Annex1: UNFPA Timor-Leste CP 4 Evaluation Matrix for data collection during the Field Phase

<table>
<tr><td colspan="3">Evaluation Question 1: To what extent is the Country Programme aligned with the UNFPA strategic plan 2022-2025 priorities and accelerators and with relevant national SDG targets?</td></tr>
<tr><td colspan="3">Evaluation Criteria: Relevance (assumptions under this criterion are common to all programme areas (SRHR. A&Y, Gender, PD and other cross-cutting areas)</td></tr>
<tr><td>Assumptions 1: CP4 is aligned with the three transformative results and the six accelerators and with the relevant national SDG targets
(Please note that UNFPA CP4 is within SP 2018-2021 and 2022-2025)</td><td colspan="2">Indicators:
i. TOC aligned with SDG3, 5 (mainly)
ii. The interconnectedness of the three outcomes is reflected in the CP 4 outputs
iii. Gender concerns are mainstreamed in the design of CP4 and work plans as a cross-cutting issue (including in humanitarian response) and GEWE specific concerns like child marriage, GBV and other harmful practices have been designed based on gender and diversity analysis
iv. A human rights-based approach is evident in the planning and implementation processes.
v. mode of implementation</td></tr>
<tr><td colspan="2">Data collected [must be strictly linked to the assumptions and corresponding to the above-indicated indicators]</td><td>Sources of information [List the source(s) of evidence for each of the data collected]</td></tr>
<tr><td colspan="2">CP4 aligns closely with the UNFPA Strategic Plan 2022-2025, particularly in its contribution to the transformative result of "ending gender-based violence and harmful practices." This alignment ensures that Timor-Leste's country-specific interventions contribute to UNFPA's global goals.

The programme incorporates several key accelerators from the Strategic Plan:
Human rights-based and gender-transformative approach: CP4 anchors its actions in international human rights norms and standards, focusing on equality, non-discrimination, quality, and accountability (as seen from the TOCs discussions with the CO staff). This approach ensures that interventions not only address immediate needs but also contribute to long-term structural changes in gender relations.

Alignment with Timor-Leste’s National Strategies and Priorities: CP4 is aligned with Timor-Leste's long-term development vision as outlined in the Strategic Development Plan (2011-2030) CP4 for Adolescents and Youth in Timor-Leste aligns strategically with the National Youth Policy and relevant government strategies, and shows, from the literature (document review) coherence with national priorities. This alignment seems to help CP4 effectively contribute to the country’s development goals while addressing the needs of vulnerable youth populations. UNFPA supported the creation of CSE manuals, such as the Healthy Relationship Manual for out-of-school youth and the Boys and Girls Circle manual for in-school youth, reflecting adolescents’ needs.</td><td>Secondary Data:
CPD4, CPAP, Results framework, Theory of Change of the CP4, Country programme documents, M&E reports, Annual Reports, Documents on SDG Reporting, Government Reports related to SDG, Reporting from Results Groups, Programme Interventions as in CP4 Outcome Areas</td></tr>
</table>

