its effort to train medical doctors, the Government has allocated a considerable budget for ongoing training of more than 1,000 medical students abroad.¹⁷ To be expected, these efforts are bound to consume a huge proportion of the state budget. Hence it comes as no surprise that Timor-Leste will continue to rely on donors for EmOC and SM interventions instead of depending on government budget.

In summary, even though CP2 attained achievements in improving EmOC service provision in Timor-Leste, because of constraints in human resources and the lack of a regular budget from the Government, personnel from the health sector reported that without support from UNFPA and other donors, they are unlikely to be ready to take over the activities implemented under CP2. This means that UNFPA may

need to continue their support in the areas of capacity development and advocacy before the activities could be completely handed over to the health sector.

2.3.4.2 Output Two

Increased access to and demand for high-quality family planning services.

Effectiveness

Similar to the SRH output, the effectiveness of FP interventions has been assessed in regards to achievements in capacity building for the healthcare system in terms of the provision of services and advocacy for changes among policy makers in policy development and implementation, and access to services among the community.

Capacity building:

Capacity building for the health sector in FP service provision is reflected in CP2 through the training of health service providers on the provision of modern contraceptives, training of counselors and nuns on family counseling in the Catholic clinics, post-training technically supportive supervision to health facilities, capacity building and technical support to LMIS system ensuring uninterrupted supply of FP modern commodities at all levels in the healthcare facilities. Because of time constraints in undertaking this evaluation, quantitative data collection methods complemented by structured questionnaires could not be conducted. In addition, the lack of CP2 baseline and endline survey data also prevented the team from undertaking an in depth analysis of these capacity building activities. In this regard, it was not possible for the team to discuss the changes in technical skills of staff and utilization of the supply that was provided under CP2. Instead the discussion here is based mainly on data collected via qualitative methods and a review of the secondary literature consisting mainly of programme reports and records, particularly the DHS 2009 and the National Family Planning Programme Evaluation conducted in 2010. However, the FP evaluation in 2010 was to evaluate the MoH FP program and it might cover all support from different donors but not only that of UNFPA. Hence, it could not serve as the 'endline survey' for this CP2 Evaluation.

In continuity with the previous CP, over the last three and half years, CP2 supported the health sector in conducting a series of in-service training for health staff including midwives and nurses of public and private sector and mobile teams (SISCA) on FP clinical skills and counseling. Nevertheless, according to the recent FP evaluation report in 2010, it was found that "*none of the physicians had FP training, 74% midwives and 42% nurses*" (Family Planning Program Evaluation, Timor-Leste 2010). Taking into account this finding, it was reported that some local doctors at Dili hospital had been trained on tubectomy and vasectomy. An impressive finding in this evaluation was that the Church counselors and nuns also received training on clinical service provision and counseling skills for modern family planning methods in Catholic Clinics, which showed strong support from the religious sector. Capacity building and technical support to LMIS system were also conducted to strengthen the capacities of the healthcare sector in the projection and distribution of contraceptive commodities, as part of FP commodity security strategy. According to the FP Programme Evaluation 2010, although capacity was strengthened, the LMIS implementation was still weak in regards to collecting up-to-date data on the Average Monthly Consumption since it was found that there had been an overstock of commodities in some DHSs (Family Planning Program Evaluation, Timor Leste 2010, page 6). It must be noted, however, that CP2 and MoH were largely successful in regards to strengthening capacities in the area of FP.

Another important effort made under CP2 is the provision of technically supportive supervision to lower levels on FP services. Technical supervision capacity of providers and counselors at all levels was

developed, and the tools for FP supportive supervision were developed and distributed. Supportive supervision missions have been conducted vertically. At the national level, a doctor from MCH who was in-charge of FP worked in close cooperation and collaboration with staff members of the UNFPA CO to conduct monitoring and supervision visits to the district and sub-district CHCs. Supervisors at district level regularly conduct supervision visits to sub-district and Suco level.

Another essential part of capacity building for the FP system was the supply of modern contraceptives. A Memorandum of Understanding (MoU) to ensure the supply of modern contraceptives was signed between the UNFPA CO and MoH. Accordingly, CP2 ensured the provision of modern contraceptives including the IUD, oral pills, implants, DEPO, and condoms. These commodities were distributed to all health facilities at all levels, as well as SISCA, the private clinics, and the Catholic clinics and, as such, these FP methods were available and accessible to the community at large. In addition, arm models and tools for education were also procured and provided to CHCs and health posts for counseling. The ET also had the opportunity to observe the availability and provision of contraceptives at selected referral hospitals and CHCs. It was confirmed that local people now have various choices in regards to child-spacing and numbering.

Because of all the above-mentioned interventions, CP2 contributed remarkably in raising the capacities of the FP system. Technical knowledge and skills of the service providers and counselors were raised through various trainings followed by regular supportive supervision. Modern contraceptives and equipment available at the different health clinics including public, private, mobile services, and civil society sectors, enhanced the access to FP services. It may be concluded that the choices available in the various clinics provided by skilled providers and the greater ease at which these services may be accessed was a significant achievement of CP2.

Advocacy:

The advocacy efforts included data collection and utilization, the reviewing and update of national policies and the development of new policies and strategies, and the raising of capacities and awareness among policymakers, managers, and religious leaders.

Data related to FP were collected through various channels including national surveys in general and health studies in specific. Information about TFR, CPR, and men's and women's reproductive ages were included in the census survey variables. The Demographic and Health Survey included an analysis of the comprehensive indicators of FP in a single chapter which discussed issues and facts of FP in the country.

During the programme cycle, CP2 provided support to a number of studies on FP namely the "*Family Planning and General Reproductive Health: Quantitative and Qualitative Analysis, 2009*", the "*Family Planning Programme Evaluation Timor Leste 2010*", and the "*Logistic Management Information System Evaluation in Timor Leste, 2012*", all of which provided more information on the actual implementation of the FP programme. Data collected through these channels were analyzed and distributed to relevant stakeholders for planning and monitoring. Besides, the LMIS and the Family Health Registry system were important sources of routine data collection. UNFPA's CP2 provided enormous financial and technical support to these channels.

Results from data collection, analysis, and utilization were used towards the advocacy, review, and revision of the national FP-related policies and strategies. The CP2 provided great support to advocacy works such as dissemination of scientific data, reviewing and revision of related policies, conducting advocacy events and activities targeting concerned stakeholders, etc. Especially, CP2 was successful in

advocating the Church in supporting birth spacing in their Pre-marriage counseling sessions and in Catholic clinics and integrating the FP issues into the Family House pre-marital training programme targeting couples intending to get married and the nuns providing counseling on child-spacing and modern contraceptives. This is an impressive achievement of CP2.

As for legal document revision and development, the inclusion and integration of FP into the important national policies were made with crucial support from UNFPA under CP2. Family Planning was incorporated into the maternal health section in the Timor-Leste Strategic Development Plan for the period of 20 years from 2011 to 2030. As a leading agency in the area, UNFPA played a convening role in FP technical assistance to the Government in preparation of the annual MDG reports. Under the support of CP2 a new National Guidelines and Regulations for FP service provision was developed. The FP policy and Clinical Standards document was updated accordingly. Last but not least, FP issues were included in the Development Partner Handover Report prepared by UNFPA in close coordination with the National Directorate for Aid Effectiveness and the South-South collaboration with other international development partners. It was aimed that this report would inform the new Government about FP issues in the country and the efforts undertaken by UNFPA so as the action plans taken by the government would continue from what UNFPA already started. This would also serve as CO exit strategy for sustainability of interventions.

Beside providing technical and financial assistance towards policy advocacy and development, the CP2 created great support to help the policy makers and health managers expose to international standards and best practices. Parliamentarians, Ministers, and Director Generals of concerned departments as well as high-ranking people received support from UNFPA to attend international events such as training workshops on FP, international conferences on Safe Motherhood, and other related events. By attending these technical events, awareness was raised and knowledge was improved in the concerned areas.

In summing up, Output 2 under the SRH outcome of CP2 made great progress on advocacy to bring about changes in the area of FP. Advocacy efforts were undertaken through various channels including technical assistance in evidence-based advocacy as a result of greater utilization of academic data, global experience and best practice provision through international related events, and community outreach advocacy. These efforts resulted in achievements since FP issues were well reflected in the more important national policies.

Behaviour change communication:

To raise awareness of the entire population on FP and to create demands for FP methods, the output conducted a series of BCC and IEC activities targeting different groups in the community. The BCC and IEC activities were conducted, involving civil societies such as NGOs, FBOs, and the Church. Information, Education, and Communication materials were developed and distributed to FP clinics and SISCA teams for counseling. Because of time constraint, the ET was not able to review the contents of these materials. Hence, the quality of messages were not analysed and thus not included in the discussion. However, it was found that the materials paid sufficient value on men's roles in family planning. The focused-group discussions also revealed that men were deeply involved in family planning and they did show good knowledge about family planning methods. In short, it could be said that male involvement in FP was granted sufficient attention in the BCC activities (see Gender Mainstreaming section for more details). This demonstrated when the DHS conducted in 2009 revealed positive changes in people's knowledge, attitude, and behaviors. Accordingly, knowledge of both men and women on all modern

contraceptive methods increased considerably to almost triple as to rates of contraceptive application among married women.¹⁸ Nevertheless, knowledge about and utilization of FP methods were still higher among women than that of men.

In summary, output 2 which dealt with FP produced crucial achievements in terms of raising comprehensive capacities of the system in service and information provision, policy advocacy, and raising the KAP of the community. Thus the activities under this output resulted in positive changes in the area of FP.

Efficiency:

Output 2 had the same figure as in output 1 in terms of budget allocation, fund raising, AWP budgeting, and budget management mechanism thus it is unnecessary to repeat the discussion in this regard. Instead, the discussion will focus on how CP2 was able to maximize costs and how this output managed with duplication and overlaps.

The supply of contraceptive commodities was procured as per request from MoH on an annual basis and reflected in the AWP. This was planned based upon the projection data from the LMIS system that UNFPA has been supporting for years. The supplies, therefore met the actual needs of the country, which was supported by evidence that there was no stock-out commodities found recently as reported by a key respondent from the MCH department. Thus, the cost for supplies was efficiently maximized. This point may be ascertained through the FP indicators revealed in the DHS 2009-10 and reinforced by the policy environment created throughout the programme cycle for FP interventions. It must be noted that the last point was only a subjective thought of the evaluator since this can only be confirmed by a cost-effective/benefit analysis.

As for the management of overlaps and duplication in the area of FP, UNFPA played a co-convening role in the FP working group and supported the regular coordination meetings attended by related partners. MoH, under CP2, played a leading role in the FP working group and the newly established FP/HIV taskforce. These attempts of both UNFPA and MoH were important for preventing overlaps in the FP area. As a result, most of the coordination tasks were done well. Nevertheless duplication related to the work of two international NGOs was discovered in this evaluation. The first duplication was related to contraceptive commodity procurement. This was undertaken by an INGO and provided to MoH with prior consultation with neither the MCH nor UNFPA CO. This unexpected supply was controversial and confusing to MoH since it caused problems for the national projection and supply of the LMIS as well as wastage. The other unwanted duplication was posed by another INGO which designed their FP programme by copying exactly what UNFPA was supporting. Aside from the waste of resources, it also challenged the South-South synergy among development partners in their effort to provide assistance to the Timorese Government.

In summing up, despite the two unwanted duplications caused by development partners as mentioned, other tasks were well managed in a way that maximized aid effectiveness. The evidence-based planning coupled with the direct budget management mechanism allowed CP2 to ensure that its investments appropriately responded to the actual needs. The joint programming in South-South collaboration and participation of concerned partners helped prevent overlaps in both the substantive and geographic areas. The FP output itself of CP2 was assessed to be efficiently implemented.

¹⁸ DHS, 2009-10, page 60 and 66

Sustainability

The sustainability of the FP interventions is assessed according to three areas over the period of implementation. These include: (a) the current policy environment, (b) capacities demonstrating Timor-Leste's readiness in taking over the activities under this output; and, (c) the extent to which the budget from the government enables the continuance of these achievements.

Policy environment

Over the last five years with support from UNFPA, the Timorese Government has created a convenient policy environment to move forward in the implementation of the FP programmes under CP2. The availability of the National FP Policy was the fundamental legal document for further investment. The National Priorities developed in 2010 mentions Maternal and Child Health as a priority and, as part of maternal health, FP would continue to be an area for further investment. This was confirmed in the 20-year National Development Strategy 2011-2030 as discussed in the advocacy section outlined above. The National FP programme evaluation conducted in 2010 showed that FP was considered a priority programme in all districts with high commitment from the leaders. Moreover, religious leaders were also involved and, in fact, this group demonstrated keen support towards the FP programme including the promotion of modern methods. Last but not least, in the Handover Report UNFPA developed and provided to the new Timorese Government, it was stated explicitly that FP appeared to be one of the major prioritized interventions. This represented a crucial effort towards preparedness on the part of the new Government in developing their new policies and priorities during the term and the FP interventions would be continuously receiving sufficient investment by the new Government.

Capacity of the network:

As discussed, the capacities of the FP service provision system in terms of technical knowledge and skills of physicians, midwives, and nurses on FP counseling and service provision was developed. Technical supervision included checklists was conducted by trained supervisors at all levels. According to the FP evaluation in 2010, the service and counseling performance was found to be good and yet there was room for improvement in counseling especially in terms of screening for new clients.

The availability of modern contraceptives in service provision facilities was generally good and stocks were ample at the hospitals and in the majority of DHs and CHCs and half of the health posts,¹⁹ which resulted in successfully meeting the needs and high client satisfaction as to the quality of services provided. Capacity in LMIS was raised yet there were rooms for strengthening the LMIS implementation in relation to AMC to better monitor overstock of commodities at the district and sub-district levels. It was impossible for this evaluation to measure other capacities in commodities storage, procurement, and distribution because of time limitation.

Some notable results created over the last two country program was that some of the achievements of UNFPA supported programs are now being taken by the Timorese MOH. These include the introduced interventions such as LMIS are implemented at national and sub-national levels; a national LMIS officer initially supported by UNFPA is now working under recruitment of the MOH. Obviously, these absorptions showed positive sustainability of UNFPA supported activities.

It must be recognized that financial resources from the Government's regular fund was integral to sustaining FP services in the country. In-depth interviews with key informants and the reviewed

¹⁹ National Family Planning Program Evaluation, 2010

documents revealed that currently FP commodity security in Timor-Leste is lacking because of the absence of a budget line from the Government. Contraceptive commodities and competency skill development for service providers continue to be donor reliant. As such, without financial support from UNFPA or other donors, it was unlikely that the respective government agencies would be able to take over or replicate these tasks independently.

In short, technically the human resource and logistics were prepared to handle FP interventions without or with minimum support from UNFPA. Yet the lack of funding from the government added a level of complication and therefore, there was still a need for UNFPA and other donor support.

2.3.5 Outcome Two

Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies.

Relevance:

Outcome 2 was formulated to be aligned with the priorities outlined in the National Reproductive Health Strategy 2004-2015, the Health Sector Strategic Plan 2008-2012, and the Basic Package for Primary Healthcare, the National BCC Strategy 2008-2012, and the National HIV/AIDS/STIs Strategic Plan 2006-2010. Particularly, the two outputs (output 3 and 4) under this outcome was appropriate with the national priorities identified in the core-cross cutting Strategies 4 and 5 of the Health Sector Strategic Plan 2008-2012. It must be noted that these strategies have been complemented by Strategy 2 (Safe Motherhood) of the Reproductive Health and Family Planning programme policy. The interventions of ARH felt under priorities of the component 1 of the National Reproductive Health Strategy 2004-2015. Essentially, youth were positioned at the starting point of the SRH life cycle according to these two strategies (see appendix 8 for more details)

Other behavior change communication and education on SRH, STD/STI and HIV activities of the outcome 2 found to be in line with the component 3 and 4 of the NRHS 2004 – 2015, that were specifically reinforce by the approaches 1 and 2 of the same document. Likewise, these also matched with the key component in health promotion and behaviour change communication (BCC) at the community level of the Basic Package for Primary Health Care Services, SRH as a priority for investment. The same picture found between the outcome 2 intervention and priorities of the National HIV/AIDS/STI Strategic Plans for the period of 2006-2010 (see appendix 8 for more details)

On the relevance of UNFPA's CP2, clearly Outcome 2 built on the strategic plans and frameworks of UN in general and UNFPA in specific. The interventions were clearly built on UNDAF 2009-2013 guided by the goals and targets of the Millennium Development. Moreover, the outcome built on the UNFPA Framework for Action on Adolescent and Youth in regards to its interventions on Adolescent and Youth Reproductive Health. Key areas identified in this framework were successfully taken into account in the formulation of the interventions.. In sum, the outcome was assessed to be relevant since it reinforces UNFPA's mandate.

In summary, Outcome 2 was designed with appropriate consideration of the national priorities. With consideration of the local culture and religion, the interventions were found to be appropriate to the context. Moreover, UNFPA's mandate was taken into account in the design of CP2 in the areas of SRH, including ASRH and, in turn, technical support from UNFPA was maximized in the implementation of the interventions. It must also be noted that under CP2, the prioritized areas identified by the Timorese Government received support in this outcome under CP2.

2.3.5.1 Output Three

Increased availability of information, counselling and services for populations most at risk, to promote healthier and safer behaviour.

Effectiveness

The effectiveness of this output was assessed in terms of its achievements in capacity building in BCC/IEC implementation, advocacy for changes among policymakers in policy development and implementation, and access to SRH information among the community.

Capacity building

Under CP2, there were efforts to support capacity building among the Timorese through trainings, development of IEC/BCC materials and supply of communication equipment, and technical assistance in planning, implementation, and monitoring and the supervision of BCC activities.

Staff members of the communication system were trained on BCC with UNFPA support under CP2, including training on IEC/BCC materials development and training on delivering RH messages to the communities using IEC materials. The BCC focal points from the district level, nurses and midwives from the CHCs, and health posts and health volunteers at the Suco level were trained on BCC skills. Health managers at the central level had also attended international training workshops on SRH behaviour change communication and IEC development with support from UNFPA.

Monitoring and supervision activities for the BCC strategy were implemented to continue back up staff members on technical skills. Technical assistance was also provided by international experts under CP2. . Nevertheless, it was not possible to assess these competencies in this evaluation because of time constraints as well as the lack of available secondary data. As such, this evaluation does not discuss the extent to which capacity has been improved. However, by strengthening the capacities of BCC networks and by making materials and communication equipment available, it may be concluded that the output contributed in improving the knowledge, attitude and behaviours of communities in SRH care, including STI and HIV. This was confirmed by data documented in the DHSTL 2009-10 which revealed that the KAP of people on STI/HIV had shown improvements over the years.

The process of IEC/BCC materials development was implemented in an evidence-based manner. A baseline study for the National Reproductive Health Behaviour Change Communication Strategy was conducted in 2008 to collect data related to three major components, including general RH, FP, and ASRH. It also explored the actual situation of SRH communication through channels such as the mass media and the role of health workers. The findings were then distributed to concerned organizations for further development of their BCC plans and IEC materials. The IEC/BCC materials were developed with support from UNFPA in terms of design, pre-test, production, printing, and distribution. Various types of IEC/BCC materials were developed for different channel deliveries such as IEC material units, IEC materials on RH for direct communication, IEC/BCC audiovisual materials for outdoor short film festival visits in the communities, radio soap operas for broadcasting through public and community radio system, billboards for ARH issues, and TV and Radio PSA materials. These IEC materials coupled with

communication equipment provided by CP2 strengthened capacities of the sectors in SRH communication.

Advocacy

The advocacy efforts under this output was successfully implemented because of relevant and timely support to data collection, analysis, and distribution, support to establishment of the management structure of the BCC strategy, and the development of relevant policies and strategies.

UNFPA's CP2 provided support to data collection on STI/HIV knowledge and behaviours through various channels. Findings from the BCC baseline study were distributed and utilized in the planning of the implementation of the strategy and later in the impact assessment. In addition, An Assessment of Drug Use in Timor-Leste was conducted in 2011 to gather evidence on drug use and its relation to HIV transmission to inform and guide national policy development and decision-making of the health sector in response to HIV and drug use. Besides, data on HIV/STI were also collected through the DHSTL—a survey which received financial and technical support from UNFPA. Results of this survey were disseminated and used in multiple ways.

In regards to the advocacy activities under this output, a number of achievements were made in the development of a coordination mechanism and legal framework. In this regard, the M&E framework for monitoring and evaluation of the BCC strategy was developed and used. Secondly, the output supported the health sector in developing a “caring and loving husband” intervention so as to attract Timorese men to become involved in SRH care. Thirdly, CP2 provided technical to MoH in developing the National HIV and STI Strategy for the period 2011 to 2016. CP2 was also found to provide support towards the development of the implementation of the BCC plan at the district level which involved the participation of communities. A number of plans and strategies were developed with support from CP2, namely the “Public Service Announcement”, “The Caring and Loving Husband Strategy”, and “Men involvement in RH Decision Strategy”.

From the above-mentioned achievements, it can be concluded that output 3 effectively contributed in improving national capacities for SRH, including STI/HIV behaviour change communication and policy development and implementation.

Efficiency

Similar to previous two outputs, the output 3 was allocated budget, fund raising, AWP budgeting, and budget management mechanism. It is thus important for the discussion to focus on the extent to which this output was maximizing its cost and how duplication and overlaps were managed.

The activities under Output 3 were implemented in close collaboration between the UNFPA CO teams and the implementing partners' staff members. Based on the reviews of the AWP and COARs from 2009 to 2010, it was found that the interventions were implemented in a logical fashion. Information, Education, and Communication materials were developed based up on evidence gathered from the BCC baseline survey and through steps of design, pre-test, printing, distribution. This assured the materials meet the needs of and used by all target groups that maximized the cost. This is the case for the supply of BCC equipment.

Because UNFPA acted as an active member of the BCC working group, BCC interventions were developed in a joint programming fashion and the IEC/BCC materials were developed by MoH under consultation with this group. For this reason, there was minimal overlap and duplication in the area of BCC. Moreover, this BCC working group was instrumental in generating synergy across different agencies and sound management of activities to avoid duplication.

In summing up, the budget allocated for output 3 was well managed through the DEX mechanism. The costs for capacity building, including training, development of materials, and advocacy were justified given the results. In the effort to provide SRH choices to local people in the context of low national capacity on BCC, the costs for technical assistance was justified despite a large budget had been expended to recruit international consultancy firms and experts. This is because of the value added brought on by in the implementation of the BCC strategy. The possible overlaps with other programmes/projects were well managed through the South-South collaboration. In short, output 3 made efficient use of the programme budget.

Sustainability

The sustainability of interventions under Output 3 that covers BCC interventions would be discussed in terms of three areas: the policy environment, capacities of the system, and financial commitment by the Government. These three areas indicate whether or not Timor-Leste is ready to take over and/or to scale-up the interventions of UNFPA as outlined under CP2.

Policy Environment

Over the years, CP2 provided valuable support to the establishment of a supportive environment for SRH behaviour change communication (BCC). These include the availability of BCC management mechanisms at all levels, the national HIV and STI strategy, and the inclusion of BCC in the National Development Strategy 2011-2030. These efforts directed at SRH communication showed UNFPA's commitment and support to Timor-Leste as part of the country's health promotion goals.

At the national level, the Health Promotion Department of MoH played coordinating roles and provided technical inputs to other sectors in material development and BCC implementation. At the sub-national level, there was one focal point in each district to coordinate these efforts. Midwives and nurses of the CHCs were tasked with conducting community communication activities as part of their daily duties. At the suco (village) level, two health volunteers in every health post were assigned to carry out BCC activities. At this point in time, it may be assumed that there were adequate mechanism and human resources for health promotion implementation in BCC at all levels.

Capacity of the network

The capacity of the behaviour change communication system including planning, monitoring and supervision, technical knowledge and skills developed with support from UNFPA under output 3. The BCC plans were developed in a participatory way from grass-root to central levels. Monitoring and supervision skills of supervisors at national and district levels were developed and missions were conducted. Nurses and midwives at the CHCs and health volunteers at grass-root level were able to use the IEC/BCC materials to conduct BCC activities in the communities as well as household visits. Nevertheless, because of the limitation of time, the evaluation team was not able to assess the quality of these BCC efforts.

Financial and human resources

As discussed in the section analyzing the capacity, the human resources available for BCC at the grassroots level relied on integrated functions of the health midwives and nurses at the Suco health posts and the PSF volunteers at the community level. There was not yet a full-time staff to handle the tasks related to BCC at this level, where the activities really take place. On this matter, it appears that the networks for BCC at the grassroots level were yet to be secured for the implementation of these activities in the long-term. The BCC interventions of the CP2 was designed to fit with the current situation of seconded staffing and provided comprehensive capacity building for those workers in BCC planning, implementation, monitoring and supervision. This, in a short term could be believed that the system could take over the job or scale-up the intervention yet it is not the case for longer term.

Another challenge related to human resources was that high-quality experts on health promotion continued to depend on international assistance. The evidence would be the development of IEC/BCC materials that required high technologies such as video clips, audio and visual dramas, and the like tended to be developed by international consulting firms under contract with UNFPA CO.

Last but not least in Timor Leste, the budget for health promotion continued to be donor reliant. It was found that this lack of a budget line from a local resource for health BCC made it impossible for the health sector to take over or replicate these interventions without support from donors.

Summing up, the interventions under Output 3 were designed in such a way so as to take into account the absorbability of the country in terms of current context of the health sector and learning capacities of staff. Although capacities of the current system were raised sufficiently, there continued to be a lack of high quality experts to sustain the high-tech tasks. A major challenge was the shortfall in regular budget from the government. For this reason, without further support, it would be hard for the country to take over or replicate the interventions.

2.3.5.2 Output Four

Increased access to high-quality reproductive health information and services for young people.

Effectiveness

Output 4 was designed with the aim of improving the RH service and information for young people in Timor-Leste. The effectiveness was assessed by looking at the achievements made in the areas of capacity building, policy advocacy, and the actual provision of ARH service and information at delivery points.

Capacity building

The capacity building interventions of this output was conducted for the health service providers on Youth Friendly Service provision, education sector on ARH education, youth volunteers on ARH peer education, and nuns in Family Centers on counseling skills for young people, and establishment of the YFS centre in Dili.

Capacity development for the health sector in YFS provision began with the development of the national guidelines for youth-friendly service provision based upon international standards and best practices from similar Asian countries. The development involved concerned stakeholders such as MoE, SYSS, the Catholic Church, VPU, the Police, and more importantly young people. It was submitted to the MoH in

both English and Tetum languages for approval²⁰. At the point this evaluation was conducted, the guidelines were approved and available. The review of Standard Progress Reports found that the guidelines development and approval took a long time throughout the years 2009 to the end of 2011. This long process caused delay in development of training materials, and training of trainers and health service providers was delayed accordingly. Consequently, the YFS systematic capacity building would likewise be delayed.

Despite the delay in the development and approval of the national guidelines, OP training was done to health workers by MoH in 2011 in collaboration with INS, civil society and SSYS. MSI did training on ARH counseling under a sub-contract project supported by CP2. Health workers and other partners such as the nuns at the Family Center, YFS centres, and Catholic clinics were trained as counselors. It was not known if training on YFS clinical services was conducted²¹. With the synergy from INGOs, the capacity of counselors was raised and Timorese youth were able to access information and services.

The capacity of the YFS provision system was also raised through the establishment of facilities in some piloted places. A piloted health facility on Youth Friendly Services in a CHC in Dili was established and renovated with rooms, equipment, logistics, and IEC materials. Another Youth Resource Centre was established by a LNGO with support from CP2 to conduct training of peer educators including in-school and out-of-school young people. In addition, the referral system for YFS health facilities and YRC was established in order to facilitate young people's access to services and information.

In the area of in-school ARH education, the capacity of the education sector was developed through a project that was piloted in ten secondary schools since early 2011 by the MoE under an MoU with UNFPA. The project came with the development of an ARH module for integration into the extra-curriculum of the pre-secondary and secondary schools. A team of international expert from Malaysia was contracted to develop the module and training materials in consultation with relevant NGOs, MoH, MCH on technical issues. The team also provided training of the national trainers who were selected from ten piloted schools, the National University of Timor-Leste, and the Training institutes of both the Ministries of Education and Health. Impressively, 2 school children from each school were involved in the training of trainers in order to express their needs and opinions which were fed into the module. These national core trainers then conducted training for their colleagues under the supervision of the master trainers. Teaching aids and equipment were provided to these ten piloted schools. Subsequently, supportive supervision was in place with supervisors trained, tools developed, and mission conducted. Primarily, capacity on ARH education was comprehensively developed for the education sector despite its late involvement.

²⁰ Source: UNFPA CO Standard Progress Report 2011

²¹ YFS clinical services include both counseling and clinical service provision such as the treatment of STIs, maternal healthcare (especially important in Timor-Leste because of high prevalence of teen pregnancy), family planning, and other RH services.

Advocacy

Output 4 made significant effort to advocate for changes in ARH information and service provision. The activities under this output including data collection, advocacy campaigns, support towards the development of policies and legal documents, and exposure to international best practices were found to be conducted in a strategic manner.

Data on Youth in general and ARH in specific were collected through national surveys and ARH particular studies. Of the national official survey, knowledge, attitude, and behaviours of young people were included in the DHS 2009-10 and a single monograph on youth was disaggregated. Under support of CP2, several studies were also conducted such as Youth RH Quantitative and Qualitative research by UNFPA CO, Health facility and youth needs assessment by a LINGO. The findings from these studies were analysed and distributed for policy and programme planning. The evaluator, however, found that there was a lack of a panel survey to collect data on youth including ASRH. As Timor-Leste is now having a population bonus structure, lack of routine data collection would not facilitate the policies and interventions to be responsive to the actual needs and rights of young people.

The advocacy campaigns were conducted through different channels to raise awareness and support for ARH interventions. Workshops were conducted at different level to advocate and consult with concerned stakeholders on ARH care and education in order to develop responsive action plans such as in-school ARH education and National Guidelines for ASRH services. The workshops also aimed at raising awareness of various stakeholders in ARH care and, hence, the interventions received great support from all groups. This was reinforced by a study tour on ASRH was conducted to Indonesia involving participants from concerned sectors, especially the Roman Catholic Church. In addition, support was also provided to celebrations of youth-related events, especially the Year of Youth implementation in 2010.

The above-mentioned efforts in advocacy were successful with remarkable results in policy changes and support from sectors and civil society. The national guidelines for ARH service and information provision were developed and approved. Youth reproductive health was included in the National Development Strategy 2011-2030 as a priority. Youth continued to be a target group of the health sector's Strategies and Plans. Most importantly, MoH developed an ARH Strategic Action plan. The ARH services received support from the civil society, especially the Roman Catholic Church. A priest who was interviewed maintained that the Church came to realise the importance of youth ARH knowledge and skill improvement. For this reason, the Church saw the need to support and participate in providing information and SRH services to young people.

Nevertheless, there was also an ASRH Counseling Manual that was drafted and submitted to MoH for approval by an INGO under a sub-contract with UNFPA. The manual covered all issues in the area of youth Sexual and Reproductive Health. Unfortunately, there was cultural and religious sensitivity around sexual issues. Hence, the Manual was still pending for approval at the time of the evaluation. However, the affects of this issue would be discussed in the efficiency section under this output.

Another shortcoming was Youth health in general and ASRH in specific were not clearly reflected in the National Priorities of Timor-Leste 2010. Likewise, the Nation Youth Policy 2007 did not explicitly mention healthcare for young people in general and ASRH care in particular. Meanwhile, these areas play very important roles in the development of young people in the early stages of life. Addressing these issues become even more important in a country where approximately half of the population constituted young people.

ARH provision

Owing to efforts on strengthening capacities in service and information provision coupled with good advocacy, ARH information and services were provided in various delivery points and schools in Timor-Leste. The YFS centre operated under support from CP2 by an LINGO was established and has since been fully functioning. Information and counseling services were provided by trained staff at the centre and by the peer educators. The resource centre operated by this NGO delivered BCC activities which targeted out-of-school young people. It also provided information about available services to young people.

The Catholic Family Center and clinics were actively participating in ARH care for young people with financial and technical support from CP2. This is an impressive effort undertaken by UNFPA's country programme. A training course on ARH and FP became mandatory for every couple including young people when they wished to get married. In other daily learning sessions in the FC, the trained nuns provided lectures on ARH and FP to young people. Moreover, the Catholic Clinics were involved in the provision of FP modern methods, information and counseling on SRH and HIV to people including youth.

Youth reproductive health education for in-school children was also initially piloted in ten pre secondary and secondary schools nationwide. The education sector had been newly involved in CP2 yet was found to be getting positive results in expanding their activities. The module developed by the international expert became a resource for school teachers to integrate SRH issues into their lectures.

Initially, it could be said that service and information on ARH were successfully provided to young people. This was done with active participation of the concerned sectors and of the civil society in a supportive environment.

Efficiency

Output 4 had the same figure for the other outputs in terms of budget allocation, management, and disbursement. As such, the discussion on efficiency under this output will focus on how CP2 managed to tailor the interventions to the local context. Discussions will also be made for possible shortcoming and management of duplication and overlaps.

A finding in this evaluation was that the interventions under this output did not place much value on adolescent sexual health because this area continued to be bound up with cultural and religious sensitivities. A key informant shared his thoughts that while education on ARH was important, Timorese culture was not ready to receive education on sexual health. Thus introducing sexual health gradually over time would be the solution. By pacing the interventions in sexual education and condom promotion for young people, it is commendable that CP2 saved its resources for other activities at the present time.

The long lasting development of the National Guidelines for ARH Service Provision as described in the previous session might not have helped CP2 maximize the utilization of the programme budget. The delay in the development of training materials and capacity for service providers would have thwarted achieving the objectives of CP2. It also might lose opportunities for piloting, drawing lessons learnt, and scale-up.

Although CP2 focused sufficient attention on the cultural and religious context, a problem was still found with regards to the development of the ASRH counseling manual which was undertaken by an INGO with financial support from UNFPA. As discussed earlier, the Manual was pending for approval because of objections from the religious sector on the sexual education part. While the delay in the approval of this document might have indicated the inefficient utilization of resources, more importantly, it would have come at a cost of compromising the reputation of UNFPA in the country.

Duplication and overlaps were minimized through an agreement among agencies on areas of coverage and through coordination via working groups. Based on the UNAIDS division of labor among UN agencies UNICEF worked as convenor and UNFPA and UNESCO as co convenors on young people programming. Taken into consideration of the areas of focus of different agencies –UNICEF on governance and education, UNESCO on education/teachers’ development and with UNFPA, SRH. This helped avoid possible overlaps and maximize resources of the agencies providing similar support to Timor-Leste.

On the coordination mechanism, there was a working group on ASRH involving members from the government- concerned sectors, UN agencies, and civil society organizations. The group functioned to coordinate adolescent-health-related programmes and projects via joint programming, regular meetings, consultation on programme/policy development, and so forth. MoH took the leading roles in coordination. New programmes/projects, AWP, IEC/BCC materials, national strategies, the Guidelines, and the Manual were developed in consultation among members of this working group.

Overall, the cost for ARH interventions was justified based on the prioritized activities identified to match local culture and religion. The interventions were also appropriate to the needs of Timorese young people as they promoted youth participation in planning. Duplication and overlaps were well managed from both the government and UN sides. Nevertheless, some delay in the implementation owing to partner involvement and the delay in receiving approval on the counseling manual might be regarded to be opportunity costs to UNFPA’s CP2.

Sustainability

Policy environment

The policy environment for ASRH was created over the years by the country of Timor-Leste. This was reflected in the various national legal frameworks, coordination and collaboration structures, as well as received the government of Timor-Leste’s commitment.

Adolescent and Youth Reproductive Health issues was included in the health sector strategies and plans, as discussed in the “relevance” section of this outcome. Support from CP2 was provided to reviewing and revision of the NRHS along with development of the National Guidelines for ASRH Services and ARH was reflected in the strategy. In contrast, youth health including ASRH was not found in the two national important documents, namely the National Youth Policy and the National Priorities 2010. Even in the National Development Strategy 2011-2030, there was no specific mention about youth healthcare although the well-being and development of young people require a multi-sectoral approach.

Youth participation was promoted in the current interventions and was also prioritized in the National Youth Policy²² and the National Priorities 2010. These efforts created a good environment for young people to claim for their rights and needs.

Data for youth in general and ARH in specific were collected, analyzed, and distributed and used for planning. Nevertheless, there was the absence of a national panel survey to collect routine data on youth in general and ASRH KAP in specific. Data about unmet needs of unmarried young people was also lacking.

MoE was involved later in the implementation of CP2. As such, their in-school ARH education activities started later. Consequently, there might be a loss in opportunities to draw lessons learnt, institutionalization, and ways to scale up the module to other schools within the country.

South-South collaboration was conducted through working groups involving participating members from international organizations, civil society organizations, and government agencies. Over the last few years with support from UNICEF, a National Youth Parliament was established with participation of MoH, MoE, MSS, NSD, and NGOs. Most importantly, there was strong support from the Roman Catholic Church for the implementation of ARH interventions in Timor-Leste. These groups played crucial roles in youth-related advocacy and coordination.

In summing up, there was a supportive environment from the health sector and national coordination structure. Nevertheless, the ARH issues were absent in other important policies of the country. The absence of detailed national data on ARH was not facilitating the advocacy and planning of ARH interventions.

Capacity

Over the last three years and a half, capacities for sectors in ASRH service and information provision were developed with support from CP2. The development of technical guidelines and the manual on ARH service provision and counseling demonstrated national ownership as discussed in the “effectiveness”. The proposed training programme on YFS services through the health system was developed and transferred to MoH. The ARH education for in-school young people was developed and implemented by MoE with technical and financial support from UNFPA under CP2. This showed that the interventions were owned by the implementing partner from the beginning and could be handed over

²² National Youth Policy of Timor Leste, 2007

to the relevant partners afterwards. Related policies and strategies were developed and owned by the government sectors..

The capacities of staff of the above-mentioned sectors in ARH information and service provision were basically developed over the last five years. Health service providers received training on YFS provision and ARH counseling to young people.. A team of national core trainers on ARH/YFS including staff from SSYS, MoEd (INFORDEFE), INS, and Sharis Haburas Comunidade (SHC) was trained. Nonetheless, a lack of national core trainers from the health sector was observed. Moreover, the monitoring and supervision system for YFS provision were not systematically developed. This challenged further technical assistance to YFS provision.

The education sector seemed to be more advanced in capacity development of their staff in ARH in-school education. National core trainers were trained and, as a result, able to conduct training for their colleagues on the module developed. The monitoring and supervision tools were developed and supervisors were trained on supportive supervision. Nevertheless, as shared by the MoEd, the capacity in curriculum development was still limited and the work continued to rely on external expertise.

As for the capacity of the networks in providing information to out-of-school children, the Catholic Family Center actively participated in counseling for young people on ARH. Nevertheless, there were requests for regular capacity building for both priests and nuns.

Adolescent Reproductive Health services were also provided under CP2. Based on reviews of the AWPAs and Standard Progress Reports of CP2, it was found that UNFPA did not give significantly technical assistance to hospitals on clinical services for young people. Unfortunately, there was no secondary data and information on how YFS provision was conducted. Therefore, it would be hard to discuss the quality of YFS in Dili.

Financial and human resources

Even though efforts were made on building capacities, there continued to be a lack of national experts on ASRH service and information provision. The interventions that require high quality expertise continued to depend on external experts.

Moreover, the lack of high quality human resources on ASRH, budget for intervention development, training of staff, development of training materials, advocacy, monitoring and supervision, and communication continued to be largely donor reliant. The lack of a regular budget from the government made it difficult for these interventions to be replicated and/or handed over to local entities.

2.3.6 Facilitating Factors (RH)

There was a convenient and supportive policy environment for efforts in improving the country's RH care system. The strong commitment from the government in strengthening the healthcare system facilitated the health sector in developing new maternal health programmes and strategies. For a young country, the healthcare system may still be considered weak since its clinicians and managers tend to be new. However, it was an easy undertaking to improve clinicians' knowledge and

skills under CP2. Likewise, their professional practice in maternal health service provision was relatively easy to be influenced which led to faster changes.

There were technical resources available from international donors and other countries under CP2. It must be recognized that these could benefit the health sector through the synergy across the programmes through a strong South-South collaboration.

2.3.7 Hindering Factors (RH)

- The poor geographical condition was identified to be the main challenge in accessing healthcare facilities in Timor-Leste. The difficult terrain in most of the areas outside Dili have caused a delay in accessing healthcare facilities at the sub-national level to higher levels. Definitely, the delay in having access to services, one of three major delays, exists.
- The lack of health clinicians in all levels, especially at sub-national levels, was also a significant challenge. An MoH officer reported that on average, there were only five midwives per hospital when there should be ten to meet the needs of the patients. In this regard, the BEmOC capacity building was challenged.
- Even though BEmOC does not necessarily require the availability of medical doctors, lack of local clinicians challenged the improvement of clinical SRH/FP services. As tubectomy and vasectomy were not provided by local doctors, choices were limited especially for men. In addition, technical assistance from doctors was still needed for assisted vaginal delivery performed by the Timorese midwives.
- The diverse external technical resource pooling that was taking place in Timor-Leste might come at a cost of confusing the local clinicians since there were no common standards for collaboration and cooperation.
- Missing ASRH care interventions in the National Youth Policy and National Priorities posed as an obstacle for a multi-sectoral approach in service and information provision.
- The cultural and religious sensitivities around sexual education for young people acted as a limitation to the comprehensive interventions in ensuring the well-being of young people.
- Lack of regular budget from the government for healthcare challenged the sustainability of CP achievements.