UNFPA's interventions contribute directly to the country's overarching goals for gender equality and women's empowerment. CP4 provides targeted support to the National Action Plan for Gender-based Violence – NAP-GBV 2 of 2022-2023 (continued from the technical support provided in the revision of the first NAP- GBV). As examples, throughout the CP4, there is evidence that six accelerators are integrated, but it is not with explicit intention to be aligned with the SP 2022-2025. The output on HIV/AIDS has used several of the accelerators during the implementation of the interventions under the output, such as human rights-based and gender sensitive approaches (reaching key populations, efforts to reduce stigma and discrimination towards PLWHA), and partnership with WHO and CSOs working on HIV prevention. Also, the alignment of the CP to SDGs is not clear as interventions for reducing adolescent fertility and early marriages is missing from the CP (SDGs 3.7.2 (adolescent fertility 10-14 years) and 15-19 years as well as 5.3.1 Proportion of women 20-24 married or in union before 15 or 18 years). Adolescent fertility is one of the UNSDCF outcome indicators. Data or reference to adolescent fertility was lacking or not available in national SDG documents.	**Primary Data:** Interviews/ key informant Interviews UNFPA staff, relevant Results groups, relevant ministry stakeholders, CSOs-partners in -evidence of human rights-based and gender transformative approaches in the SRH, AY and Gender interventions (both in development and humanitarian settings)
Assumptions 2: The objectives and strategies of the programme components are consistent with relevant national and sectoral policies (in both development and humanitarian) (similar to Assumption 5, but this one is for relevance to objectives and strategies)	**Indicators:** i. TOC reflects the use of national and sectoral policies ii. Gender concerns are mainstreamed in the design of CP4 and work plans as a cross-cutting issue (including in humanitarian response) iii. Evidence of national and sectoral policies reflected in the programme planning and implementation iv. Evidence of established partnerships v. Evidence of active SSTCs
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
The CP does not include services for adolescents though the national health strategic plan 2011-30 and the subsequent essential package of services includes services for adolescents and youth health. CP4 shows strong alignment with various UN frameworks. UNDAF/UNSDCF (United Nations Sustainable Development Cooperation Framework 2021-2025): The programme addresses key outcomes outlined in the UNSDCF, such as outcome 4 and outcome 5 ● Outcome 4: "By 2025, the people of Timor-Leste increasingly demand and have access to gender-responsive equitable, high quality, resilient and inclusive Primary Health Care and strengthened social protection, including in times of emergencies." CP4 contributes to this outcome through its focus on strengthening the health sector response to GBV, improving access to sexual and reproductive health services, and enhancing the overall health system's capacity to address gender-related health issues (i.e. the establishment of safe spaces for survivors and strengthening of referral networks such as shelters, justice, and health facilities).	**Secondary Data: (Document Review)** CPD4, CPAP, Results framework, Theory of Change of the CP4, Country Programme Documents, M&E Reports, Annual Reports, Documents on SDG Reporting, Government Reports Related to SDG, Government Policy Documents AWPs, Programme Interventions as in CP4 outcome Areas, SDG Results Dashboard, UNFPA Contribution, National and Sectoral Policies, Reports related to Humanitarian Response

● Outcome 5: "By 2025, the most excluded people of Timor-Leste are empowered to claim their rights, including freedom from violence, through accessible, accountable and gender responsive governance systems, institutions and services at national and subnational levels." CP4 aligns with this outcome through its efforts to strengthen institutional capacities for implementing the National Action Plan on Gender-Based Violence, promoting community awareness, and empowering marginalized groups to access services and claim their rights (particularly the access of health for survivors of GBV). CP4 integrates the core principles of the ICPD, focusing on reproductive health and rights, gender equality, and population issues. This integration ensures that gender equality efforts are not isolated but are part of a broader approach to human development and rights. The programme contributes significantly to SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality). By addressing GBV and promoting women's empowerment, CP4 directly supports the achievement of these global goals in the Timor-Leste's context. SSTC: An active (SSTC) initiative has been established, specifically the TICA midwife training program. Regarding Adolescents and Youth, UNFPA CP4 key initiatives are aligned with Timor-Leste's National Youth Policy to empower young people by improving access to education, health services, and economic opportunities. The program focuses on enhancing access to Sexual and Reproductive Health (SRH) services and Comprehensive Sexuality Education (CSE) for adolescents and youth, by developing resources like the Healthy Relationship Manual for out-of-school youth and the Boys and Girls Circle manual for in-school youth. Despite challenges such as resource constraints and community resistance, UNFPA collaborates with government and community organizations to ensure sustainable implementation and continues to address gaps in SRH education and services, especially for marginalized groups. PD is in line with the government – **Statistics Law Article 7**. Responsibility for compiling required statistics 1. The agency responsible for compiling required official statistics is the National Statistics Directorate of the Ministry of Planning and Finance. 2. The respondents of official statistical surveys shall provide the National Statistics Directorate of the Ministry of Planning and Finance (DNE/MPF) with the requested data accurately and completely, within the established time limits. 3. The conduct of required statistical surveys by other government agencies shall be subject to the prior authorization of the National Statistics Directorate. 4. The provision contained in the preceding numeral shall specifically cover the situations envisaged in Section 2.1(d) of Regulation No. 2001/3 on the Establishment of a Central Civil Registry in Timor-Leste. 5. Declarations of imports into and exports from Timor-Leste shall obligatorily be submitted to the DNE within three months of their receipt	**Primary data: Interviews/ key informant Interviews** UNFPA staff, relevant ministry stakeholders, CSOs Partners in -evidence of human rights-based and gender transformative approaches in the SRH, AY and Gender interventions (both in development and humanitarian settings)