2.4 Population and Development

2.4.1 Context

Timor-Leste's current population of 1,066,409 is one of the fastest growing in the world and is likely to double within the next 17 years. The population of Timor-Leste is predominantly rural: 70% of the population lives in rural areas. Indicating internal migration to the cities from rural areas, population

density in urban areas, highest being in Dili, is 352 per square kilo meter while that of rural areas is 53 per Km².

Table 2. Population by Rural and Urban areas

Population	Both sexes	Male	Female
Total	1,066,409	544,198	522,211
Urban	316,086	166,163	149,923
Rural	750,323	378,035	372,288

Source – Census 2010, Timor Leste

Figure 1: Age Pyramid of Timor Leste in 2010

Fig. 1.a Population Pyramid

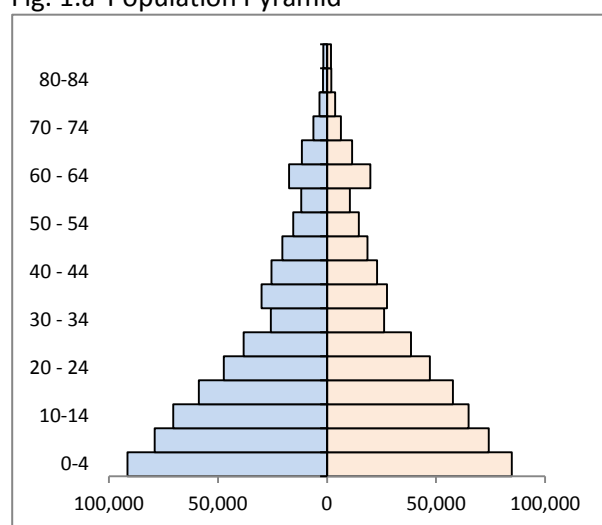
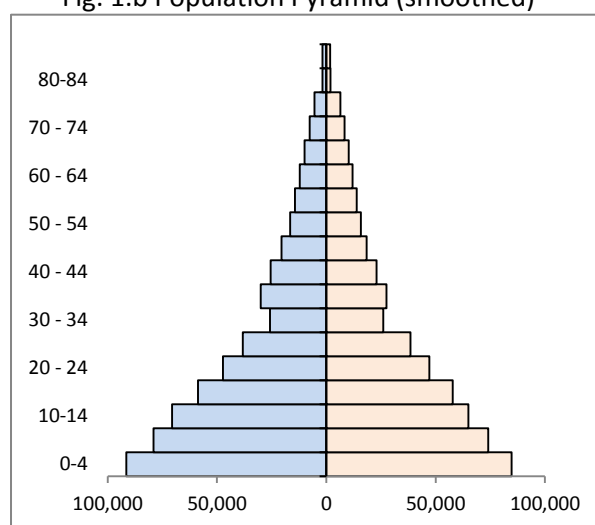


Fig. 1.b Population Pyramid (smoothed)



Source: Census 2010, Timor Leste

Life expectancy for East Timorese is low by regional standards - 60.5 years for females and 58.6 years for males. Mortality rates remain high, and children are particularly vulnerable, with under-five mortality estimated at 130 per 1,000 live births. With high birth, high death rates leading to a relatively low life expectancy at birth, population pyramid from the 2010 TLS census depicts a youthful structure. The pyramid also depicts a concentration of people at age 60-64 years, which is quite unusual, but on closer examination it was found that most people who are slightly younger than age 60 had reported as 60 years in order to qualify for the government's social security disbursement. The Government of Timor-Leste has initiated as a policy that all its senior citizens aged 60 years and above are given a monthly allowance for their upkeep. As such, the population data for the country was smoothed to bring forth to the one presented above figure 1 (1.a and 1.b).

Census data (2010) show a significant proportion of young people in the population and the heavy process of urbanization. About 41% are under 14 years of age and over half of the population (53.9%) is economically productive age group (15-64) with 4.7% over 65 years of age making the dependency ratio of the country at almost 86%.

2.4.2 Programme Design (PD)

PD component is designed to achieve the outcome that *“Data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS available, analysed and used at national and sub-national levels to develop and monitor policies and programme implementation”*.

To achieve this outcome, three outputs are targeted employing the following strategies and activities:

Output 1: Policy makers and planners at national and sub-national levels are sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies.

Strategy adopted is to sensitize key policy makers in government on the need to establish a mechanism to coordinate population and development issues and to integrate them in policies and programmes.

Activities that are designed to produce output 1 (Upstream Advocacy):

- Assist in the establishment of a National Population Commission and/or Secretariat to coordinate population issues and to formulate a National Population Policy that ensures population, reproductive health and gender concerns are integrated into all sectoral programmes.
- Support the NPC in the development of a National Population Policy in line with the ICPD PoA and national policies

Output 2: Strengthened analytical capacity at national and sub-national levels for utilizing data on population, reproductive health and gender in order to develop, implement and monitor policies and programmes.

Strategies adopted are to build national capacity for planning, implementing and monitoring population programmes, and promote the use of existing data generated by the household based surveys and censuses.

Activities that are designed to produce output 2 (Capacity Building):

- support the introduction of courses on population and development including gender analysis at a national university
- support planners and public officers in relevant ministries to undertake national and international training on population and development issues
- Provide support in data analysis, production and dissemination of user friendly materials for the use in planning and implementing programmes

Output 3: Improved availability of disaggregated demographic and socio-economic data at national and sub-national levels.

Strategies adopted are to strengthen the institutional and technical capacity of the National Statistics Directorate and other implementers to collect, analyze, publish, disseminate, and use accurate and timely data).

Activities that are designed to produce output 3 (Support surveys and establishment of data systems):

- Support planning and implementation activities of the 2010 Population and Housing Census,
- Carry out training on data management to encourage utilization of existing data;
- Support the Health Management information system (HMIS) team in analyzing data and publishing its annual reports;
- Support the development of systems to facilitate population registers; and
- Support the implementation of 2009/10 Demographic and Health Survey (DHS)

Programme design under population and development has identified appropriate strategies in implementing the programme and focuses on upstream advocacy, national capacity building and support to providing quality and reliable data to achieve the stated outcome.

In PD, one of the key objectives is to make data available for evidence based planning specifically in key components of sexual and reproductive health and gender. Evident from national strategies and policies; and feedback from data users, PD has been able to achieve the intended objective of providing and supporting data bases that are accessible and applicable to the users. Although PD program vision is commendable and the strategies and activities employed are relevant, more strategic outlook towards long-term sustainability issues and sound exit strategies would have been useful in the long run.

Given the national capacity, and the excessive dependency on international consultants, if the five year planned period is adequate enough to have a sustainable process in place to achieve the planned outcome is questionable. On capacity development front, it seems that PD component has considered issues relating to “capacity of whom and capacity for what” when providing training. However, long-term plans on human resource issues and exit strategies do not seem to have received adequate attention for long-term sustainability, maintaining high technical quality, and retention of skills within the partner institution (NSD). This is not to underestimate the tremendous efforts already in place to strengthen NSD, but to emphasise the need to focus on the capacity issue more since NSD is the key agency which provides and coordinates much needed data for country’s development planning.

While the theory of change is fairly explicit in the programme design, program logic is appropriate for the planned strategies and activities that contribute to the stated objectives and expected outcome. Little attention has been paid to the process indicators and monitoring of the same. This has resulted in delays in achieving certain activities/outputs within the anticipated time frame due to over ambitious and unrealistic targets. Some output statements are quite complex and specifically the activities planned to achieve the output 2 involve change in attitudes and behaviour that needs more time and careful crafting of advocacy programmes. Although the three outputs are logically linked and well justified to be in the programme to achieve the planned outcome, the level of planning and type of input to each output under PD seem to have been underestimated. As such, some outputs may not be able to achieve (e.g. NPC) during this programme cycle and the process to achieve those will have to be monitored now and be included in the next cycle as well.

2.4.3 Programme Management and Partnerships (PD)

While the government and the UNFPA are jointly responsible for the effective management and delivery of results, the main implementing partner and the Programme Component Manager (PCM) for PD is the National Statistics Directorate (NSD aka DNE-Direcção Nacional de Estatística) under the ministry of Finance (MoF). PCM coordinates the AWP’s and several of IP’s working towards achieving the outputs under PD.

For example, DHS was successfully carried out in close collaboration with other partner agencies such as USAID, IRISH AID, UNICEF, WHO, UNDP, Ministry of Health and other development Partners with UNFPA taking the lead role in terms of funding, mobilizing and implementing the survey in close association with NSD.

Monitoring of activities are accomplished via standard progress reporting, quarterly updates, and Annual Work Plan (AWP) Monitoring tool. As stated under the programme design, there is no clear exit strategy mentioned in the plans and this lack of an exit strategy both in the CPAP and in the AWP assumes that the external support is going to continue and this may hamper the development and the urgency of local capacity to take over. While a fully-fledged exit strategy cannot be developed for a short term period, to ensure smooth transfer of responsibilities to the implementing partners, process indicators have to be developed and managed to monitor exit strategies. Similarly, all capacity building interventions will have to pay due consideration to the institutional structures and the systems within which the human resource capacities are developed and strengthened. It is not only enough to develop capacity of individuals, but institutional capacity has to be given attention as well and UNFPA should be able to advocate such capacity improvements. Some efforts are made for the government to absorb staff members who are currently supported by UNFPA on contract/short-term basis. This can further be systematized strategically (e.g. signed MOU upfront, if feasible) to have a clear understanding that transfers take place and sufficient ground work is done for a smooth transfer.

2.4.4 Outcome One (Programme Relevance- PD)

Key strategies followed by UNFPA to achieve the outputs under the main outcome can be stated as upstream advocacy, capacity building, and support to national surveys for establishing quality data bases. Key interventions under these are: establishing a National Population Committee as a mechanism to coordinate population and development programme, building capacity of national staff, completing the census survey, and DHS and disseminating the survey results.

UNFPA's proposed programme in Timor Leste responds to the priority national development Challenges identified in the national planning frameworks (National Priority) of the country. It also responds to the UNFPA Strategic Plan 2008 – 2011, in particular, operationalizing the development results framework at country level in order to accelerate progress and promote national ownership of the ICPD programme of action. It also builds on the 2009 – 2013 UNDAF, which is guided by the goals and targets of the National Priorities of Timor Leste and the Millennium Development Goals Declaration.

As such, given the UNFPA mandate and the PD expected outcome²³ and the strategies employed to achieve the outcome; the degree of programme relevance to country's plans and priorities, UNDAF outcomes, especially outcomes 2 (Poverty Reduction & Sustainable Livelihood) and Outcome 3 (Basic social Services) is high. The information on household amenities will also provide supporting information to the UNDAF Outcome 2. Further, the Information generated from DHS will contribute to the UNDAF outcome as defined.

In light of the country's challenges with population dynamics and desire to change the livelihood of the population, the need for up-to-date, timely and reliable data is particularly important. It is essential not

²³ *"Data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS available, analysed and used at national and sub-national levels to develop and monitor policies and programme implementation".*

only for the development of evidence based policy making at all levels, but also for monitoring progress against the Millenium Development Goals. The 2010 Census is also expected to provide benchmark to monitor sustainable balance among population growth, distribution, the economy and the environment.

Awareness created during census about the data and its use in planning and policy making has made service providers understand the value of data. Practically, all those officials who were interviewed mentioned census data and how they intend to use it for target setting and planning based on the population. As such the relevance of the programme stems from the advantages it offers through the evidence-based planning of policies to enable a good service to people, especially at sub-national level.

In all key policy documents reference made to Census, DHS, and other data indicates the trend towards awareness in using these data in the decision making. According to a key informant, the results of an-depth analysis of DHS data had contributed to the development of Nutrition Strategy of the country. This is good evidence of how data had been used to advocate strategy development. However, there is not much of convincing evidence, although data are cited in policy papers and strategies, as to how much of P&D issues are integrated into sector planning (except to a certain extent in health and education sectors) and monitoring of implementation progress of government policies and programmes. The indicator matrix (M&E framework in CPAP) is not explicit about how this can be measured if one were to integrate PD into sector planning. This may not have happened due to the fact that the national population commission (NPC) to oversee the integration of PD is not formed yet.

The relevance of the programme, on citizen's perspective, has to be assessed at how data contributes to changes/improvements in services and benefits that the nation will reap as an end result. In general, if the national development policies aimed at citizens are improved as a result of evidence based planning; one can assume the relevance of census and DHS data for the public. While 2009-2010 DHS data and 2010 census data are just being put to use, and there is awareness and willingness (evident in interviews and focus group discussions with health service providers and population planning officials) to use the data for service planning, the change or improvement of quality of services available to citizens as a result of availability of these data in a user friendly manner is too early to assess.

In summing up, the UNFPA support has been highly relevant in the framework of country's national strategic policies, UNDAF outcomes, MDG goals and development programmes, specifically in UNFPA focus areas.

While the above discussion, at outcome level, focused on Relevance, the following section discusses the DAC criteria Effectiveness, Efficiency and Sustainability for the three outputs mentioned.

2.4.4.1 Output One

Output 1: Policy makers and planners at national and sub-national levels are sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies.

To achieve this output, plans are to strengthen the institutional mechanism for the integration of population issues into development programmes and plans and to assist in the establishment of a national population commission/secretariat and a technical working group to formulate a national population policy to ensure population, RH, and gender concerns are integrated in all sectoral programmes.

Effectiveness:

Sensitization of parliamentarians in the effort to establish a National Population Commission (NPC) as a mechanism to coordinate population and development programme has taken place to a limited extent and more work on this front is planned to be accomplished during the rest of the CP2 cycle. Some Parliamentarians and high-level government officials' participation in regional meeting on Population, Gender and Health issues has given some awareness on PD issues at high level. The process toward establishment of NPC and the Population Policies is ongoing; there are delays and the activity will be included in CP3. The lack of process indicators does not allow monitoring of the inputs and outputs related to this activity. Similarly, there are no indicators to monitor if the PD issues are integrated into sectoral planning. Although it is expected to happen, how one should monitor the progress is not clear.

A technical committee is established to oversee the technical aspects of PD and that has been effective and had been a contributory factor for successful operation of the national surveys carried out so far. In addition, commitment of the Ministry of Finance including the allocation of budget from the Government for PD, strong support from NSD in all stages of census activities, flexibility in resource allocation and integration of UNFPA-supported AWP activities with NSD/DNE's annual work plan have been made the programme effective. On the other hand, key informants felt that while tremendous achievements are realized, lack of skilled staff as well as lack of interest and commitment of some staff in the implementing agency has lowered the effectiveness to some extent.

Efficiency:

Capacity development of national counterparts and the number of trainees who will remain in the country will be an investment on human resource building. Establishment of technical committees and proposed National Population Commission are efficient strategies since this may ensure long-term sustainability and carryover of investments in capacity development. UNFPA works in collaboration with other UN agencies and government counterparts to provide a platform to build synergies and buy in from development partners and ownership. It takes some time for the government counterparts to learn and adapt to the UN working style, processes and systems. As such, working with the same partners, in the long-term make the programme operation and management more efficient as the counterparts get more familiar with the operation, management and monitoring of the development interventions.

Sustainability:

The most important factor regarding sustainability of UNFPA support has been the careful mutual consultation approach that has secured a high level of ownership. Additionally, the continuous support to the same partners along different cycles allows for the design of long-term strategies conducive to sustainability. Human resource development under PD has been done with careful planning and skilled persons will make the system sustainable. However, one issue is the incentive for trained persons to remain in the position they were trained for. Transfers and brain drain might impede the sustainability in terms of human resources, if exit strategies and capacity development strategies are not regulated.

The government reporting system for handing over, especially when a new government comes in to power, is a good way for the government to be aware of accomplishments, progress and future plans of all development partners. This might enhance the sustainability as this provides a platform to share information with the government as well as among key development partners in the country.

2.4.4.2 Output Two

Output 2: Strengthened analytical capacity at national and sub-national levels for utilizing data on population, reproductive health and gender in order to develop, implement and monitor policies and programmes.

Strategies adopted (according to CPAP) are to build national capacity for planning, implementing and monitoring population programmes, and promote the use of existing data generated by the household based surveys and censuses.

Effectiveness:

A large number of national staff had been trained in geo-spatial applications, data collection, data entry and analysis during the implementation of both DHS and Census projects which is expected to increase NSD's capacity to conduct future surveys. UNFPA has completed and has plans to continue with support to long and short term training in population studies/demography and other census related topics. UNFPA plans to continue consultations with National Universities regarding the incorporation of a statistics or demographic subject into an undergraduate studies curriculum. This activity has not happened yet, but the consultations and development of MOU is being discussed at the moment.

Due to the long list of training that had been completed under this component it will not be reported here, a detailed list is attached in the Appendix.

While developing the capacity at national level has been given emphasis, there is weak capacity at sub-national (district) level. Planned activities under the output do not focus much at sub-national level although the objective is to improve both national and sub-national level capacity. During census preparation some training had taken place, but in terms of analytical skill and other technical skills, there is a lot more to be accomplished. Since the teams on the ground were trained this did not affect the execution of the census, but the sustainability and the contribution to future survey activities, the capacity at sub-national level is not adequate.

Lack of skilled human resources at district level creates heavy dependency on national level input. Staff at district level has limited or no analytical skills to make use of the data for planning or guiding those in need of assistance in developing project proposals at district or sub-district level. While computer skills are not at best at district level offices, infrastructure and intermittent supply of electricity in those areas limit the use of available computers.

Efficiency:

Efficiency under this component is related to capacity enhancement and several issues are already discussed under output one. Under Output 2, support to national universities would be an efficient strategy for capacity development; however the activity has not taken place yet.

Coordinating and integrating well with NSD has been efficient. However, the extent of efficiency will depend on how future surveys are conducted using technical skills and capacity already developed as well as the use of equipment that were purchased and remained for future use.

Sustainability:

Most of the issues discussed under capacity development above apply under this output as well. Some planned activities under output 2 did not take place and difficult to comment on sustainability of those. In general, UNFPA's close coordination and well integration with NSD in programme implementation of PD component ensures sustainability.

2.4.4.3 Output Three

Output 3: Improved availability of disaggregated demographic and socio-economic data at national and sub-national levels

Key activities under this output were to implement census and DHS surveys, carryout training on data management to encourage utilization of existing data; support the Health Management Information System (HMIS) team in analyzing data and publishing its annual reports; and support the development of systems to facilitate population registers.

Effectiveness (Census and DHS)

Capacity building component in the Census project can be categorized into three components, long term technical training (leading to master degree), short term training and institutional capacity development. Besides, on-the-job trainings throughout the life of the project are an integral part of its strategy which has produced positive results. A detailed account of capacity building outcome is in Appendix 3 (Capacity Building in PD – Effectiveness).

Strategic advocacy at high level (MoF), at proposal development time - before the Census and DHS were implemented, to ensure and increase data utilization was effective as it promoted government support and buy in from the government side. Ability to secure government funding to fill the gaps was also effective. Ministries and development partners have also come to regard the DHS to be the most reliable data currently available. Thus far, the data has been cited in various Ministerial and Parliamentarian speeches, indicating the government's interest in including women's issues in the national agenda.

Key objective of Census is to provide benchmark information on the size, distribution, composition and other socio-economic characteristics of the population; and for planning policies and programmes, monitoring the implementation of national and global development agenda and research. According to the key informant feedback, the training of a large number of national staff in geo-patial applications, data collection, data entry and analysis during the implementation of both DHS and Census projects had

contributed increasing NSD's capacity to conduct future surveys. UNFPA supported long and short term trainings in Population studies/demography and other census related topics and has plans to continue this support. UNFPA will also continue consultations with National Universities regarding the incorporation of a statistics or demographic subject into an undergraduate studies curriculum.

Major activities under Census were found to be completed as planned. Awareness campaigns were built into the system during 2010 census. Feedback from interview respondents, government officials as well as a few selected people from communities indicated that implementation of census 2010 made more people aware of the nature of census and the value of the census after the fact despite awareness before the census taking. There are still some with limited understanding of census data (sp. sub-district level) which undermines the value of census data lowering the credibility of survey data in general and Census data in specific. This may affect district and sub-district planning using Census data. Undertaking census was a large operation and the capacity at sub-national level seemed to be inadequate mainly due to the lack of skilled human resources at that level. Overall, the census exercise was done well²⁴ and has produced a data base for strategic planning. A detailed account of capacity building undertaken in connection with census is in Appendix 3.

- In summary: As planned major activities under DHS was found to be completed;
- Census data are analysed and made available from national to Suco level;
- Preparation of monographs for publication in process;
- NPC process is going on (not accomplished yet – expected in CP3);
- UNTL (Universidade Nasional Timor-Lorosa'e/ Timor-Leste National University) process is going on;
- Data utility for advocacy (advocacy started up front);
- Coordinating well with other agencies – data sharing and meeting requests for data.

Efficiency (Census and DHS)

The measure of efficiency depends on the country context and it is difficult to make a comparison of cost efficiency of conducting census and other surveys. Review of national planning documents shows frequent reference to Census and DHS data and use of data as the base for preparing policies and strategies. As such, evident by reference to survey data generated by UNFPA supported initiatives in policy planning, strategy development, and situation analyses, the impact of these two survey outputs cannot be measured in terms of the money spent. Some investments made on equipment are still in use and can be used in the future as well. As such actual or expected outputs could be justified in terms of the costs incurred.

UNFPA had planned strategically, well in advance, how to use these for future activities, when equipment and vehicles were purchased for DHS and Census. Efficient and transparent use of resources was also reported by a partner agency key informant during the interviews.

DHS integrated key questions from MICS and now TL-DHS is being used in the global comparisons of MICS. Good example of efficient use of resources avoiding overlap and duplication. This could be an example on combining the two surveys for other countries as well, especially in an era when “Delivering as One “ is being discussed as saving of resources and working effectively within and among UN agencies.

²⁴ Based on key informant interview feedback and reports from NSD

Sustainability:

Technical skills and capacity that were developed in the process of Census and DHS implementation will remain in the country and that will be an asset to the country, NSD in particular, for planning and conducting future surveys. Under the PD component, the international consultants supported by UNFPA are giving continuous in-house trainings in different technical fields to the national staff as a part of capacity development plan. Close coordination with NSD make UNFPA support sustainable.

Working in collaboration with other UN agencies, buy in from the government, strategy endorsements will contribute to sustainability and government ownership. The 2010 census main results were launched on 8 July 2011 at the Ministry of Foreign Affairs office. It was launched by Vice Prime Minister, Minister of Finance and UNFPA representative and was attended by Member of Government, member of National Parliament, UN-representative, Diplomatic corps, National and International Agencies, Academics, NGO's and ISF.

Although capacity development had got enough attention, being a new country, there will still be dependency on external expertise in the area of PD. While it may be too premature to develop short-term exit strategies, there should be long-term strategies for human resource development to ensure sustainability.

2.4.5 Facilitating Factors

Committed and skilled staff to execute the census and DHS surveys, good leadership with lessons to share from previous country experience, good management and peoples' skills has been able to contribute to accomplishing the work in an efficient and cordial manner. Budget allocation from the government and UNFPA to carry out the activities, clarity on division of labour, close cooperation with MoF and housing of UNFPA staff in NSD premises also made it easier to integrate well with NDS staff. Good coordination of UNFPA CO PD section with line ministries, NGOs and donors who seek data and services of the survey unit. Most importantly, CO's careful and mutual consultation approach led to a high level of ownership of Census which by the government, specifically MoF. This enhanced the wide dissemination, awareness and utility of census data. Strong government commitment from the MoF side and its vision are facilitating factors.

2.4.6 Hindering Factors

Geographic situation of the country limits easy access to remote areas and supervision and monitoring becomes difficult and costly.

Lack of an exit strategy and no clear cut capacity development strategy may contribute to uncertainty of retaining qualified staff in positions that are crucial in maintaining the technical quality of survey and analytical work under PD component.

While computer skills are not at best at district level offices, infrastructure and intermittent supply of electricity in those areas limit the use of available computers.

2.5 Gender

2.5.1 Context

The Government of Timor-Leste is committed to addressing gender equality in all spheres of life as evident in Article 17 of the Constitution of the Democratic Republic of Timor-Leste. This commitment has been further reinforced in the country's Strategic Development Plan 2011-2030, with the vision that in 2030 the country will be gender equal in every respect where women's rights are recognized, protected, and promoted. The government's commitment to gender equality has also been expressed in its decision to ratify several international conventions related to the promotion of gender equality such as the Millennium Declaration and the Convention on the Elimination of All forms of Discrimination against Women (CEDAW).

In 2008, the SEPI was established by decree law No. 16/2008, replacing the former Office for the Promotion of Gender Equality (OPE), to play a catalytic role in achieving the objective of promoting gender equality through gender mainstreaming in all government policies, programmes, processes, and budgets. In the same year, the Dili Declaration was signed in which various stakeholders demonstrated their commitment to promoting gender equality in several areas, which included the elimination of violence against women and girls and the adoption of the Law Against Domestic Violence (LADV), and a funded implementation plan to deal with domestic violence (DV) issues.

Since UNFPA's 1st Country Programme 2003-2008, there have been significant achievements attained in the area of gender. The Law Against Domestic Violence has come into effect in 2010. There have also been changes to the Electoral Law to ensure an increase in the number of women candidates for the National Parliament and a Resolution establishing Gender Working Groups across the ministries and districts.

The gender component of UNFPA's CP2 is focused on addressing gender-based violence (GBV). The GBV component of CP2 contributes to UNDAF Outcome 3 which aims to improve the quality of life of children, young people, and women and men by reducing malnutrition, morbidity and mortality, and strengthening learning achievement and enhancing social protection. CP2 also reflects the MDG goal of explicitly promoting gender equality and empowerment (MDG 3). In addressing GBV, CP2 dovetails with the national objectives of the Timorese government to empower women. Specifically, CP2 reinforces the country's national priorities from 2009 to 2011 in two areas: (a) access to justice, and (b) the provision of social services and service delivery to the public. By addressing GBV, the aim is to bring about gender equality over time and enable women to participate fully and on equal terms with men.

Status of Women

In Timor-Leste, the status of women varies depending on context with gender gaps being more pronounced in some areas than in others. In the political arena, for example, Timorese women fill 38% of the National Parliament seats, which is above the global average of 17%. In contrast, female representation on Suco Councils could be much stronger since women constitute only 2.5% of the Suco Council Chiefs. It must be noted, however, that quotas have been determined for female representation in Suco (village) Councils and National Parliament (through party lists); quotas for Suco Council members are 28%, while for National Parliament members, it is 29%. Moreover, the positions of Minister of Finance and Minister of Social Solidarity are now held by women. In addition, the Vice-Minister of Education is a woman, two Vice Ministers of Health and three Secretary of States are women. Aside

from women's participation in politics, women's labour force participation is relatively promising as women make up 27% of civil servants and 16% of Directors or Chiefs.

According to the Timor-Leste Demographic and Health Survey (TLDHS) 2009-10, however, literacy rates indicate distinct gender gaps. Generally, it has been found that men are more literate than women although the gap is much smaller in the urban areas such as Dili. However in higher education, men clearly outnumber women. Interestingly, there is a positive correlation between literacy rates and wealth; only 47% from the lowest wealth quintile are literate while 92% of the women from the highest wealth quintile are literate. In contrast, there is an inverse relationship between employment status and wealth with 49% of women in the poorest households engaging in wage work compared with 32% of women from the wealthiest households.

Having said that, significant gender biases persist in various spheres linked to Timorese culture. Cultural norms, for example, posit differing roles for men and women, thereby reinforcing the power differentials between the sexes. Kinship systems also tend to be largely patrilineal although there are some groups that are matrilineal. In terms of land rights, customary law tends to prevail, privileging men over women although civil law maintains that both men and women enjoy equality in this area. Hence, patriarchy tends to be prevalent in the country, contributing to much of the gender inequality felt by women.

An obvious area in which gender inequality persists is in gender-based violence. Domestic violence (DV) is the most common form of gender-based violence faced by women. DV includes physical and sexual violence, verbal abuse, restrictions of freedom of movement, and withholding funds from a woman. The persistence of GBV has been attributed to the entrenchment of patriarchy in society that has perpetuated certain expectations of women's roles in society and religion. Notions of women's sexuality are also bound up with patriarchy such that many women hold to the view that marital rape is acceptable. A baseline study of 2009 found that domestic violence was a 'normal' occurrence for many women. During the political crisis of 2006, sexual abuse and harassment were also prevalent among female internally displaced persons (IDPs).

According to findings in the 2009-10 TLDHS, the incidence of GBV is highest among those aged 25-29 which was at 48.1%. These women are also more likely to experience physical violence sometimes or often in the past 12 months. In the same survey, it was found that domestic violence was most prevalent among the divorced/separated/widowed at 52.9%, many of whom have not been able to obtain justice. In the same survey, an inverse relationship between household decision-making and GBV was found in that women who participated in three or four household decisions are less likely to experience spousal violence. Moreover, 73% mentioned that they do not have family members outside the home to provide shelter for them for a few nights if needed, which increases their vulnerability.

2.5.2 Programme Design (Gender)

UNFPA has identified gender as a component in its CP with the explicit objective of addressing GBV. In UNFPA's CP2, three strategies have been adopted to address GBV: prevention, intervention, and policy advocacy. UNFPA works with SEPI and the Ministry of Social Solidarity (MSS) as key partners in addressing GBV.

In CP2, the three outputs in the gender component flow logically from the main outcome which deals with the law, the role of service providers, and SCR 1325, each of which has the effect of engendering

gender equality and enabling women and girls to exercise their human rights while being free from discrimination and violence. Moreover, the three outputs, while distinct, tend to complement each other and at the same time are linked directly to achieving the outcome.

The indicators for each output have been kept to a realistic level. Moreover, the activities under each of the outputs are relevant to the indicators. The activities have also been paced out fairly well over the three year period covered by the evaluation, with each activity being allocated sufficient time for completion within the allotted year.

By and large, the coordination of the various activities under the indicators for each of the three different outputs has been managed well. This may be because the activities undertaken by the IPs and sub-contractors identified under Output 1 and 2 do not overlap and, as such, each meets the targets of the respective output. Nevertheless, it must be highlighted that a smooth coordination of the activities has been achieved because SEPI, MSS, and each of the sub-contractors under CP2 have been committed to promoting gender equality and eradicating various forms of discrimination against women and girls.

2.5.3 Programme Management and Partnerships

CP2 aims to promote gender equality and eradicate GBV and is in line with government policies and priorities. CP2 also reinforces UNFPA's mandate, in particular, the International Conference on Population and Development (ICPD) of Cairo, 1994 which emphasizes the gender rights dimension of population issues. Because gender-based violence has a relatively high incidence rate in Timor-Leste, addressing the issue is a relevant component in UNFPA's CP2.

Under CP2, UNFPA has worked with various partners, both government and NGOs, in executing its strategies in order to achieve the programme's outcome and concomitant outputs. For example in order to achieve output 1 of CP2, UNFPA has worked closely with SEPI to ensure the implementation of policies and laws relevant to addressing DV and GBV. On UNFPA's part, the technical advice provided has been paramount in enabling SEPI to strengthen its national capacity to address gender-based violence. Moreover, the technical advice provided has been appropriate and its quality has been sound as it has been tailored to meet SEPI's needs.

Another key partner for the implementation of the LADV is MSS since MSS, in contrast to SEPI, is the lead coordinating agency overseeing service provision to GBV victims. UNFPA's contribution to MSS's work has been instrumental through its providing an international consultant who was tasked with leading the process to develop the Standard Operating Procedures (SOPs) for the referral network and managing of shelters, as well as creating a systematic data management system.

Other key partners are the Vulnerable Persons' Unit (VPU) of the National Police of Timor-Leste (PNTL) and the Justice and Peace Commission (JPC), as well as the Dioceses of Dili and Baucau for the organization of events for the promotion of gender equality. UNFPA's role in providing technical input to these partners has been critical to the implementation of CP2.

In addition, UNFPA has developed partnerships with the following local NGOs: Judicial System Monitoring Programme (JSMP), FOKUPERS, PRADET, Holy Spirit Sisters, and Casa Vida. In contrast to the other key partners mentioned above, UNFPA's role in providing technical input has been minimal.

The evaluation team confirms that the selection of strategic partners on the part of UNFPA in implementing CP2 has been superior. In fact, the selection of partners has been strategic because each of them has played an integral role either in the areas of prevention (through the establishment of legal frameworks), intervention (social protection services to reduce vulnerability of women and girls as well as strengthening protection), and policy advocacy (advocate to build national capacity for the implementation of the UN Security Council 1325 on Women, Peace and Security). In particular, the NGOs have had a long-standing track record of providing relevant and quality services to GBV victims (some having been in existence for more than ten years) owing to their structure and a relatively strong capacity to reach out to women and men at the grassroots level. The organizational and strategic visions of each of these NGOs are also in sync with UNFPA's mandate.

UNFPA also has monitoring and evaluation systems and processes put in place to make it possible to assess changes in risks and assumptions although these systems and processes may be strengthened. This has been complemented by spot checks on select few sub-contractors although these have been largely random rather than systematic.

The following outcomes and outputs were drafted under the gender component

Outcome: Strengthen national capacity to promote gender equality and prevent gender-based violence through improved policies, protection systems, the enforcement of laws and the provision of reproductive health services.

2.5.4 Outcome One (Programme Relevance - Gender)

The outcome spelled out in the programme, in covering a range of strategies to address the issues such as from policies and protection mechanisms to legislation to criminalize domestic violence and other forms of GBV and the provision of relevant services targeted at GBV victims, is relevant to CP's aim in promoting gender equality and eradicating GBV.

Strengthening national capacity to prevent gender-based violence inevitably includes the promulgation of relevant legislation. On 21 June 2010, the Law Against Domestic Violence (LADV) was successfully promulgated after years of lobbying with significant technical advice and input from UNFPA to various government agencies, in particular, SEPI. The need to promulgate such a law is relevant for several reasons. First, Timor-Leste needed its own national legislation, as until 2009, the Indonesian Criminal Code was in force. The Indonesian law, however, had several shortcomings. For example, it did not treat domestic violence as a public crime. Second, the LADV is necessary because the Timorese Criminal Code, which was eventually adopted in 2009, does not contain any specific crime of "domestic violence", although it does cover a fairly broad range of offences against the person, which also includes human trafficking, sexual exploitation, including that of an adolescent. Third, the definitions of "sexual coercion" (Art. 171, which basically refers to sexual assault) and "rape" (Art. 172) in the Timorese Criminal Code require that the suspect uses violence, serious threats, made the person unconscious or put them in a position where it was impossible to resist. But these definitions rely solely on the use of force in order to achieve successful prosecution of the crimes, which means that sexual assaults which do not involve physical evidence (such as psychological violence or intimidation or abuse of authority) would not be considered a crime. This psychological aspect is included in the definition of domestic violence in Art. 2 of the LADV. Fourth, the LADV, in contrast to the Criminal Code, is necessary because it treats DV from the perspectives of prevention, protection, and prosecution. In this regard, it adopts a

multi-sectoral approach, covering justice as well as health, education, and social services. For example, Art. 22 of the LADV emphasizes the role of the health sector. Here, hospital services are obliged to provide medical assistance and care towards DV victims, preserve evidence related to alleged crimes, report the facts of the case to the police or public prosecutor, and refer the victim to a shelter. In the same vein, social service providers are responsible for reporting cases of domestic violence to law enforcement officers, facilitate the transfer of victims to a safe place, provide support at the victims' request, and monitor cases in court (Art. 23). Moreover under the LADV, the government of Timor-Leste is obliged to raise public awareness of domestic violence through media campaigns (Art. 9), development of information and training materials (Art. 10), incorporation of domestic violence into the school curriculum (Art. 11), and supporting domestic violence research (Art. 12). Fifth, the Criminal Code has another drawback in that it does not include crimes of marital rape or incest.

Because the rights of women and girls have been severely violated in Timor-Leste as a result of war, CP2 of Timor-Leste is committed to realizing UN SCR 1325—a resolution which is timely and relevant in a post-conflict country. Recognizing the importance of SCR 1325, SEPI has included elements of SCR 1325 in its National Action Plan (NAP) on GBV together with its strategies to realize the implementation of the LADV and other activities aimed at addressing GBV and promoting gender equality in the country.

That CP2 has been inclusive in respect to the need for appropriate and coordinated service provision to GBV victims and their children is relevant since civil society organizations providing these services tend mostly to be working independently. As such, UNFPA's role in bringing together several NGOs addressing the needs of GBV victims has been critical in raising the efficiency levels of this group of organizations so as to better meet the needs of GBV clients.

2.5.4.1 Output One

Contribute to implementing the national domestic violence law.

This output aims to: (a) advocate the need to promulgate and implement the draft Law Against Domestic Violence among key line ministries, the National Parliament and civil society; and (b) produce information, education, and communication (IEC) materials to educate the population on its benefits.

Activities planned under this output include: (a) lobby for the promulgation of the Law Against Domestic Violence and; (b) conduct a national campaign to raise public awareness about the Law on its promulgation; and (c) training of the police, prosecutors, judiciary, Suco chiefs, and key partners in the referral network of support services and other stakeholders on the use and application of the Law.

Effectiveness

UNFPA's role has been critical in the implementation of the law starting from the lobbying stage right up to its socialization at the community level. At the onset, it must be said the promulgation of the LADV is critical in addressing the problem of DV and GBV. In essence, the law represents the government's position on DV, namely, that DV cannot be treated as a private matter but a public crime against humanity as a whole and women more specifically. The Law is also necessary for preventing and investigating DV crimes and establishing appropriate remedial measures for victims. Translations of the Law have already been undertaken both in Portuguese and Tetum. Briefing kits on the law have also been produced for council ministers, members of the National Parliament, and civil society organizations. This briefing kit has also been successfully translated into Portuguese and Tetum, a task which is necessary since Portuguese has been declared the national language and Tetum would facilitate

the law being understood by the local population. Complementing the work of SEPI in this regard is JSMP which has also distributed copies of the law in Tetum in the districts and rural areas. Specially brochures containing information on the role of the law and how to access justice have been produced and distributed.

The implementation of the LADV has been largely successful because of the various efforts in raising awareness on the Law—an effort in which UNFPA has played a significant role. This can be gleaned in the training provided to the different stakeholders critical to the implementation of the law. For example, there has been training conducted in three districts (namely, Manufahi, Covalima, and Oecusse) on the law which was targeted at the *Chefes de Suco*. The training was expedient for a number of reasons. It helped the *Chefes* understand that DV is a public crime and that perpetrators are liable to be prosecuted according to the criminal law. This is important given the fact that they were the mediators of disputes under the traditional justice system. The training also enabled them to understand that they have the capacity to settle a marital dispute if the victim so wishes, and that they also have the responsibility to take the appropriate steps to address the matter in accordance to the law if the victim chooses to have the matter settled in court. Moreover, the training also imparted information on how DV and sexual violence cases need to be referred. This is very important as many *Chefes* still see themselves as traditional mediators. In sum, *Chefes de Suco* learned about the extent of their authority in dealing with GBV and DV through the training.

In a workshop organized by JSMP/VSS, participants provided positive feedback on the training they received on the law, responding that the quality of the training was high and the use of examples and the materials covered were useful in understanding the nature of the crime and how they should deal with DV and GBV cases. Training was also given to PNTL so that they know their responsibility and how they should refer cases since often it is the police who are the first line of contact for the victim. In fact, at least 70% of all clients across the country approaching a *Fatin Hakmatek* have been found to have been referred by PNTL. An interview with a police officer confirmed that the training received was extremely useful especially since DV and GBV crimes need to be differentiated from other crimes. This police officer also learned that DV and GBV are public crimes, which means that law enforcement takes precedence, i.e. the police need to investigate the case, irrespective of the victim's wishes, and this needs to be reiterated to the victim. If this is not highlighted, victims may not understand the full consequences of what is meant by a "public crime". It must be noted that some participants of the training on the law found the training to be useful since the law contains technical terms in Portuguese which are difficult to understand as the majority of the Timorese population do not speak this language.

It must also be reiterated that the idea of deploying individuals from the community to conduct training on GBV has a number of advantages. For example, SEPI's Gender Focal Point in Oecusse has been tasked with providing training to PNTL and *Chefes de Suco*. Because she is from the district and speaks the local dialect, the advantage she possesses is her ability to connect to the trainees. JSMP/VSS has also recognises the usefulness of training para-legals from the local community since these individuals bring with them not only the advantage of language, but are already known among the community and, as such, are able to build trust more easily than an outsider.

At the community level, regular public awareness campaigns were planned to introduce the LADV. A case in point is the National 16 Days Campaign to End Violence Against Women organized by SEPI with technical input from UNFPA. To reinforce the work of SEPI, this campaign has been complemented by the efforts of various NGOs. FOKUPERS, for example, has been using radio talk shows to disseminate information on the LADV. In addition, it has organized a nation-wide campaign on the law with support

from UNFPA, UNIFEM (now UN Women), and SEPI. In fact at the suco level, it is the role of NGOs that is paramount in getting the message out on the LADV. The modus operandi of these NGOs have been to use drama, dialogue, and movies to increase awareness on the DV law and SEPI recognizes that these efforts tend to complement SEPI's activities which largely involve training, dialogue, and discussion.