Evaluation Question 2: **To what extent has UNFPA ensured that the varied needs and capacities of targeted populations, including women and girls, adolescents and youth, survivors of gender-based violence, people at risk of and living with HIV, and also of government and civil society organizations at national and local levels, have been taken into account in both the planning, implementation and monitoring of all UNFPA-supported interventions under the country programme action plan?**	
Evaluation Criteria: Relevance	
Assumptions 3: Needs of the vulnerable and marginalized groups* were (identified and) considered in both design and implementation stages and meaningfully involved in CP4 planning, implementation and monitoring *(Marginalized groups) women and girls, adolescents and youth, survivors of gender-based violence, people at risk of and living with HIV, LGBTQI, other identified vulnerable populations Assumption (16 in the matrix) 1: Needs of the youth (including adolescents) in all their diversities (age, location, gender, sexual orientation, ability, employment, marital status etc.) are taken into consideration in CP4 design, planning and implementation and results reporting. (Assumption 3 and 16 (in the EM) are discussed together as they contribute to the answers to the same question, EQ2)	**Indicators:** i. Evidence of the use of data for Vulnerability survey, Needs Assessment/ or other studies/analyses for the design and development of CP4. ii. Evidence that "no one left behind" is given consideration and integrated in planning and implementation (evidence from assumption 1 can be used) iii. Documentation of Consultation Processes with vulnerable groups when developing CP4 and annual work plans (AWPs) (this is an indicator that consultation process took place in developing CP4, priorities and workplans; documentation or evidence of identified vulnerable groups participated in the developing process) iv. Interventions in AWPs that reflect targeted approach (inclusion of most vulnerable population groups) - The interventions that are tailored to problems and challenges that affect particular groups, inequalities and discrimination patterns. v. Disaggregated data available for evidence-based planning from relevant ministries vi. Intersectionality identified and taken into consideration in the planning documents vii. Reports providing evidence of the populations served viii. Indicator to show that gender analysis has been conducted and results included in the design of CP4 for integration in GEWE, GBV, SRHR and AY.
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Notes: AY- Finding 2: UNFPA conducted targeted assessments, including the 2017 SRHR Assessment, Teenage Pregnancy Study, and 2018 Nossal Institute Assessment on People with Disabilities and these studies still provide the background to inform inclusive programs. It is evident that barriers remain for women and girls in accessing health services without targeting SRH education and specialized support for GBV survivors. UNFPA has implemented initiatives to improve maternal health, expand family planning, address GBV, and empower women and girls. The program also provides comprehensive sexual education (CSE) and offers HIV prevention, testing, and treatment, (see below). Despite progress, challenges like social resistance and logistical barriers persist, leading UNFPA to adopt innovative solutions like mobile clinics and digital platforms.	**Primary Data -** KII interviews Informal group discussions Interviews with relevant GEWE component stakeholders

UNFPA remains committed to improving its performance against evaluation-related key indicators, as set out in the United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women and the United Nations Disability Inclusion Strategy, which aims to strengthen the utility of evaluation by integrating a gender equality and disability inclusion analysis lens throughout the process

Service Provision and Beneficiaries Among Adolescents and Youth:

"Service Provision and Beneficiaries Among Adolescents and Youth"					
Service Provision		**2021**	**2022**	**2023**	**Total Beneficiaries**
Comprehensive Sexuality Education	In School	N/A	103	3.862	3.965
	Out of School	40	559	1355	1.954
HIV/AIDS prevention, testing and treatment		11.077	11.382	52.956	75.415
Total		**11.117**	**12.044**	**58.173**	**81.334**

Source: UNFPA 2021, 2022, 2023 annual report-Timor-Leste

Gender equality and women's empowerment component (cross-cutting)

Targeted populations:

- The programme focuses on key populations including women and girls, adolescents and youth, survivors of gender-based violence, and people living with HIV.
- There is an emphasis on reaching vulnerable and marginalized populations to improve their access to services.