That all these efforts have been successful is evident in the rise in number of DV cases reported to the police. In 2011, for example, there were 755 GBV cases, as compared to 688 GBV cases in 2010 and 679 GBV cases in 2009. In fact of all the crimes reported to the police in recent years, DV crimes tend to be the highest in all the districts. In Oecusse, for example, all the 15 victims who have approached PRADET for assistance since its "Safe (Quiet) Place" (Fatin Hakmatek) opened on 21 February 2012 have come from the *aldeia* which indicates that DV and GBV awareness-raising campaigns and efforts have also achieved a measure of success in the rural areas. While this may be a positive sign that more people are aware that DV is a public crime and not a private matter, it must be noted that not every crime of this nature would be reported and, as such, the actual numbers are most likely much higher than the reported numbers.

Since the LADV classifies DV as a public crime and not a semi-public crime, as it was previously regarded, we should expect that it would take time for the implementation of the law to take complete effect. This would also entail a complete shift in mindset of the government officials as well the community. For example, it was found that Chefes de Suco continue to resolve DV cases through traditional processes and only refer to the formal justice system should the traditional structures fail to provide some resolution such as in the case of murder or rape. It was also discovered that often Chefes de Suco leave it to the women to decide if they want to bring the case to a higher level in the justice system although the perpetrator is expected to sign a letter not to repeat the offence. While this may signal an attempt to empower the victim, which in this case is most often the woman, it may also be indicative of the lack of understanding of the recently-adopted criminal legislation such as the Timorese Criminal Code. In this regard, much more needs to be done in increasing awareness on the criminal legislation and the reasons for why the formal justice system should be given at least equal consideration to existing customary laws, especially where serious cases are involved such as SGBV crimes. This should be regarded as an important element in the socialization of the LADV so as DV and GBV victims do not lose trust in formal justice mechanisms and come to a conclusion that these have no weight.

Efficiency

In 2009-2011, around USD 427,778 was spent on the implementation of the LADV under Output 1. The amount is justifiable since the output yielded 21 activities during the period of 2009-2011, including relatively large chunks channeled towards developing and distributing advocacy materials and the National Socialization Campaign on LADV and GBV, as well as formulating the NAP on GBV and training for police, legal sector, and Suco Councils. Some USD 26,000 was also spent on research for a project on teenage pregnancy. This research extended over a year.

All the sub-contractors receive support from various donors for their activities causing some overlap or duplication of activities. For example, in 2009 FOKUPERS received support from various donors for the nation-wide media campaign on the LADV. However, this overlap and duplication may be justifiable because the support given was fairly small and it is understandable that FOKUPERS needed to rely on several donors to conduct this campaign.

On the part of the sub-contractors, because funds come from various sources, this has made financial management more complicated for them. Delays in receiving funds from UNFPA (owing to MDG-F Secretariat delaying the release of funds to all five participating UN agencies until approximately mid-year) have also been a problem in the last year with some of the NGOs finding themselves having had to drop some of their activities. Such was the case of PRADET's outreach to students. In the case of JSMP/VSS, the delay meant that staff members would not have received salaries for four months— a situation which was averted because another of its donors was willing to give its financial support ahead of time to cover the shortfall in JSMP/VSS's operating budget.

Sustainability

Bearing in mind the withdrawal of UNMIT from Timor-Leste, it has been planned that UNFPA will continue to support SEPI in the implementation of the LADV in conjunction with the NAP on GBV as it has in the development of the NAP on GBV, in particular, the establishment of the Technical Drafting Committee led by SEPI and consisting of members from the following key ministries such as Justice, Education, Health, Social Solidarity, Security, Provedoria, as well as civil society. UNFPA also supported four districts and two national consultations with communities on the drafts of the NAP on GBV. Moreover, UNFPA supported SEPI in the drafting of the Resolution for the establishment of the Inter Ministerial Commission to oversee the M&E of the implementation of the NAP on GBV.

Under CP2, UNFPA staff has also successfully provided training to the VPU/PNTL, Criminal Investigation Section, Taskforce, Community Police and the Police Training Centre on gender, GBV, human trafficking, some child protection mechanisms, the referral network of support services, as well as the legal framework related to GBV. Because of growing demand for training in these areas by the taskforce and immigration police, much more effort needs to be channelled into increasing the numbers of trainers through training of trainers (TOT) which would also facilitate the permanent handing over of this activity to the government and other relevant stakeholders. Granted that the process is relatively slow since it is difficult to identify suitable and competent trainers who would be able to undertake the work based on their knowledge and presentation skills, there needs to be a greater effort to prioritise this area to meet the growing demand for such training. While SEPI staff may also be competent to provide training, because of the limited current staff at SEPI, it would not be possible for it to cover all training independently; suggesting that UNFPA's technical input in this area continues to be critical. Moreover because of increased demands for training, SEPI is in a position where it is more likely need to depend on UNFPA's continued support, at least in the immediate future.

Because of having received guidance from UNFPA on organizing the National 16 Days Campaign to End Violence Against Women for several years already, SEPI has become confident in independently organizing this event. For example for the 16 Days Campaign, SEPI brings together all civil society groups so that ideas and opinions can be shared. Since the Campaign was first launched in 2002, SEPI has continued to replicate how it has coordinated with the relevant NGOs. SEPI also recognizes that such partnerships are necessary to achieve success and avoid duplication of work.

On the dissemination of information on LADV, SEPI foresees that they will continue to require financial support from UNFPA in carrying out its activities in the immediate future since currently only operational costs tend to be borne by the Timorese government. In this case, SEPI is aware that it would need to continue to lobby more aggressively for funds from the government to continue its activities which it has already started. The NAP on GBV has already been adopted and the Inter-Ministerial Committee is being established, which would enable SEPI to take ownership of more activities under this

output. This is particularly crucial especially since efforts towards the socialization of the law at the district and suco levels have been largely adhoc since the law has been promulgated, owing to minimum funding and limited human resources at SEPI. Should lobbying with the government be successful and the budget allocated to SEPI increase steadily, SEPI staff report confidence in implementing most of the activities related to the LADV and the implementation of the NAP given their current staff strength, having gained the relevant experience under UNFPA's guidance. But should there be a dramatic increase in funds on the part of the Government to SEPI, the Secretariat is not likely to be able to implement all the activities unless there is a significant increase in the number of staff with the appropriate skills.

In so far as generating its work plans and activities are concerned, SEPI continues to benefit from the technical input provided by UNFPA staff, thus calling to question whether SEPI would implement a national GBV programme wholly independently. It must also be mentioned that SEPI has a limited monitoring department and, as such, it is unable to measure the effectiveness of its activities in relation to dissemination of information on the law. On this matter, SEPI has signed a four-year programme with Spanish NGO (non-government organization), Paz y Desarrollo to, inter alia, assess the effectiveness of SEPI's socialization efforts and production and dissemination of IEC materials. This monitoring has been reflected in the NAP on GBV. Currently, quarterly reports of its outputs are recorded and sent on to UNFPA. Besides, financial and national reports on all activities conducted are also produced.

The sub-contractors unanimously said that they would have to scale down on their services should they not receive funding from UNFPA in the near future. Because the number of DV and GBV cases has been increasing since the promulgation of the law, any reduction in funding to sustain current activities would be a major impediment not only to the work of the NGOs but also to clients in need of their services.

2.5.4.2 Output Two

Increase access to emergency medical, shelter, counseling, and legal services available for victims of domestic and gender-based violence in Dili and other districts.

To achieve this output, the programme will: (a) support awareness-raising and training for communities, police, the legal sector and health workers on gender-based violence and support services; (b) support initiatives to expand services to victims of gender-based and domestic violence; and (c) develop protocols and operating procedures to regulate the existing referral network of services and reinforce data collection on cases of domestic and gender-based violence.

The main strategic approaches to achieve this output are: (a) strengthening mechanisms for coordination, information-sharing and complementarity of services, especially between the MSS, SEPI, Ministry of Health (MOH) and the NGO service providers; and (b) increasing the capacity of the MSS to strengthen and coordinate existing case management and data collection systems.

Activities planned under this output include: (a) the expansion of the referral network of support services to the districts and improvement in the quality of information and services provided to victims of violence; (b) the formulation of regulations and protocols governing the referral network; (c) the systemization of data collection, monitoring, and evaluation of GBV cases, including identification of a core of GBV indicators which will regularly be monitored and analyzed; and the installation of a GBV database; (d) the partnership with men's organizations such as the Assosiasaun Mane Kontra Violencia (AMKV) in initiatives aimed at changing the attitudes of men towards women and the use of violence; (e) the improvement of women's access to formal legal mechanisms and access to information about

their legal rights, formal justice processes, and support services; and (f) ensuring that women and children's issues are represented in discussions on justice and legal protection in both the formal and traditional justice systems.

Effectiveness

In the past three years, there has been an increase in shelters and Safe Places for GBV victims with support from UNFPA through its various sub-contractors under CP2. UNFPA continued their support to FOKUPERS from CP1 to CP2 and then their Shelter in Maliana in 2010. The Holy Spirit Sisters also run a shelter in Salele, Covalima with funding from UNFPA since 2011. Casa Vida is a shelter for female victims of sexual assault up to the age of 18 years old located in Dili. Funding only started to be channelled to this NGO in 2011. UNFPA also funds a Fatin Hakmatek located in Dili. The facility is run by PRADET. On 21 February 2012, another Fatin Hakmatek or Safe (Quiet) Place, located adjacent to the Oecussi Hospital, was opened with support from UNFPA and other donor funding.

These shelters and Safe (Quiet) Places, which have been in operation for several years, have seen an overall increase in GBV clients in the last three years, suggesting an increase in access to relevant medical, shelter, counseling, and legal services made available to GBV victims. The figures showing this increase in GBV clients for each NGO funded by UNFPA from 2009 to June 2012 are tabulated below:

Table 1: Number of GBV clients approaching NGOs funded by UNFPA, January 2009-July 2012

Year \ NGO	2009	2010	2011	2012 ³
JSMP	176	245	237	132
FOKUPERS	92	149	137	83
PRADET	209	273	56 ²	126
Holy Spirit Sisters	-	-	11	8
Casa Vida ¹	-	-	26	42

Sources: Data compiled from interviews with NGOs and annual reports submitted to UNFPA.

¹ UNFPA only started to support Casa Vida and Holy Spirit sisters in 2011.

² Because of the late disbursement of the MDG-F funding from New York, UNFPA only provided funding to PRADET in the last quarter and, thus, this figure reflects that period only.

³ The data presented for this year is up to July 2012 only.

It bodes well for UNFPA and the respective government departments that data collection has been identified as an area to be strengthened by both the government and NGOs, as a systematic mechanism for the collection of information to better serve the needs of GBV victims. A more rigorous method of collecting data had to be produced because the data from the various NGOs was problematic in a number of ways. First, since each NGO was gathering its own data, it was surmised that there might have been a duplication since it is not uncommon for a victim to approach more than one NGO for assistance at a time. Second, the definition of what constitutes violence is highly varied across the NGOs addressing GBV. FOKUPERS, for example, has more than 20 categories of violence which complicated how recording was carried out. The police, in contrast, use the Criminal Code as a reference point for defining violence. There have also been gaps in the information collected. For example, while FOKUPERS collects details on the age of each client seeking their assistance (although this may not be reflected in the reports they submit to UNFPA), JSMP collates this information by age cohorts only although they

may document the exact age of each client as they come in. The lack of systematic data was a concern for another reason. Because the exact numbers and profiles of GBV victims are unknown, this would make it difficult to prioritise activities and improve services especially in relation to resource mobilization. Moreover, having a systematized database to which all service providers might utilize would also help to prevent a victim from being re-traumatized which would happen should each and every service provider seek details from a victim. It must be mentioned, however, that there has been an attempt to produce a database by the police with technical assistance and funding from AusAID Justice Facility. Under this system of collecting data, each client was assigned a number. But UNFPA together with MSS decided that the database was more relevant to collection of criminal statistics. Moreover, certain fields were absent such as the number of clients requesting medical attention.

For this reason among others, UNFPA's international consultant who had been hired to work in MSS was tasked with leading the process of producing the Standard Operating Procedure (SOP) for data management. The push for this SOP comes from the acknowledgement that accurate data is essential to strengthen policy and strategy across ministries as well as NGOs, thereby increasing the effectiveness of the services provided to GBV clients. At the time of the evaluation, the SOP has already been implemented at the district level. The plan, however, is to encourage each service provider addressing GBV to use the template. With frequent use by each service provider, UNFPA is confident that this method of collecting data will yield the expected output in due course.

Concurrently in JSMP, a database manager was hired to gather and analyse data on GBV victims. JSMP recognizes that tracking the numbers of clients is important since there has been a gradual increase in the number of GBV victims with more than 20 clients a month approaching them for assistance. The aim of JSMP was to increase the quality of services in accordance to the rising demand as a result of greater awareness of the law.

In ensuring that UNFPA's CP is positioned within the national agenda, both MSS as well as UNFPA staff and international consultants have been in regular consultation to ascertain that MSS's work plan is aligned with the country's national priorities. It was reported that UNFPA has played an integral role in acting as a "good bridge" between MSS and the larger national machinery. UNFPA has also been useful in assisting MSS develop a monitoring system so that the Ministry can track the progress as well as effectiveness of its activities. Since the Ministry considers monitoring to be a priority, efforts to monitor its activities have become part of its NAP for three years.

Efficiency

Strengthening and increasing relevant services to GBV clients through the NGOs was possible with the funds provided by UNFPA. Funds to PRADET, for example, increased from USD 88,669.60 in 2009 to USD 129,428.40 in 2010, an amount that is justifiable because of the increase in activities. The amounts are also justifiable since there has been an increase in GBV clients received by this IP.

Because MSS's efforts to provide suitable and timely services to GBV victims have been hampered by the lack of coordination across the various service providers, MSS took it upon itself to generate a referral pathway under UNFPA's guidance. An international consultant was hired by UNFPA to lead the process of developing the SOP as well as a separate SOP for data management. As a result, the SOP for the referral pathway has been developed and has been in use since then. While the SOP provides for an efficient mechanism within which each stakeholder knows what his/her role would be should he/she be the first contact point for the GBV victim, it also serves to guide each stakeholder as to how he/she

should assist the victim. Although in the initial stage of development, there has been an absence of a monitoring system to measure the outcome of this SOP, having the SOP in place in the first instance might be considered as a step forward for service providers since they now have tools to guide them when previously they would only gather for monthly meetings and discuss their progress. Furthermore, MSS plans to conduct follow-up monitoring of the functioning of the SOP on referrals in the districts, as part of Phase II of its work on strengthening referral networks. For the above reasons, the funds channelled into producing this SOP are well-justified.

It is difficult to conclude, however, as to whether the SOP for the referral network has translated into improved services for GBV victims unless every stakeholder in the referral network is fully committed to adopting it. Based on interviews with relevant individuals in the health sector during the fieldtrips made by the ET, the referral network appears to have been relatively well-adopted and fairly entrenched. For example, interviews reveal that there is every effort made not to re-traumatize the victim, thereby avoiding the duplication of effort. In Oecusse, it was found that details from the GBV victim, mainly the situation of the case as well as the victim's condition, were first documented by the police; this was followed by PRADET's staff who then documented details on the case as well as specific injuries using the Medical Forensic Protocol, followed by the provision of relevant medical treatment. The use of the referral network also enabled PRADET to provide sensitive and culturally-appropriate services to the victim, which has the effect of reinforcing Strategy 9 of the Health Sector Strategic Plan 2008-2012. In this case, victims are referred directly to PRADET's facility by the police instead of being sent to the hospital so that her privacy is respected since the hospital may be crowded with other patients. In Maliana, the interview revealed that details documented by the police were also used by the FOKUPERS staff handling the victim; here, the staff was aware that she should avoid re-traumatizing the victim. The individual from FOKUPERS also reported that coordination among the different service providers is good in Maliana as the police have been swift in acting as well as JSMP staff who have travelled from Suai to deal with the case. In this case, speed is of the essence to help the victim so that they know that the law has force.

While the referral network has been in place for some time, this does not preclude problems from surfacing which have affected the efficiency of services provided to GBV victims. For example, a nurse from the hospital tending to GBV victims arriving at PRADET's "Safe Room" (Fatin Hakmatek) was not on call 24 hours which meant that GBV victims who sought help after working hours would have to wait until the next morning to be treated. Moreover in Dili, it was discovered that the work of PRADET is yet to be fully integrated into the health sector, raising concerns on the extent to which the health sector is concerned about GBV although GBV is clearly outlined as a priority in the national health strategy. Specifically, there is a lack of awareness among the health providers in the hospitals, especially the new arrivals, that a GBV victim would require a series of treatments such as psychosocial assistance as well as counseling, aside from medical attention. At the time of writing, PRADET was undertaking a series of "rounds" of the hospitals to raise awareness among medical staff, doctors, and nurses in the emergency department, where often victims are referred as a first point of contact for help. Thus, it is unclear if the health sector is fully committed in addressing GBV since there appears to be a lack of coordination between the Ministry of Health, IPs (implementing partners), and other government ministries. In fact, the interview with the Director of the hospital in Pante Macassar, Oecusse revealed that while there are plans to have about five or six healthcare providers from the hospital receive training on the medical forensic protocol, they are depending on PRADET to cover the fees incurred for the training because of having limited funds themselves rather than funds coming from MOH or the hospital for this purpose, calling to question MOH's commitment to addressing GBV, although the Health Sector Strategic Plan (2008-2012) mentions the suppression of GBV in Strategy 8. In light of this, much more needs to be done

to lobby MOH to address DV/GBV as a health issue and to strengthen the relationship between MOH and PRADET.

In order to increase the quality of services to GBV victims, an SOP was developed for the management of shelters for GBV victims. The rationale for the SOP was to ensure that shelters could be run in a coordinated and efficient fashion.

Overall regarding the activities funded by the MDG Joint Programming and Irish Aid, the respective activities were executed for the most part in a timely fashion as well as reports were submitted on time. Multilateral donors also observed that the activities were efficiently run according to the work plan mostly owing to good coordination and communication among the respective government staff and UNFPA officers. The technical advice given to the government has also been relevant and useful. Both multilateral donors concluded that the partnership has proven to be a success.

Sustainability

In regard to UNFPA's exiting strategies, it was found that UNFPA staff stationed in the respective government departments was still shouldering many responsibilities, although some gradual handing over of these tasks to local officers is happening. For example, some simple tasks, such as writing of reports and letters, are still being undertaken, or at least overseen by UNFPA staff.

The shortage of skilled local Timorese with the necessary human capital complicates the sustainability of the work currently undertaken by MSS and SEPI. In the districts, for example, child protection officers double up as GBV coordinators, some of whom may not have the needed skills in counseling trauma victims, especially women who have suffered violence. Besides, these officers are forced to take on too many responsibilities for which they are unable to cope. Moreover, dealing with GBV is a specialized task often distinct from child protection. Because of this complication, UNFPA has proposed newly recruited focal points to take on the task of dealing with GBV cases separately from child protection at the district level—an individual whose core functional skills include case management and data management.

2.5.4.3 Output Three

Contribute to developing a national action plan on Security Council Resolution 1325.

The programme will: (a) raise awareness of the Security Council Resolution and the need to draft a national action plan; (b) strengthen national capacity to monitor the implementation of international human rights legislation that protects the rights of women and young girls, including reproductive rights; (c) provide gender-sensitive training to military and civilian personnel in the peacekeeping operation; and (d) provide training on Security Council Resolution 1325 for civil society.

UNFPA will facilitate South-South cooperation with countries such as Nepal and Sri Lanka to enable Timor-Leste to benefit from other country experiences on developing a national plan of action for SCR 1325. UNFPA will work in partnership with IOM and UNICEF to strengthen policies against trafficking and provide services to victims of trafficking.

Effectiveness

UNFPA's role has been largely technical by way of providing consultation to SEPI as well as other UN agencies and, as such, has contributed to raising the profile of SCR (Security Council Resolution) 1325 on the national agenda. Furthermore, the SEPI/UNFPA Programme Manager contributed to the DPKO (Department of Peacekeeping Operations) Gender & Policing Best Practices Toolkit (2011) as Team Leader for Module 7 on Victim Support Services and was Team Member for Module 6 on Investigating SGBV (sexual and gender-based violence) crimes. This toolkit has since been piloted by the DPKO Office of the Rule of Law and Security Institutions (OROLSI) Policing Division (New York) in different post-conflict countries. UNFPA also sent a representative to the N-Peace Regional Conference in Bangkok, in October 2010 and 2011, to share experiences, alongside a SEPI staff member from Timor-Leste, based on the technical knowledge he had received in Timor-Leste.

Cartoon books on SCR 1325 content have already been published by UNMIT Human Rights Section, both in English as well as in Tetum. UNFPA's role was to provide technical advice in its development as well as contributing funds towards its publication. While it is difficult to measure the effectiveness of this output, plans are underway to have these book distributed to schools.

On this output, the relevant UNFPA staff also participated in early consultation groups established to work on the draft law on Human Trafficking.