Government and civil society engagement:

- The programme was developed in consultation with government partners (although requires more comprehensive multisectoral approach involving Government partners in the beginning of program design i.e. problem formulation).
- It involves collaboration with government implementing partners such as the Ministry of Health, Ministry of Education (not previously), Ministry of Social and Solidarity (not currently) State Secretary of Equality and Inclusion, Ministry (then State Secretary) of Youth and Sport, and General Directorate of Statistics.
- Collaboration with local civil society partners is continued and expanded, with efforts to develop capacities of civil society organizations (from CSOs perspective more efforts to develop capacities is needed to better advocate for and support the NAP-GBV in ending GBV).

Secondary Data: (Document review)

CP Planning Documents, (if any) notes from planning meetings/workshops
Needs Assessment/Survey Documents, Annual Reports, MTRs (if available)
Evaluation Reports, AWPs, Field Mission reports etc
United Nations in Timor-Leste. (2023) UN Timor-Leste Annual Report 2022.
United Nations Population Fund of Timor-Leste Annual Reports (2021,2022 and 2023)
UNFPA Strategy Plan (SP) 2018-2021, 2022-2025
CCA,
ICPD POA
ICPD25 background papers
Partnership framework (UNDAF)

Needs assessment and planning:

- The programme drew on lessons learned and recommendations from the previous programme evaluation (CP3).

It aims to address identified needs like strengthening integrated sexual and reproductive health systems, improving data collection and utilization, and building capacity for addressing gender-based violence (the Integrated SRHR need to be improved – SRHR services often are not integrated/combined to address multiple health needs of women/pregnant women in a single visit because of factor such as medicine/test kits stockouts).

Implementation approach:

- The programme uses a multi-sectoral approach, working across health, education, youth, and other sectors (UN Joint programmes – Spotlight and T4E).
- It focuses on capacity building of government and civil society partners (health sector response to GBV in addition to SRHR services).
- There is an emphasis on rights-based and gender-responsive service provision.

Monitoring and adaptation:

i. The country office aims to respond and adjust to shifts in national needs and priorities, including those of vulnerable populations.
ii. The programme includes efforts to strengthen data collection and use to better identify specific needs of women and girls.
iii. Specific interventions (cross-cutting theme in other outcome areas):
iv. Support for integrated sexual and reproductive health services, including family planning and GBV response.
v. Development of in-school teaching materials on SRHR, gender and GBV prevention.
vi. Support for implementation of the National Action Plan on Gender-Based Violence.
vii. Efforts to improve adolescent sexual and reproductive health.

Additional note: additional targeted focus to meet the needs of women and girls with disabilities and members of LGBTQ+ community (found to be very limited)

Assumptions 4: UNFPA has taken into consideration the Needs and capacities of civil society organizations at national and local levels, during planning, implementation and monitoring UNFPA-supported interventions under the country programme action plan	**Indicators:** i. Evidence of consultations with CSOs and relevant organizations ii. Evidence of human resource analysis for decision- making iii. Application/utilization of IP assessment results/outcomes for any changes needed in the program (design, plan and or implementation) iv. Level of satisfaction with the outcomes of CP4 interventions implemented by CSOs
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*