Efficiency

UNFPA has granted SCR 1325 the least importance to this output among the three outputs it had carved out in the gender component of CP2. For this reason, the funds that have been allocated towards this output have also been extremely small in comparison to the amounts channelled into the other outputs of the gender component as well as the other components of CP2. However, the decision to channel the funds directed to this output has been justifiable especially since there were other UN agencies that became involved later in contributing to the NAP on SCR 1325 such as UNMIT Gender Affairs, UNIFEM (now UN Women), and UNDP.

Sustainability

Discussions on incorporating the principles of SCR 1325 into the GBV NAP have been recent and ongoing. Thus far, SEPI has decided to incorporate the principles of the draft NAP on SCR 1325 into the NAP on GBV rather than produce a separate NAP on SCR 1325. The Gender Working Groups established across the ministries and districts (in addition to inter-ministerial and inter-district working groups to coordinate gender mainstreaming efforts at a national and district level) has already been formed to discuss how SCR 1325 may be implemented in Timor-Leste. It was felt that forming these gGroups was to be far more strategic than having gender focal points in each ministry since members of the Working Groups would comprise of policy and technical level staff who have a greater influence in policy and strategy because of their respective Portfolios.

On the part of UNFPA, because UNFPA's global mandate has been made to eventually remove this output, the issue of sustainability no longer applies to this output.

2.5.5 Facilitating Factors

The capacity of qualified and suitable international consultants was integral to much of the success achieved particularly in regards to Output 2. Aside from being experts in the areas in which they were appointed, the cultural sensitivity and knowing the local language (as well as Bahasa Indonesia) demonstrated by some consultants proved to be of immense importance to the success of their work. Interestingly, NGOs reiterated the same idea: that is, the importance of having Timorese among the staff because of their being skilled in the local language and having greater sensitivity because of cultural factors.

2.5.6 Hindering Factors

Although improving, coordination across the government agencies in addressing GBV has not been as strong as anticipated because not all ministries prioritise the issue of GBV. Because of this, there is a need for strengthening the links between the Ministry of Health, Ministry of Justice, Ministry of Education, Ministry of Social Solidarity, Secretariat of State for Security, and SEPI, in particular, at the higher levels of Government and especially in light of the recent adoption of the NAP on GBV by the Council of Ministers, which requires these sectors to coordinate and monitor implementation of the NAP. Moreover it must be borne in mind that some Ministries do not have the required human resources to deal with the issue. In some instances, there has been a high turnover of national staff as individuals move on in search of better jobs. Another obstacle is that many other Ministries are not convinced that the needs of GBV clients are pressing since this group of women are a sub-set of a larger group of women and girls. For example, the focus of MOH is in EmoC/Safe Motherhood, while MOE focuses on increasing the number of girls in schools as well as improving literacy rates among girls and women.

That there is a shortage of human resources is a concern in both the IPs and sub-contractors. Under CP2, SEPI has four staff members working in its office funded by UNFPA. Capacity-building continues to be a concern because of the shortage of skilled local professionals. Moreover in SEPI and MSS, it is not uncommon for one staff member to cover several roles in his/her job. In most instances, individuals find it difficult to juggle the different roles they are tasked with, resulting in some of their work being neglected. In this regard, increasing the number of staff through recruitment may not be the solution since it is difficult to find suitable candidates among the Timorese population. The shortage of skilled personnel also means that should UNFPA withdraw in the immediate future, this would have severe repercussions on how some activities may be carried out. The NGOs also suffer the same fate albeit in a different way. JSMP/VSS finds that the quality of the new lawyers joining the NGO to be fairly weak. But a few years into the job, many end up leaving its organization for better paid jobs in the public and private sectors after having improved their skills significantly. For JSMP, retaining qualified and experienced staff has been a challenge in their effort to provide adequate and high quality services to their clients.

By and large, the UNFPA-funded sub-contractors have not been systematically monitoring the implementation of their activities targeted at GBV victims. The lack of capacity to undertake this task is one reason for why they have not engaged in this important task. The only form of assessment the NGOs have used to assess their achievement is to keep documents of the increase in the number of clients recorded in the last 3½ years. However, they are unable to assess how their clients have found the quality of their services. In this regard, there is a genuine need for each sub-contractor to build its capacity in the area of monitoring. Moreover, the lack of a monitoring system has also meant that if

decisions were to be made in the event there are changes in the internal or external environment, they tended to be knee-jerk reactions rather than based on reasoning.

3.0 Conclusions and Recommendations

3.1. Three Focus Areas

3.1.1. Conclusions

Conclusions (RH)

- The RH component, designed in accordance with national priorities, the local context, and the current situation of the health sector, has made an effective contribution to the improvement of service provision. With technical assistance of international professionals, capacity of the right target groups was developed basically in order to quickly respond to the needs in BEmOC/FP/ARH. Capacity of the health facilities in the provision of BEmOC and FP was strengthened with sufficient equipment, contraceptives, and transportation. Quality services were initially provided and choices were informed to quickly respond to the needs of the local people. The programme, hence, added value to the improvement of SRH care in Timor-Leste.
- There is still room for further assistance in capacity development for the health sector in provision of BEmOC and ASRH. National core trainers and technical experts in EmOC and ARH were missing. Capacity for RH and FP commodity securities were not yet properly developed leading to weak implementation of RHCS. There was an inadequate number of qualified local staff to provide SRH care. Technical supervision was not functioning regularly. Moreover, service utilization at the sub-district levels was still limited, leading to limited opportunities to practice learned technical skills leading to continued challenges to maintain the capacities that were developed over the last five years.
- The RH component made great efforts in policy advocacy for changes. The interventions received valuable support from religious authorities and community, policymakers, and health managers. The new government was informed of the existing programmes in the areas of support from UNFPA under CP2. Consequently, policy documents and legal frameworks have been revised and newly developed so as to create a supportive policy environment for RH care.
- The Family Planning interventions have made remarkable contribution in strengthening capacity of the current system and staff members in provision of services and information. However, capacity of the physicians in providing FP clinical service was still limited because of lack of human resource. The LMIS system was well functioning yet capacity in collecting up-to-date data on the Average Monthly Consumption. This coupled with the lack of in-depth data, especially those on unmet needs of unmarried people and youth, could weaken the basis for long-term planning of interventions in family planning.
- The ARH service and information provision was primarily establish and functioning under support of the CP2. Young people can initially have access to information about ARH through various channels

including in-school and out-school. Nevertheless, there was still lack of National Core Trainers in ARH clinical services, lack of a system of ARH monitoring and supervision, and lack of service and information in sexual health. Likewise, although youth profile based on DHS was done and youth in-depth analysis using Census is in the pipeline, these surveys did not provide routine data on 13 themes of youth as identified in the Global Declaration on Youth 2010. These shortfalls would weaken the basis for ASRH programming and long-term advocacy.

- Even though reproductive health was within the national priorities of Timor-Leste, the lack of a regular budget from the government was a challenge for the health sector. Interventions related to capacity building and service provision were still reliant on international donors. This in fact hampered the health sector on being proactive in carrying out their strategies and action plans independently.

Conclusions (PD)

- The Population and Development (P&D) component has three key intervention areas: Upstream advocacy, capacity building and Survey implementation. All areas have been designed in close cooperation and continuous consultation with the Timorese Government, specifically, NSD in MoF authorities in a participatory process that has combined demand-driven initiatives with UNFPA proposals. This mutual consultation approach has ensured a satisfactory level of alignment that is reflected in the key informants' feedback and in the content of the key strategic documents of the country (e.g. SDP-strategic development plan and other documents).
- The level of ownership by MoF and continuous support to NSD strengthened the collaboration and has produced good quality data and acceptance by data users. Overall, most of the components included in the expected outcome are achieved and the activities planned to be completed in the remaining period and the processes to achieve the outcome are in the right direction. The delays in establishment of National Population Commission (area of upstream advocacy) have been taken into consideration by the programme managers and intend to carry on with these efforts in the next programme cycle.
- There is no shortage in terms of national data. While DHS, Census (NSD), HMIS (MOH), EMIS (MOE) and LSMS (World Bank) are major data bases, there are multiple sources of data from various research, studies and surveys. Several other ministries such as Ministry of Estatal, Ministry of Justice, and Ministry of Agriculture also collect national data. If an inventory existed (and kept updated), data duplication (if any) could be avoided, and also would allow data users to supplement or complement their data needs. Issues related to data credibility, efficiency, and effectiveness can be regulated and enhanced if one central agency such as NSD can bear the responsibility to ensure the reliability, validity and accuracy of national data bases.
- Compared to the last Census, disaggregated data are available for planning and data projections were done and disseminated to relevant ministries. However, integration of population data in sectoral planning seems weak – specifically, at district level capacity is weak for the country to make full benefit of abundant data that is available for development planning.
- Although PD program vision is commendable and the strategies and activities employed are relevant, more strategic outlook towards long-term sustainability issues and sound exit

strategies would have been useful in the long run. At the design stage itself a longer term plan has to be kept in mind and exit strategies have to be designed at the inception of project ideas and objectives.

In summing up, UNFPA, at upstream level, uses its comparative advantage in supporting the accessibility and availability of quality data for evidence-based planning in the three programmatic areas (RH, Gender and P&D). While it is still too early to assess the usage of the data and its full integration in sector planning, integration of population data into sectoral planning seem weak. Several monographs based on Census data will be published soon and these would contribute to better understanding the country situation for planning. Compared to the last Census, disaggregated data are available for planning and data projections were done and disseminated to relevant ministries.

Conclusions (Gender)

- Timor-Leste is clearly committed to gender equality as encapsulated in its national priorities and strategies. Thus far, the country has achieved a significant measure of success in addressing GBV and DV made possible because of financial and technical support from UNFPA under CP2. While UNFPA's role cannot be underestimated, it must be recognized that this success could have only been attained because of the strategic, efficient and strong collaboration across some of the stakeholders—both government as well as civil society organizations.
- Under CP2, the promulgation of the LADV may be considered a significant step forward in addressing the problems of GBV and DV in the country. UNFPA has not only played a critical role in lobbying for this law but has also been heavily committed to its implementation. While the implementation of the law has had a measure of success under CP2 since GBV and DV cases have been increasing in the last few years, it is clear that the interventions linked to the implementation of the law need to be carried through in the long-run so as to ensure the greatest effectiveness of the law. Service provision to GBV and DV victims is also a critical area of intervention for which UNFPA has played an instrumental role either through funding or technical support. While the support given by UNFPA has been important, much more needs to be done on the part of the government to play a more proactive role by way of funding in independently executing the interventions related to the implementation of the LADV, namely the NAP on GBV, and service provision towards GBV and DV victims. While greater commitment in addressing GBV by all relevant Ministries is still required, there should also be more attention paid to the efficient coordination across the various stakeholders.
- Looking forward in terms of addressing GBV and DV, capacity building is critical and equipping the various stakeholders with the relevant skills set and knowledge becomes essential so that efforts towards reducing GBV and DV can be maximized. In the short run, it can be expected that progress may be slow but over time as more local staff gradually build greater capacity; it would be much easier for the Timorese government itself to implement the interventions for reducing GBV and DV rather than relying on UNFPA technical support. Moreover, all stakeholders involved in addressing GBV should be equipped to undertake monitoring exercises for the activities or services provided to GBV victims.

3.1.2. Recommendations

Recommendations (RH)

- Continue to support the health sector in completion of capacity building in BEmOC focusing on three tasks. Firstly, continue to provide refresher training to midwives and nurses who have received training on BEmOC. Secondly, support the development of a team of National Core Trainers in EmOC. The trainers could be selected midwives and nurses who have trained and are competent to provide BEmOC services. Thirdly, support to development of teams of national and sub-national technical supervisors for BEmOC. The supervisors may be selected from those who have received sufficient training and are competent in professional performance. Finally, as soon as new Timorese medical doctors finish their university study and are installed, in service training on EmOC should be provided since EmOC services in all health delivery points require team approach. Such training would benefit doctors in correcting and sharpening their skills from beginning of their career, which is always easier than later. Their later practice would be in line with what exists in the system. Moreover, these doctors could act as critical human resource agents to develop the National Core Trainers as well as to help further comprehensive EmOC interventions.
- Continue to support family planning system with strengthening capacities of LMIS in collecting data on AMC for better projection, especially that of the sub-national levels. Support capacity building for new Timorese doctors on vasectomy and tubectomy. Support the health sector to collect, analyze, and utilize data of unmet needs of young people and the unmarried in Family Planning and RH care. This provides crucial evidence for further policy advocacy and community mobilization in providing sexual education and family planning services to young unmarried people.
- Support the MoH to develop capacity for National Core Trainers and Supervisors on ASRH. The trainers must be trained on ASRH counseling and clinical service provision for young people. Gradually address sexual education and condom promotion for young people through activities paced out over a period of time. Could be started with education on delay in sexual debut and abstinence. This could obtain support from the religious sector and culture before bringing in other safe sex issues.
- Support the implementing partners of different sectors to advocate for a budget line from the government for RH care. Achievements, experiences, and lessons learnt from the previous interventions should be documented to facilitate this effort. The advocacy should focus on a budget line for FP, BEmOC first since these intervention has obtained considerable achievements over years.

Recommendations (PD)

- Continue to work on establishment of the National Population Commission (and/or Secretariat) to coordinate population issues and to formulate a National Population Policy that ensures population, reproductive health and gender concerns are integrated into all sectoral programmes. Currently, this integration is a weak area which needs strengthening and monitoring. It is important to set indicators to be able to measure if in fact this integration has taken place or not. Indicators for this may be qualitative and/or quantitative in nature and will

be useful to establish both process and output indicators to ensure achievement of expected outcome.

- Given UNFPA mandate to support credible data, UNFPA should support the government, specifically NSD, in streamlining data collection efforts in the country. Currently, several ministries are collecting household data and some regulation would be necessary to ensure the reliability, validity and accuracy of national data bases and to increase the efficiency of data collection exercises. Assist preparation of an inventory of data bases (research, surveys, and studies) specifically related to UNFPA mandated areas.
- Continue with targeted capacity building in PD – i.e. identifying where the gaps are, and then planning with a thorough understanding of “capacity for what” and “capacity of whom.” This may entail conducting an organizational capacity assessment and a needs assessment prior to targeting capacity development programmes. For example, previous capacity assessment of NSD²⁵ indicated several core functions to be weak thus identifying areas that need attention/specific improvements. Same or similar assessment could be administered to identify the capacity improvement needs, institutional and individual. This should be done at district /sub-national level as well, to identify the areas needing specific capacity development interventions at that level.

Integrated to this plan there should be an exit-strategy on capacity development for long-term sustainability of the UNFPA programme. While a fully-fledged exit strategy cannot be developed for a short term period, to ensure smooth transfer of responsibilities to the implementing partners, process indicators have to be developed and managed to monitor exit strategies. Similarly, all capacity building interventions have to consider the institutional structures and the systems within which the human resource capacities are developed and strengthened. It is not only enough to develop capacity of individuals, but institutional capacity has to be given attention as well and UNFPA should be able to advocate such capacity improvements.

- UNFPA should continue to support in the preparation of Census and DHS until the national capacity is established. Preparation for the next census would happen in the next CP cycle as the country’s desire to repeat the census exercise in five years instead of ten years. Lessons learned from the past census exercise (for example, need to strengthen capacity at sub-national level and creating awareness on census procedure and the importance of reliable data need to be addressed in the initial stages of planning) should be taken into consideration.
- In general, common to all programme components in the CP, UNFPA CO should pay more attention to establishing a workable/manageable M&E system. This entails establishing baseline data, measurable indicators and regular feedback to the M&E officer to update the RRF, via systematic meetings/communication. The current CP lacks evaluability assessments. Although the M&E results framework has established baseline values and targets with a monitoring system that includes indicators for outputs, some were not complete. The updating of the M&E framework was limited due to the inconsistency in the way feedback reports/progress reports measured progress.

²⁵ Operations identified under article 17 of decree law No. 13/2009 (Strategic Planning Worksheet for DNE/NSD) Strategic Planning, 2010.

Although it may not be required by UNFPA, M&E guidelines to conduct evaluability assessment during planning stage, involving IPs in evaluability assessments would be helpful in setting up and agreeing on indicators, baseline values and targets. This would also help in developing an integrated and comprehensive M&E plan, as planning an intervention and designing an M&E strategy are inseparable activities.

Recommendations (Gender)

- Capacity building in GBV should be made a priority. Training in all areas related to the prevention, intervention, and advocacy at the national, district, and suco levels should be stepped up. Specifically there should be an increase in the frequency and length of training as well as the numbers of people receiving these trainings. At the national level, training priorities should be targeted at government counterparts in SEPI, MSS, PNTL as well as officers working in LTC (legal training centre). At the district level, district administrators and suco council members should also receive relevant training in GBV. Depending on the priorities of SEPI, training may also be implemented among school teachers, inspectors, as well as individuals working in faith-based organizations.
- There should be a joint monitoring mechanism in place—a mechanism which is systematic and formalized. One possibility is for the M & E officer in UNFPA to oversee four-six monitoring sessions a year at the national level in the various districts with its implementing partners. The monitoring exercises should be well formulated with questionnaires developed jointly with NGO partners which collate feedback on the service/activity and recommendations. First, this effort would represent a systematic means of monitoring all the activities under GBV CP2 activities. Second, UNFPA, government departments, bilateral donors, and all IPs and sub-contractors would benefit from learning from the progress made by others in serving the needs of GBV victims. This would also prevent the duplication of work such as data collection. Information/results will be useful to help NGOs programming and the activities they undertake as well as UNFPA's assessment of their effectiveness and whether UNFPA should continue to fund certain types of activities.
- Coordination across all the key players in addressing GBV is critical in addressing GBV and should be strengthened. In particular, the role of the health sector has to be reinforced as this sector appears not to be as actively engaged in addressing GBV issues unlike the NGOs engaged in service provision. Because coordination across the stakeholders is critical and needed in addressing GBV, UNFPA CO should identify a short-term consultant to undertake a risk assessment of the Ministries of Health and Social Services' capacity to support an NGO Uma Mahon or Fatin Hakmatek in terms of both staffing issues as well as long-term funding. The relevant NGOs should be consulted as to the appropriate timing for such a study, and conclusions and recommendations from the assessment should help the respective government departments in programming, more specifically how these services can be built up, what is needed where, and what would be feasible.

4.0 Evaluation Utilization

To systematically ensure that the results of this evaluation are used to inform programming and strategic and policy decisions, UNFPA evaluation will prepare, implement, and monitor implementation of management responses.

New programme documents or new strategic or policy decisions may be reviewed to assess the extent to which they used results and recommendations from UNFPA evaluations.

UNFPA CO could develop a dissemination plan to inform relevant stakeholders. Explore possibility of the use of DevInfo as a platform for government organizations and agencies to be linked to the data base.

Appendix

- Appendix 1: TOR
- Appendix 2: Country Programme (all – RH, PD and Gender) Components
- Appendix 3: Evaluation questions under RH, PD and Gender
- Appendix 4: Capacity development in PD (effectiveness)
- Appendix 5: Additional Recommendations for information
- Appendix 6: List of persons interviewed and sites visited
- Appendix 7: Bibliography/documents reviewed

Appendix 1: Terms of Reference

**Terms of Reference for International Consultants
for Final Country Programme Evaluation (CPE)
(Shorter Version of the TOR)**

Organisation: United Nations Population Fund (UNFPA)
Location: Timor-Leste (Dili)
Duration: 5 weeks

Introduction and Background:

The UNFPA Second Country Programme to assist the Government of Timor-Leste started in 2009 and will end in 2013, with major counterparts such as Ministry of Health (MoH), Ministry Finance (MoF) through National Statistics Directorate (NSD) and the Secretary of the State for the Promotion of Equality (SEPI), other partners such as Ministry of Social Solidarity (MSS) and number of local and international Non-Government Organizations in Timor-Leste. With the forthcoming end of the programme cycle, the project partners wish to review the progress and direction of the initiative. Given existing political, human resources and other constraints, it is also an opportunity to re-assess the feasibility of current objectives and strategies with all levels of MoH, MoF and SEPI, other implementing partners - local and international NGOs in Timor-Leste. This evaluation also aims to assess the alignment of UNFPA Strategic Development Plan 2012-2013 and its Business Plan with the current Timor-Leste National Development Strategic Plan 2011-2030.

2. Purpose

The objective of this end-point review is to assess the Country Programme (CP) progress and achievements to date and to determine the appropriateness of the CP strategy and proposed outcomes in the current and changing context of Timor-Leste.

3. Evaluation Objectives and Scope

A. Evaluation Objectives

UNFPA has been supporting the Government of Timor-Leste since 1999 in the areas of reproductive health (RH), population and development, and gender. After its restoration of independence, UNFPA signed the first country programme of support to the Democratic Republic of Timor-Leste (2003-2005). In the year 2005, in order to harmonize its planning cycle with the National Development Plan, UNFPA first country programme was extended until the year 2007. Due to the security situation following the events on May 2006, a further year of extension was required till the end of December 2008.