Parts of the discussion above are relevant to this as well. Notes: The programme's focus is on the health sector response to GBV according to its global mandate. By strengthening the capacity of health professionals to identify, treat, and refer GBV cases, CP4 contributes to a more robust and responsive health system. This approach not only addresses the immediate health needs of GBV survivors but also plays a crucial role in breaking the cycle of violence by providing timely intervention and support. Furthermore, CP4's emphasis on community awareness through collaboration with local Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs) such as HAMNASA, ALOLA Foundation, Belun, FOKUPERS as implementing partners ensures that interventions are contextually sensitive and reach grassroots levels. This strategy helps in changing societal norms and attitudes towards gender equality and GBV, which is essential for long-term, sustainable change.	**Secondary Data:** Mission reports, IP reports, UNFPA Progress Reports Planning Documents (minutes, notes of relevant meetings) Review/monitoring reports, Progress Reports, IP Feedback Reports **Primary Data:** II interviews Informal group discussions UNFPA Pos CSOs Government IPs
Assumptions 5: Needs and capacities of the government and sub-national level are taken into consideration when planning, implementing and monitoring CP4 interventions (This one is on implementation) Assumption 2 is on Design	**Indicators:** i. Alignment of UNFPA support and its specific interventions in CP4 with National priorities and strategies on SRHR, including Adolescents and Youth and youth policy, disabled, inclusive of GBV, child/early marriage (in implementation and monitoring) ii. Reference to govt priorities in CP4 work-plans (CPAP) and in Humanitarian response iii. Allocations (budget) on priority areas
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
Same as above, addition is the part on implementation The programme's focus is on the health sector response to GBV according to its global mandate. By strengthening the capacity of health professionals to identify, treat, and refer GBV cases, CP4 contributes to a more robust and responsive health system. This approach not only addresses the immediate health needs of GBV survivors but also plays a crucial role in breaking the cycle of violence by providing timely intervention and support. Furthermore, CP4's emphasis on community awareness through collaboration with local Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs) such as HAMNASA, ALOLA Foundation, Belun, FOKUPERS as implementing partners ensures that interventions are contextually sensitive and reach grassroots levels. This strategy helps in changing societal norms and attitudes towards gender equality and GBV, which is essential for long-term, sustainable change. Field visits: Observations- was no evidence of services to people with disability. However, there was evidence of awareness about special needs of people with disability. No evidence of ASRH services. About early marriage, the CP 4 does not have any focus on child/early marriage. While CP4 has taken into consideration the national policies and priorities of the government, and the needs of sub-national level, whether their capacity is taken into consideration is not evident. The budget allocation by UNFPA for CP4 is available in Table under CO financial structure. Information on allocated budgets not available.	**Secondary Data (Document Review)** Mission reports IP reports UNFPA Progress Reports Planning Documents (minutes, notes of relevant meetings) Review/monitoring Reports Progress Reports, IP Feedback Reports **Primary Data** KII Interviews, Informal Group Discussions UNFPA POs CSOs, -government IPs

Evaluation Question 3: **To what extent have interventions led and supported by UNFPA changed the access to, and use of quality human-rights based integrated sexual reproductive health (maternal health, family planning, HIV/STI) services and gender-based violence response mechanism**	
Evaluation Criteria: Effectiveness (the extent to which the intervention achieved, or is expected to achieve, its objectives and results, including any differential results across groups) The effectiveness criteria cover the three outputs under CP 4 and to the three SP outcomes. SRHR outcome has three outputs. These three are discussed here and the relevant tables, charts and figures are attached at the end of the Matrix and they are referred to as Annex1-A, Annex 1- B and Annexx1-C. Output 1.1. The capacity of the national health system to provide high-quality, rights-based integrated sexual and reproductive health and HIV services, including availability and increased demand for family planning, response to GBV, in line with essential service package, stigma-free HIV services and referrals is strengthened, including in humanitarian settings. Output 1.2. The capacity of skilled birth attendants to provide high-quality maternal health services, including antenatal care, EmONC, postpartum care, and elimination of mother-to-child transmission of HIV and syphilis, as well as to carry out maternal death reviews, is strengthened, especially in areas most in need. Output 1.3. Awareness on prevention, transmission and treatment of HIV and other sexually transmitted infections, and uptake of HIV testing, especially among key populations, young people and pregnant women is increased, contributing to reduced stigma.	
Assumptions 6: Quality, rights-based, integrated SRH services especially services and information for FP, adolescents and young people and for survivors of GBV are accessible, particularly in underserved areas, and for vulnerable populations including persons with disability (PWD) in development and humanitarian situations. (Linked to output 1.1)	**Indicators:** i. Evidence of improved availability and access to of rights-based and quality FP services at various levels of the health system as per Essential Services Package (ESP) in underserved areas. ii. Availability of rights-based and quality FP services for vulnerable including PWD iii. Evidence of integration of FP in services for postpartum women, HIV and GBV iv. Reproductive Health Commodity Security (RHCS) system is operational with improved availability and minimum stock-outs of commodities v. Integrated services for survivors of GBV including referrals are available and accessible at all levels of the health facilities especially health posts and community health centres as per ESP. vi. Evidence of capacity for provision of integrated SRH services including services for survivors of GBV in humanitarian situations through implementation of Minimum Essential Services Package (MISP) vii. Quality, adolescent and youth- friendly SRH services are available and accessible in health facilities as per the Essential Service Package (ESP) viii. VIII. Data on utilization of FP and GBV services as available (HMIS)
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]

Progress of output indicators and contributions towards UNFPA SP outcome indicators **Finding 1**: Indicators related to Output 1 on building capacity of national health system on high quality, rights-based and integrated SRH and HIV have progressed, despite some of the initial set back due to the COVID-19 pandemic. (annex A) shows the status of the indicators. 61% of Community health Centres (CHC) is reported to be providing good quality comprehensive SRH services including HIV and family planning compared to none in the baseline. However, a major concern is the delivery of services in an integrated manner as discussed under Finding 7. The second indicator related to percentage of health facilities with no stock out in the previous year showed that that 72% of facilities surveyed in the 2022 assessment of reproductive health commodities had no stock out of 'any contraceptive' in the previous 3 months to the survey, which is a progress compared to the baseline figure of 38%. Data on stock-out for the previous year as in the indicator is not available.	CPAP, CO MEL report 2023, Annual reports 2021-23, UNFPA. Report of an assessment for reproductive health commodities and services 2022, visits to municipal health departments and health facilities, national INFPM (national store) and regional store in Baucau, interviews with UNFPA programme staff, MCH Directorate, Annex A

It should be also noted that for three modern methods of contraception (which is expected to be available at all levels of health facilities), the level of 'no stockout' was 54% (shows improvement). However, during visits to municipalities stockouts of selected contraceptives and other RH supplies have been reported (details give under Finding 7). The progress of the third indicator related to the number of CHCs providing services to survivors of GBV is good (46%). It is likely that the progress will be 100 % by the end of the CP. **Finding 2**: The indicators cover family planning, supply chain management, health sector response to gender-based violence, integrated SRH and HIV services and SRH services in humanitarian crisis through minimum initial services package. The following paragraphs are aligned to the indicators listed above against assumptions. Family planning (linked to indicators i-iii, viii) to the indicators related to the assumption The current National Family Planning Policy 2022 focuses on the role of family planning in improving maternal health and promotes right-based approaches in family planning service delivery for married couples, in the context of SDGs and religious teachings. The policy promotes comprehensive approaches to family planning services by promoting a comprehensive history and physical examination that includes breast and pelvic examination and screening for GBV. However, there are some critical concerns with the policy such as restricting provision of contraceptives to adolescents and promoting only spacing methods of contraception; thus, denying the rights of adolescents (in the context of teenage pregnancies being a concern) and denying the rights of couples to limit their family. Based on the discussions with CO staff and other partners, UNFPA's advocacy could not achieve the desired impact in promotion of universal access to family planning services due to overwhelming political and religious pressures. Emergency contraceptive pill, a critical product for reducing the chances of unwanted pregnancies after sexual assault, is also banned; higher doses of contraceptive pills are prescribed as an alternative (severe side effects of high doses are well known). As the lead agency for family planning and in the context of its corporate outcome of reduced unmet needs, the lack of influence on the policy is a setback for UNFPA. The restrictions on adolescents' access to contraceptives is also a setback for UNFPA CO, both at the country level where it is the lead agency in the UNCT for young people and at the global level as a lead agency for ASRH. The restrictions further worsen the existing level of risk of adolescent pregnancies and HIV/STIs. During the development of the past policies, UNFPA played a significant role in developing the policy, ensuring universal access to family planning services and had successfully advocated to the Parliamentarians and Religious Leaders. UNFPA's advocacy in the past had helped to include family planning in the National Health Strategic Plan and Essential Services Package and other policy documents. Regardless of the gaps in the policy, MOH Is committed to family planning as evident from the supplies compact signed as described under the section on supply management system elsewhere in this section.	Annual reports 2021-23, National Family Planning Policy of Timor-Leste, 2022, National Health Strategic Plan 2011-30, Essential Services Package, MOH.HMIS reports, Interviews with UNFPA programme staff, MCH Directorate (FP staff), Facility visit (Annex 1-B)