UNFPA is currently providing assistance to the Ministries of Health, the National Statistics Directorate (Ministry of Finance), and the Secretary of the State for the Promotion of Equality (SEPI) through the three programme components.

The second CPE will cover the following outcomes and outputs from the three programme components: Reproductive Health, Population and Development and Gender.

B. Scope

The CPE covers the period 2009 to present of the 2nd UNFPA country programme cycle. For each outcome and output, issues of *programme design* are to be assessed by using the Results and Resources Framework of the CP Action Plan.

4. Evaluation Criteria and Questions

Core programme areas such as relevance, effectiveness, efficiency, and sustainability will be analyzed. Outputs should be evaluated in terms of their impact based on the questions below:

Programme relevance:

- Are the outputs in line with the government's priorities and policies?
- Are they in line with UNFPA's mandate?
- Are they considered useful by the target population?

Effectiveness:

- To what extent were the expected outputs of the CPAP achieved or are likely to be achieved?
- To what extent are population data (demographic statistics, census data, etc.) taken into account in national poverty reduction strategies, policies, plans and programmes?
- To what extent has the country programme contributed to improving the quality and affordability of SRH services provided, particularly for the management of delivery and of its complications, including the surgical repair of obstetrical fistulae?
- To what extent have the interventions in gender contributed to (i) raising awareness on gender-based violence, (ii) positioning this theme on the national agenda and (iii) the implementation of Law Against Domestic Violence?
- To what extent were the targeted groups of beneficiaries reached by UNFPA support?

Efficiency:

- Did the actual or expected outputs justify the costs incurred?
- Did programme activities overlap and duplicate other similar interventions?
- Are there more efficient ways and means of delivering more and better outputs with available inputs?

Sustainability:

- To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
- To what extent were activities designed in a manner that ensured a reasonable handover to local partners?

As a cross-cutting component the evaluation will touch upon programme management issues and answer the following questions:

Programme management:

- Were sound financial and equipment management procedures practiced? Were the financial, human and material resources managed responsibly and efficiently?
- Was the technical assistance provided appropriate and of good quality?
- Did the monitoring and evaluation systems and processes allow for adequate assessment of changes in risks and opportunities in the internal and external environments? Did they contribute to effective decision making in the course of programme implementation?

6. Evaluation team composition:

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, and Youth areas. The evaluators will be selected by UNFPA Timor-Leste CO in consultation with the Asia and Pacific Regional Office (APRO) and the Evaluation Management Committee. The **Team Leader** will be selected based upon the following criteria:

- No. of years of relevant work experience
- Extensive experience in conducting evaluations
- Knowledge of one or more of the three UNFPA components
- An international expert

S/he is responsible for the design, conduct and preparing the final report. S/he will provide guidance, technical support and oversight to evaluation team throughout the entire evaluation period, especially in enforcing agreed upon methodologies, field-research and writing of assigned sections of the report. The responsibility for the quality of the final, consolidated Evaluation Report rests with the Team Leader. The Team Leader will liaise closely with the CO so that the recommendations are developed in a participatory manner.

7. Evaluation Management Structure and roles:

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 a task force to serve both the Evaluation Management Committee and an Evaluation Reference Group. The composition of this task force is as follows:

Evaluation Management Committee (UNFPA):

- CO Representative
- CO M&E focal point
- Component Programme Officers
- Admin/Finance Associate

The Evaluation Management Committee (EMC) will be charged with all preparations for the evaluation and supervise all logistical aspects of the evaluation. UNFPA Timor-Leste will assemble in advance and have ready for the evaluators use, relevant background documents and information such as CPD and CPAP documents, MTR, annual review reports, field mission reports, relevant national country policies, plans and surveys. The evaluation team will report to the UNFPA Representative and get daily logistical support as well as informational briefings from the UNFPA Monitoring and Evaluation focal point, as well as technical information from the component areas programme officers.

Evaluation Reference Group (ERG) – (one representative each):

- Evaluation Management Committee
- Ministry of Health (MoH)

- National Statistics Directorate (NSD)
- Secretary of State for the Promotion of Equality (SEPI)
- RH and Gender NGOs
- WHO
- UNICEF
- UNDP (gender aspects/Joint Programme)

The ERG is chaired by a senior government official with the UNFPA Representative holding the Deputy Chair.

The ERG will oversee and supervise the evaluation team in all technical matters but not limited to approval of TOR, Inception Report of the ET (document review, overview understanding of the CP, budget, partners, and proposed methodology, etc.), CPE Report review, comment and approval.

8. Location

The evaluation will cover partner institutions at central level to assess assistance provided nationwide as well as representative samples of local level institutions and be able to generate results allowing comparison of outcomes and impact between focus and non-focus areas.

9. Evaluation Methods

In terms of data collection, the evaluation will use multiple methods that may include document review, group discussions, key informant interviews, in-depth guided interviews, and/or structured interviews, as appropriate and as feasible. Methods may vary depending on the source of information and will reflect the precise nature of the aspects under examination. The ET should explain their proposed methods and approaches especially those related to sampling, data collection, and data analysis in both the inception report and final report. The evaluators should also explain in their final report (a) how its methods suitably addressed the review's objectives and (b) the weaknesses or limitations of the methods and sampling. As a preliminary step in the process the Evaluation Team will conduct a Stakeholder Mapping exercise to prepare a basic mapping of stakeholders relevant to the evaluation. The mapping exercise will include national institutions and civil-society stakeholders. The Evaluation Team (ET) will further develop the methodology of the evaluation in relation to the scope of evaluation in consultation with Evaluation Reference Group. Attention should be given in generating gender-disaggregated data.

The ET should use triangulation in the absence of a reliable quantitative data as substitute for obtaining reasonably solid and reliable evaluation results. UNFPA typically supports this being achieved through the application of three evaluation approaches: Perceptions, Validation and Documentation. Perceptions will be elicited through interviews with internal and external stakeholders and key informants. Validation will be achieved through stakeholder meetings, such as debriefing meetings with UNFPA staff and/or with the ERG; through direct observation during field visits; and through specific studies such as case studies, beneficiary assessments, impact studies, etc. Documentation will include CP-related documentation, relevant national policies, strategies and action plans, national statistics, midterm analyses, external reviews, and other external documents.

10. Ethical considerations

The evaluation will be conducted in accordance with the principles outlined in the UNEG "Ethical Guidelines for Evaluation". Ethical considerations should include:

- Respect for local customs, beliefs and practices; respect to people's right to provide information in confidence and ensuring that sensitive information cannot be traced to its source;
- Informing interviewees in advance on what the interview ground rules are and obtaining their informed consent for participation;
- Right to privacy and minimizing demands on time of the people participating in evaluation

To avoid conflict of interest and undue pressure, evaluators need to be independent, implying that members of an evaluation team must not have been directly responsible for the policy/programming-setting, design, or overall management of the subject of evaluation, nor expect to be in the near future. Evaluators must have no vested interest

and have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.

The purpose of the evaluation has to be clearly conveyed to managers from implementing partners. Target groups should be informed of the evaluation purpose, rights and obligations of participating in the evaluation and agree to participate voluntarily. Target groups have the right to refuse the interview and the evaluation should cover only those who agree to participate.

11. Evaluation Quality Assurance:

UNFPA decentralized evaluations should follow the following principles:

- **High quality** – Evaluations should be of high quality, utilization-focused, follow ethical standards ([UNEG ethical guidelines](#)), and provide credible information to support policy, management, and programming decision-making and improvement. In order to ensure compliance with international quality standards, the Evaluation Branch at DOS has developed a Quality Assessment grid that needs to be applied to all evaluations undertaken in/commissioned by UNFPA. (see paragraph 24)
- **Impartial and objective** – Evaluations should be carried out with the highest level of objectivity and impartiality, which should be ensured through the use of external peer reviewers, advisory committees and independent evaluators with no conflict of interest.
- **Focus on performance results** – Evaluations should focus on programme performance and achievement of development results.
- **Effective development assistance principles** – In line with the General Assembly resolution on the triennial comprehensive policy review ([GA 56/201](#)), UNFPA evaluations should be undertaken with a view to strengthen national evaluation capacity and increase the participation of national counterparts through inclusive and participatory approaches.
- **Gender-based, human rights-based approaches and ethical standards** – UNFPA evaluation are expected to apply gender-based and human rights-based approaches, and ethical standards in line with United Nations Evaluation Group.
- **Harmonized with the United Nations evaluation** – UNEG norms and standards provide overarching guidance to UNFPA evaluations. UNFPA should harmonize and align evaluation processes and procedures with United Nations system partners through country-led evaluations and joint evaluations.
- **Utilization-focused** – They should be conducted in response to needs for evaluative evidence to inform programming – strategy selection, designing, planning, budgeting, implementation and reporting.

12. Management Response and the dissemination of final report:

- A. A Management Response lists responses and follows up actions to each valid recommendation. It indicates whether a recommendation is accepted, partially accepted, or rejected; and, for the accepted recommendations, it specifies the follow up actions, the timeline, and the roles and responsibilities for implementing these actions. **It must be noted that recommendations are valid only when they logically flow from conclusions, and that, in turn, the conclusions supporting these recommendations arise from findings that are based on reliable data, sound methodology and analysis.**
- Management responses should be prepared within one month of receiving the evaluation final report.
 - The Evaluation Manager is responsible in coordinating the process of developing and implementing the Management Response.
 - Preparation of a management response should be done collaboratively with key stakeholders primarily relevant administrative units in UNFPA.

Disseminate the Evaluation report by CO promptly to internal and external stakeholders to in a timely manner to inform future decision-making. The dissemination process will be conducted through workshops, meetings and conferences with all stakeholders. The Evaluation Reports will also be posted in Docushare.

13. Timeline:

The evaluation starts in approximately mid July 2012 but not later than mid August 2012. The following tentative schedule of activities is only illustrative and a final evaluation timeline will need to be refined and presented by the Team Leader of the Evaluation Team to the Evaluation Reference Group:

Dates	Activity
July 16-19	Arrival of the evaluation team and initial orientation
July 20-27	Submission of Inception Report by the ET and revision if required
July 28-Aug 08	Field work
August 09-16	Joint team analysis, drafting of the report, supplementary interviews, if needed and presentation of the 1 st draft and feedback of Evaluation Reference Group
August 17-18	Submission of Final Report

14. Expected services and products to be delivered:

The evaluation Team Leader shall deliver electronic versions of the following to UNFPA Representative or her/his designate with a copy to the M&E focal point and each ERG member:

1. Inception report including methodology and schedule of activities.
2. First draft report over the course of the evaluation with a set of prioritized, strong and actionable 10-15 recommendations.
3. A final report, edited and ready to print.

The Team Leader should try as far as possible to develop a strong first draft report, to facilitate clear and constructive feedback.

Allocation of the payment according to deliverable results:

Activities	Percentage of Payments
Submission of Inception report	20%
Submission of First draft report	40%
Submission of Final report	40%
Total	100%

Annexes:

Annex 1: Outcomes and outputs of the three programme components:

(same as Appendix 2)

a. Reproductive Health:

Outcome 1: Increased access to and utilization of comprehensive reproductive health services, including those focusing on maternal health, family planning, and the prevention of sexually transmitted infections and HIV, especially for vulnerable groups.

Output 1: Increased demand for and access to high-quality maternal health services, including emergency obstetric care.

Output 2: Increased access to and demand for high-quality family planning services.

Outcome 2: Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies.

Output 3: Increased availability of information, counselling and services for populations most at risk, to promote healthier and safer behaviour.

Output 4: Increased access to high-quality reproductive health information and services for young people.

b. Population and Development

Outcome: Data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS are available, analyzed and used at national and sub-national levels to develop, implement and monitor policies and programmes.

Output 1: Policy makers and planners at national and sub-national levels sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies.

Output 2: Strengthened analytical capacity at national and sub-national levels for utilizing data on population, reproductive health and gender in order to develop, implement and monitor policies and programmes.

Output 3: Improved availability of disaggregated demographic and socio-economic data at national and sub-national levels.

c. Gender

Outcome: Strengthened national capacity to promote gender equality and prevent gender-based violence through improved policies, protection systems, the enforcement of laws and the provision of reproductive health services.

Output 1: Contribute to implementing the national domestic violence law.

Output 2: Increased access to emergency medical, shelter, counselling and legal services available for victims of domestic and gender-based violence in Dili and other districts.

Output 3: Contribute to developing a national action plan on Security Council Resolution 1325.

Appendix 2: List of Publications

1. UNFPA Global Strategic Plan
2. [UNFPA evaluation guidelines](#)
3. [UNEG Norms](#) and [Standards](#) for evaluation
4. DOS evaluation quality assessment tools:
 - [DOS Evaluation Quality Assessment Criteria](#)
 - [DOS Evaluation Quality Assessment Criteria Explanatory Note](#)

Country-Specific Documents

1. Common Country Assessment (CCA)
2. Current UNDAF
3. Current CPAP
- Incl. (a) Results and Resources Framework
- (b) Planning and Tracking Tools
- (c) Monitoring and Evaluation calendars
4. Relevant national policy documents for each focus area
5. Annual Work Plans [Year x] per focus area
6. Annual Standard Progress Report for each AWP
7. Mid-Term Review current cycle
8. Surveys and Studies
9. Baseline and End line survey reports for current CPAP

Appendix 3: RH Evaluation Questions

Relevance

- What were the Government's priorities in SRH service provision? Which national and health sector's policies and strategies contain these priorities?
- How was the CP2 formulation conducted? How were the interventions identified? To what extent were the Governmental counterparts involved in this formulation?
- To what extent did the CP2 interventions support those priorities and policies?
- To what extent did the CP2 enable UNFPA to better advocate for and build consensus around the ICPD agenda, especially with regard to sensitive or complex issues (e.g. integrated RH services, abortion, gender equity, RH rights, etc.). Give examples of CP2 contribution to this.
- To what extent did the target groups get involved in design and implementation of CP2 activities? How did they think the interventions useful? Did the interventions provide sufficient support to the Health sector in improving SRH services?

Effectiveness

- To what extent does the SRH project support strengthening capacities of health sector in provision of SRH services including EmOC, FP, ARH areas?
- How did CP2 support advocacy for policy and support from various stakeholders to SRH and FP interventions?
- What are the constraints that challenge the contribution of CP2 in improvement of SRH services?

Efficiency

- How was the program budget maximized in the CP2 in order to provide support with the highest aid effectiveness?
- What were other similar programs implemented in the same field at the same time?
- To what extent did UNFPA CO collaborate with WHO, UNICEF, NGOs, and other development partners in the area of SRH care? Suggestion of concerned beneficiaries about possible improvement?
- How did the CP2 provide TA to the Gov in planning, implementation, monitoring and evaluation, and development of national policies?

Sustainability

- To what extent were interventions of CP2 integrated into the regular tasks of concerned institutions?
- Any mechanism and resources to sustain the interventions afterward from the Government?

- Did capacity exist within CP2 partner organizations to achieve national RH programme goals?
- Were the models developed under CP2 costly for further maintenance by the local capacities?
- Are key RH posts filled with skilled personnel at all levels of the system? If not describe the gaps.

Program management

- What was the management mechanism of the CP2? How was the resource mobilization and allocation made?
- How was the quality assurance implemented? What were the procedures of Procurement, distribution, and asset management?
- How were the development and approval of AWP's conducted?
- How did UNFPA CO provide TA to the implementation of SRH project? This included both national and International TA resources.
- Was there an M&E frameworks for the CP2 implementation? Describe how it has been developed? Are there indicators at different levels developed and used?
- Did the CP2 M&E system currently measure appropriate RH indicators to capture its contribution to the ICPD agenda?
- What were the challenges that limit achievements of the CP2? How did you overcome or suggest overcoming in the future?

Appendix 4: Output 3 Effectiveness

CAPACITY BUILDING ACTIVITIES FOR TIMOR-LESTE CENSUS PROJECT UNDER UNFPA SUPPORT

Capacity building component in the Census project can be categorized into three components, long term technical training (leading to master degree), short term training and institutional capacity development. Besides, on-the-job trainings throughout the life of the project are an integral part of its strategy but have not been highlighted in this brief though it needs to be mentioned as it has borne quite significant results.

Long term Training

The census project with support from UNFPA fully sponsored three national staff members, Mr. Cesar Melito, Mr. Afonso Martins and Mrs. Anastasia SEP Vong for master degree course on demography (two at Indonesian National University and one at Gadjah Mada University). The choice of Indonesia was influenced by the language as studies are done in Bahasa Indonesia which Timorese are fluent in.

The training duration was October 2008 to August 2010, upon arrival all the three were posted to the census project to have hands on experience and use their newly acquired knowledge on the remaining census phases. Currently, Mr. Afonso Martins works at MDG Secretariat (Ministry of Finance), while Mr. Cesar Melito and Mrs. Anastasia SEP Vong work in the census project.

The other trainings undertaken in 2009 include:

Training on Census and Surveys Processing System (CSPRO), data processing software developed by the US Census Bureau and used by developing countries to capture, edit and analyse census and survey datasets. A three week training course was organised by UNFPA Regional office and two national staff attended. They include Mr. Silvino Lopes (Head of IT and Data Processing Division of NSD also responsible for Census data processing), and Mr. Manuel da Silva (Data Analyst Assistant). The course was taken in April 2009.

- Workshop on Planning and Implementation of Population and Housing Census for countries that were in the process of planning for their censuses. It was organized by UNFPA APRO-Bangkok in November 2009. Attended by Mr. Elias dos Santos Ferreira – Director DNE and Mr. Helio Xavier – National Census Coordinator
- Workshop on Estimation of Maternal Mortality Ratio using census data. The workshop was organized by UNFPA APRO-Bangkok and facilitated by London School of Economics and Tropical Medicine. It was held in December 2009 and attended by Mr. Fredrick Otieno – CTA, Mr. Elias dos Santos Ferreira – Director DNE, and Mr. Helio Xavier – National Census Coordinator

All these were to develop a solid base for the implementation of the 2010 TLS census.

2010

- Study tour to Cambodia held in May 2010. The purpose of the study tour was to gain knowledge and strengthen the preparatory activities relating to implementation of the census in 2010 in Timor-Leste. A team of 13 people of Timor Leste formed the delegation, they were policy makers; Director General Policy, Analyze, and Research - Ministry of Finance, Director NSD - Ministry of Finance, Director Civil Service Commission, District Administrators of two districts and other technical staffs from different units of the census.

2011

Training on Gender Statistics using Census Data in Chiba-Japan, May 2011 attended by census staff (Mr. Helio Xavier) APRO and funded by UNFPA

Training on CSPRO (Data Processing and Creating databases) in Bangkok-Thailand in June 2011 attended by a NSD staff (Mr. Cesar Melito) APRO and funded by UNFPA

Training on Data Processing and Dissemination in Suva-Fiji in July 2011 attended by a NSD staff (Silvino Lopes) APRO and funded by UNFPA

Training on Census Results Dissemination in Chiba-Japan in July 2011 attended by a Census staff (Anastasia SEP Vong) APRO and funded by UNFPA

Workshop on differences between Multiple Indicator Cluster Survey (MICS) and Demographic and Health Surveys (DHS) organized by UNFPA APRO, Bangkok-Thailand in October 2011 attended by both Government and UNFPA staff. (Fredrick Otieno UNFPA Census Project, Anastasia SEP Vong UNFPA Census project, Joao da Silva Ministry of Health and Eduardo Ximenes - NSD)

Need Assessment Conference on the Census Analysis (NACCA III), Bali-Indonesia in November 2011 attended by two Senior Government Officers and UNFPA Staff. (Mr. Elias dos Santos Ferreira- DNE Direct, Mr. Filomeno Tilman- Manufahi District Administrator, and Mr. Fredrick Otieno – CTA Census)

Training on the Population Situation Analysis by Technical Division UNFPA HQ in partnership with APRO, held in Bali-Indonesia, November 2011 attended by a UNFPA staff (Fredrick Otieno, UNFPA)

In-country training on Data Processing by the UNFPA Data processing adviser; there were 15 officers from DNE and census staff trained on CPro and REDATAM in March 2011. The objective was to enhance the capacity of DNE and census staff in data processing.

In-country training course on Analysis and Dissemination of Population and Housing Census Data with Gender Concern held in October 2011. Organized by NSD and UNSIAP attended by 27 participants both Government and UNFPA staff

2012

Regional Training Workshop on the Censuses Results and Evidence-based Policy Making in Chiba, Japan in May 2012. Attended by Mr. Elias dos Santos Ferreira – DNE Director, Mr. Felix Piedade – MDG Secretaria Adviser, and Mrs. Carla da Costa – UNFPA NPO for PD and Gender. It was organised and supported by APRO UNFPA

Training workshop on REDATAM SP+ Software July 2012 in Bangkok, Thailand (Mr. Helio Xavier – National Census Coordinator, Mrs. Anasatasia SEP Vong – Demography Officer, and Mr. Pedro Almeida da Costa – DNE attended. The training was supported by APRO and facilitated by staff from CELADE – Santiago, Chile (CELADE are the developers of REDATAM with financial support of UNFPA)

INSTITUTIONAL CAPACITY BUILDING ACTIVITIES

The other capacity development initiatives of the project include:

1. GIS Laboratory (equipped with Printers/Plotters, computers, software and other GIS equipments)
2. Data Entry and Training Room (Computers, network, etc. established under the census project)
3. IT Equipments used by the census project, government and some district offices
4. Publicity equipments
5. Vehicles (UNFPA donated some vehicles after conducted 2010 census to government: 4 vehicles to NSD (Ministry of Finance) and 1 vehicle to Ministry of Health (to support HIMS) others to NGOs working in areas of UNFPA mandate
6. The UNFPA advised the Government of Timor-Leste (Ministry of Finance) to establish a census office, now a building for the census operations and staff are in place.
7. Store room with shelves and racks for keeping questionnaires, other census and surveys materials

Appendix 5: Additional Recommendations for RH (information only)

(Due to the limited number that can be included in the main report, additional recommendations are attached here for information only)

- As Timor-Leste has a large proportion of young population, it is essential that they receive proper health care and that their needs and rights must be sufficiently covered by national policies and healthcare services. In this regard, it is important that UNFPA work together with other donors and UN agencies to support the government (whether it is NSD or SYSS) on routine youth-related data collection. The data should cover detailed information on the thirteen themes identified by the World Youth Conference 2010 Declaration. The conference was held in Mexico in 2010 under the support from UNFPA HQ with participation of more than 150 countries worldwide. Findings from this panel survey would provide great inputs for further policy advocacy, policy development as well as intervention planning.
- Together with other agencies such as UNICEF and WHO, support the MoH to develop and institutionalize National Standards and Guidelines for SRH care. The document should cover all components of comprehensive RH care. In future, any external technical assistance should be in line with this document as it serves as the fundamental frame within which all types of assistance should adhere to.
- Support the MoH to implement backward mapping for RHCS. This means that technical and financial assistance needs to be provided for the implementation of RHCS. Throughout the implementation of the backward mapping for RHCS, necessary capacities of the health sector will be sufficiently developed and strengthened. Lessons learnt from this implementation will be documented and used to advocate to the government for a budget for further investment.
- Continue to support to create demands for SRH care among community people. Support the health sector to advocate for more full-time paid staff working on BCC in the communities.

Appendix 6: List of Implementing Partners Met

In addition to these, UNFPA CO staff and consultants were met several times by the evaluation team to obtain feedback and to validate information received.

RH Key people met

1. National Directorate of Statistics, Director General and International advisor
2. Ministry of Education (MoE), Director of Adolescent Reproductive Health of MoE
3. Ministry of Health (MoH), Director of MCH,
4. Ministry of Health (MoH), Director of Human Resource department
5. Ministry of Health (MoH), Health Promotion Officer,
6. Ministry of Health (MoH), FP National Officer
7. National Hospital in Dili, International BEmOC trainer (Dr. Amita Thapa)
8. Youth Friendly Service Center (YFSC), Chairman and young volunteers
9. Sharis Haburas Comunidade (SHC), Director of SHC and staff members
10. Catholic Family Center, Priest
11. District Health Service Office in Maliana, MCH coordinator
12. Maliana Referral Hospital, Midwives at OBGY department and 04 couples
13. Maliana Referral hospital, UNV OBGY specialist
14. Balibo Community Health Center, Midwife and 04 couples
15. District Health Service Office in Oecusse, MCH Coordinator
16. Oecusse Referral Hospital, Director and Midwives at OBGY department
17. Oecusse Referral Hospital, Mothers and their husband at OBGY department
18. Passabe CHC in Oecusse, Director and Midwives
19. Mari Stopes International Timor-Leste (MSI-TL) Director of MSI-TL
20. UNFPA CO in Timor Leste, RH Program Manager, POs, and International Consultants NICEF CO in Timor Leste, Child health manager
21. WHO CO in Timor Leste

Appendix 7: Documents Reviewed

Documents Reviewed
Strategic plan 2010-2015
National Health Strategic plan 2011-2030
Health Sector Strategic Plan 2008-2012
National Reproductive Health Strategy 2004-2015
Timor Leste 2010 National Priorities Outline
National BCC strategy for RH/FP/SM 2008-2012
Summary of the Baseline Survey on National RH BCC, 2008
Basic Service Package for Primary Health and Hospital, 2007
National HIV/AIDS/STIs Strategic Plan 2006-2010
National Family Planning Policy, 2005
National Youth Policy of Timor Leste, 2007
Timor Leste National BCC Strategy for RH/FP/SM 2008-2012, MoH Timor Leste, UNFPA
Drug Use in Timor Leste – an assessment, UNFPA Timor Leste, 2011
Timor Leste National HIV and STI Strategy 2011-2016 (Draft version)
Family Planning and General Reproductive Health: Quantitative and Qualitative Analysis, UNFPA in Timor Leste, 2009

Documents Reviewed
Family Planning Program Evaluation, Timor Leste 2010
Report on Logistic Management Information System (LMIS) Evaluation in Timor Leste 2012
Youth Reproductive Health: Quantitative and Qualitative Analysis, Timor Leste, 2009
EmoC Needs assessment, 2008
DHS Women empowerment and GBV 2009-2010
DHS Monograph on Youth
DHS Key findings
DHS 2009/10
Law against DV
National Action plan on GBV
Census 2010 Volum 2
Census 2010 Volum 3
Census 2010 Volum 4 SUCO report
Strategic plan of MOFI
Statistical Work Plan 2010-2019
Statistical Work Plan 2010 - 2019
SEPI/CEDAW National Action Plan on GBV 2012-2014
MTR of MDG/F Joint Program 2010
UNFPA OMP and Organogram
UNDAF 2009-2013
UNDAF Annual review year 2 2011
UNDAF Annual review year 2 2010
CPA 2007
UNFPA Specific Documents:
CPAP 2009-2013
UNFPA's Midterm review of SP
MTR of UNFPA of strategic plan 2008 - 2020
UNFPA CP2 MTR
MTR of UNFPA of strategic plan 2012-2013 - Devel and Management result frameworks
CPA 2007
UNFPA's Evaluation process guidelines
Norm and Standards
Policy procedures for CO program evaluation
Evaluation quality assessment grid
Quality Assessmet Criteria
UNFPA's Business Plan for 2012-2013
PD
AWP 2010
AWP 2011

Documents Reviewed
AWP 2012
COAR for PD 2010 (2009 missing)
COAR for PD 2010
RH
EmoC needs assessment 2008
AWP for 2009
AWP for 2010
AWP for 2011
AWP for 2012
COAR 2009
COAR 2010
COAR 2011
GBV
COAR 2009
COAR 2010
COAR 2011
AWP 2009
AWP 2010
AWP 2011
AWP 2012

Appendix 8: Alignments of SRH component and National priorities

CPAP	Outcome 1: Increased access to and utilization of comprehensive reproductive health services		Outcome 2: Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies	
Government priorities	Output 1: Maternal health including emergency obstetric care	Output 2: Family planning services	Output 3: Increased availability of information, counseling and services for populations most at risk, to promote healthier and safer behavior	Output 4: Increased access to high-quality reproductive health information and services for young people
Health Sector Strategic Plan 2008-2012	<ul style="list-style-type: none"> • Core Cross-cutting strategy 3, priority area 1 (Health service delivery): <i>Strengthen the quality of services delivered (especially in the mother and child field) in all facilities through capacity development in areas such as BEOC, IMCI, nutrition and Facility-based delivery and post-natal care</i> • Core Cross-cutting strategy 9, Priority area 4 (Human Resource): <i>Increase the number of skilled midwives through enhanced pre-service and articulated training opportunities and through improved supervision and control measures at work</i> <p><u>RH and FP component:</u></p> <ul style="list-style-type: none"> • Strategy 1: (Safe Motherhood): <i>Revise and update the current Reproductive Health and Family Planning Strategic Policy document to provide additional guidance on determined priority areas and to accommodate the service and programme directives of the BSP</i> • Strategy 3 (Safe Motherhood): <i>Improve utilisation rate and quality of institutionally-based comprehensive maternity and new born services (prenatal, delivery, postnatal and perinatal health care in keeping with the role delineation directives of the BSP)</i> • Strategy 7 (General Reproductive Health): <i>Increase</i> 	<ul style="list-style-type: none"> • Strategy 6 (Family Planning): <i>Increase community knowledge and awareness about reproductive choice to assist in behaviour change</i> • Strategy 2 (Safe Motherhood): <i>Increase the level of awareness in the population about matters relating to pregnancy and childbirth</i> • Strategy 8 (Primary health care component) Blood-borne and Sexually Transmitted Diseases: <i>Build on the strategic foundations established through the production of the National Reproductive Health Strategy, and the National HIV/AIDS Strategy while integrating ongoing strategic activities to the role and functional delineations of the BSP, and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives in particular the integration of HAST activities</i> 	<ul style="list-style-type: none"> • Core Cross-cutting strategies 4 and 5: <i>Behavioural change/ health promotion</i> • Strategy 2 (Safe Motherhood): <i>Increase the level of awareness in the population about matters relating to pregnancy and childbirth</i> • 	<ul style="list-style-type: none"> • Strategy 4 (Young People): <i>Strengthen the provision of information to, and capacity development of reproductive health and family planning skills for young people, families and communities to assist in achieving an optimal level of health and development in young people</i> • Strategy 5 (Young People): <i>Increase accessibility to a wide range of suitable young person-friendly reproductive health and reproductive choice services and programmes</i>

CPAP	Outcome 1: Increased access to and utilization of comprehensive reproductive health services		Outcome 2: Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies	
Government priorities	Output 1: Maternal health including emergency obstetric care	Output 2: Family planning services	Output 3: Increased availability of information, counseling and services for populations most at risk, to promote healthier and safer behavior	Output 4: Increased access to high-quality reproductive health information and services for young people
	<i>overall commitment across the MOH and partner organisations to sexual and reproductive health services for men and women</i>			
National Strategy for Reproductive Health 2004-2015	<p>Component 3: <i>Safe Motherhood</i> Component 4: <i>General Reproductive Health,</i></p> <ul style="list-style-type: none"> • <i>Objective 4:</i> To reduce the level of maternal mortality and morbidity. • <i>Objective 5:</i> To reduce the level of perinatal and neonatal mortality and morbidity. • <i>Objective 6:</i> To reduce the burden of STIs/HIV. • <i>Objective 7:</i> To meet changing reproductive health need over life cycle and to improve the health status of reproductive age people. 	<p>Component 2: <i>Reproductive Choice (Family Planning),</i></p> <ul style="list-style-type: none"> • <i>Objective 2:</i> To promote family planning to stabilize population growth rate and reduce the incidence of unintended, unwanted and mistimed pregnancies. 	<p>Component 3: <i>Safe Motherhood</i> Component 4: <i>General Reproductive Health,</i></p> <ul style="list-style-type: none"> • <i>Objective 1:</i> To substantially increase the level of knowledge in the general population on issues related to sexuality and reproductive health. • <i>Objective 3:</i> To ensure that all women and men have access to basic reproductive health care services, health promotion and information on issues related to reproduction. 	<p>Component 1: <i>Young People's Sexual and Reproductive Health</i></p> <ul style="list-style-type: none"> • <i>Approach 1:</i> Strengthen the provision of information and skills to young people, families and communities in order to achieve an optimal level of health and development in young people. • <i>Approach 2:</i> Increase easy access to a broad range of young person-friendly services.

The Health Sector Strategic Plan HSSP 2008-2012 of the MOH has adopted 57 strategies to be implemented within the five year cycle. However, because of lack of resources and human capital, 32 cross-cutting strategies have been selected for immediate implementation, out of which 17 core cross-cutting strategies were developed and related to 10 areas within the health sector priorities over the 5-year implementation period. These 10 areas identified as follows: health service delivery, behaviour change/health promotion, quality improvement, human resource development, health financing, asset management, institutional development, HMIS, Gender equity, and research. Out of these 17 core cross-cutting strategies, the Strategy 3 indicates the need for capacities to be developed in the area of quality service provision including basic emergency obstetric care, integrated management of childhood illness, nutrition and facility-based delivery and post-natal care. Likewise, Strategy 9 of the priority area 4 refers to the need for increasing the number of skilled midwives via pre-service training and articulated training and continuous technical supervision.²⁶

The National Reproductive Health Strategy 2004-2015 developed by the MOH with support from UNFPA and WHO is considered the backbone for long-term improvement of RH quality services. The strategy has set up 04 components which reflect the life cycle approach to reproductive health. The interventions linked to this strategy cover: (i) young people's reproductive health, which includes strategic approaches aiming at "*Strengthening the provision of information and skills to young people...*" and "*Increasing easy access to a broad range of young person-friendly services*"; (ii) family planning, which includes approaches to ensure the provision of information about child-spacing and numbering and the availability and accessibility of FP commodities with technical and financial support from international organizations; (iii) safe motherhood, which includes approaches aiming at the improvement of knowledge on pregnancy and childbirth, the enhancement of quality service in prenatal, intra-partum, post-partum, and perinatal care, the improvement of Emergency Obstetric Care, and integrated management of STI/HIV, including perinatal care; and (iv) general reproductive health which focuses in increasing knowledge of the general population on reproductive health, increasing male commitment and involvement in sexual and reproductive health, making high-quality services of STI and HIV/AIDS available for people, especially those who are living with HIV, and the provision of health care services for gender-based and sexual violence victims.

The National Family Planning Policy initially drafted in 2003 with the support of UNFPA and in close consultation with related stakeholders including concerned National sectors, international organizations, and more importantly the religious sector was adopted in 2005. Three major policy components, including (i) service delivery, (ii) human resource, and (iii) information, education, and communication, have been identified by the NFPP to ensure family planning services and information provided to local people integrated within the overall SRH services in effective ways that these are universally accessible, acceptable, made convenient through health center-based and outreach deliveries by skilled health providers at all levels.²⁷

CP2 of UNFPA was designed following the previous country programme. Outcome 1 consists of comprehensive reproductive health interventions in the areas of Maternal Health, prevention of STI/HIV, and Family Planning, all of which responds to the national health priorities of the country's strategic plans.²⁸ The maternal health interventions respond appropriately to the needs of

²⁶The Health Sector Strategic Plan HSSP 2008-2012

²⁷ National Family Planning Policy, 2005

²⁸ Country Program Action Plan, UNFPA in Timor Leste

comprehensive capacity building for the healthcare system at all levels in BEmOC, facility-based delivery and post-partum care through in-service training and refresher training for healthcare providers on BEmOC, provision of BEmOC equipment and ambulances, technical supportive supervision, and deployment of EmOC experts. In addition, support to the establishment of a midwifery school for the pre-service training programme is also provided in order to ensure long-term human resource development for skilled birth attendance. Apparently, these are completely aligned with identified priorities of the core cross-cutting Strategies 3 and 9 of the HSSP, components 3 and 4 of the NRHS, and the Basic Service Package for Primary Health Care and Hospitals.

The Family Planning interventions provide solid technical and financial support to the above-mentioned strategies and policies and the NFPP through the designed activities which were found to add value to the actual implementation of these frameworks. In response to the need to enhance capacities to increase the skills of healthcare providers in the provision of quality family planning information and services, the FP sub-component has focused on raising the capacities of the healthcare system at all levels in the provision of counselling on FP and clinical-based FP methods. To ensure FP service delivery, the sub-component was designed with strategies with the aim of strengthening service planning and provision through advocacy for FP as part of the comprehensive SRH program. Support to strengthen national capacities in LMIS for better forecasting and distribution of FP commodities and the integration of FP into the SRH service provision system was a key priority of the country programme.²⁹ Moreover, to better cope with the unmet needs in FP in the country, civil societies were involved in the coordination and provision of modern FP methods.

Aligning Outcome 1 with national priorities were specified through the synergy of each specific output with particular strategies and objectives in the above-mentioned documents [I think better to mention these documents again because by this time, the reader would have lost track of what you were saying]. In this regard, it is clear that the outcome was designed in keeping with the national frameworks on SRH and FP for the same period. As such, CP2 adds value to the current situation of reproductive healthcare service provision and utilization in Timor-Leste.

As discussed in Outcome 1, the Health Sector Strategic Plan HSSP 2008-2012 of MOH adopted 57 strategies for implementation in the long term. Nevertheless, because of the current situation in terms of the lack of resources and limited capacities, 32 cross-cutting strategies have been selected for immediate implementation, of which 17 core-cross cutting strategies formed the essential core strategies in 10 areas of the health sector priorities implemented over the five-year period. Out of these 17, the core-cross cutting Strategies 4 and 5 covered the following: *“Change for the better the attitudes of health care providers sector-wide to effectively communicate with consumers especially in relation to the needs of the poor and other vulnerable groups through sensitisation and the building of good interpersonal skills”* and *“Strengthen BCC/BCI activities to promote better community appreciation of the value of effective evidence-based medicine and health care, and, as a consequence, promote more appropriate behaviour in this important area.”*³⁰ It must be noted that these strategies have been complemented by Strategy 2 (Safe Motherhood) of the Reproductive Health and Family Planning programme policy which aims to *“Increase the level of awareness in the population about matters relating to pregnancy and childbirth”*. In contrast, Strategies 4 and 5 indicated intervention providing for ASRH information and friendly services to young people.

The National Reproductive Health Strategy 2004-2015 developed by MOH with support from UNFPA and WHO may be regarded as the backbone for long term improvement of RH quality services. This

²⁹ Country Program Action Plan, UNFPA in Timor Leste

strategy contains 4 components which reinforces the life cycle approach to reproductive health, as discussed in Outcome 1 of the relevance session. Accordingly, component 1 of this strategy aims to “Strengthen the provision of information and skills to young people...” and “Increase easy access to a broad range of young person-friendly services”. Essentially, youth are positioned at the starting point of the SRH life cycle according to these two strategies. It was found that the two components, that is, 3 and 4 of the strategy, included sufficient attention on “...integrated management of STI/HIV while perinatal care” and “general reproductive health focusing on increasing knowledge of the general population on reproductive health, increasing male commitment and involvement in sexual and reproductive health, making high-quality services of STI and HIV/AIDS available for people, especially those who are living with HIV, and provision of health care services for gender-based and sexual violence victims”.³¹ These priorities have been reinforced by Approach 1 “Strengthen the provision of information and skills to young people, families and communities in order to achieve an optimal level of health and development in young people” and Approach 2 “Increase easy access to a broad range of young person-friendly services” (NSRH 2004-2015, Timor Leste)

The Basic Package for Primary Health Care Services proposed various efforts in improving a range of public health issues. The Family Health Promoter Programme that had been described in the Draft Guidelines Promotor de Saude Familiar Programme was taken as a key component in health promotion and behaviour change communication (BCC) at the community level. According to this programme, meeting the SRH needs of vulnerable groups including people who live in remote and disadvantaged areas have been identified as a priority for investment.³²

The National HIV/AIDS/STI Strategic Plans for the period of 2006-2010 covers specific programmes on HIV/STI prevention and education for the general population, young people, and most-at-risk groups based upon three major objectives: (i) to promote an environment that is supportive of HIV strategy initiatives; (ii) to ensure all members of the population have access to information to reduce their risk of HIV infection; and (iii) to reach people at higher risk that may not be accessed through more specifically targeted programmes.³³

Outcome 2 consists of two outputs which aimed at implementing interventions to improve prevention of STI/HIV and provision of ARH youth-friendly information and services to enhance life skills for young people on prevention of STI/HIV and unwanted pregnancies. Output 3 under this outcome provided financial and technical support to two main strategies including (i) advocacy and policy dialogue for STI/HIV prevention and diagnosis and management of STIs, and (ii) strengthening capacities of the health system in provision of integrated SRH and HIV services including STI prevention and treatment.³⁴ These two strategies contributed in reducing Sexually Transmitted Infections and HIV/AIDS. Output 4 under this outcome focused its interventions on provision of reproductive health information and services to young people through three major strategies including (i) integration of life-skill based sexual and reproductive health education in to in school training curriculum, (ii) support to establishment of youth-friendly services and a referral system between the schools and health facilities in order to better improve access of young people to services, and (iii) targeting out-of-school youth and youth in

³² Basic Package for Primary Health Care Services- Achieving the MDGs by Improved Service Delivery, Timor Leste 2007

³³ National HIV/AIDS/STI Strategic Plan 2006-2010, Timor Leste MoH, 2006

³⁴ Country Program Action Plan, UNFPA in Timor Leste

vocational training through building capacity for youth organizations and civil society. These strategies under Outcome 2 were found to be aligned with the above-mentioned priorities and, as such, added values to the implementation of the relevant legal frameworks.