Finding 2 (Continued): The indicators cover family planning, supply chain management, health sector response to gender-based violence, integrated SRH and HIV services and SRH services in humanitarian crisis through minimum initial services package. <u>The following paragraphs are aligned to the indicators related to the assumption.</u> Despite the setback with the policy advocacy, UNFPA continues to be the major agency for family planning services in the country in capacity building with skilled human resources as well as necessary equipment and provision of quality contraceptives (details on support of supply systems is described elsewhere in this section). Family planning services were available at all levels of health facilities visited – referral hospitals, CHCs and health posts. Condoms, combined oral contraceptives and progestin-only pills and injectable contraceptive are available at all facilities with implant (Jadelle) and IUCDs (Copper T 380) being available, where trained providers and necessary instruments are available. Client records and registers are available at all facilities. Client screening check lists and counselling tools are available in most places visited. Marie Stopes supports public facilities for insertion of implants and IUCDs where no skilled providers are available. In its commitment <u>to reach underserved areas,</u> UNFPA in collaboration with Maternal and Child Health (MCH) Directorate and District Public Health Officer (DPHO) MCH at the municipality, have conducted outreach clinics in underserved areas in all the 14 municipalities from 2021-22 and in 9 municipalities in 2023. Services were provided to more than 6000 clients and all methods were offered, implant being the most popular method (see Chart 1 Annex C). In the previous CP, UNFPA had supported the development of rights-based family planning training package based on international training modules. The capacity building of doctors, midwives and nurses continued in the current CP through support to National Institute of Public Health of Timor Leste (INSPTL). Counselling and informed choice were important elements of the training. Marie Stopes, Timor Leste had also collaborated on the training. So far 199 have been trained of which 99 were certified competent. UNFPA's support to the training had to be discontinued in 2021 due to changes in the curriculum and duration of training, which affected the quality of training and UNFPA did not concur. WHO also provided support for training for a short period. Review of the training package and interviews with stakeholders pointed that the current training package does not include topics such as family planning for people with disability and for women who experience violence, female condoms, infection prevention, etc. However, there are plans to restart the training and the revision of the training materials. Currently the family planning services do not include adolescents and key populations (due to the restricted provision of family planning services ONLY to married). Family planning is promoted during ANC and is well-integrated with PNC as was evident in the national guidelines and during visits to facilities. It is not integrated with HIV/STI services and services for GBV survivors. *Despite some of the gaps, CO's efforts has contributed to improving the quality of family planning services ensuring informed choice.* Chart 2 Annex C shows some of the achievements at national level to which UNFPA contraceptive supplies (the only agency providing contraceptives) and UNFPA supported training have contributed significantly to improving CPR of modern methods (reports of MOH collected through District Health Information Software2 (DHIS2) /Health Management Information System (HMIS). *Another positive finding is that UNFPA and Marie Stopes are assisting the MOH to review and refine indicators for the family planning programme and recently has added indicators related to screening for HIV and STI and referrals for services.*	Annual reports 2021-23, National Family Planning Policy of Timor Leste, 2022, National Health Strategic Plan 2011-30, Essential Services Package, MOH.HMIS reports, Interviews with UNFPA programme staff, MCH Directorate (FP staff), Facility visit (Annex B)

Supply chain management (Linked to indicator iv) UNFPA is recognized by the MOH and donors for its leadership in Reproductive Health Commodities Supply (RHCS) Systems and access to quality contraceptives and reproductive health commodities. The key achievements of UNFPA includes continuation of the implementation of the RHCS strategy, developed at the end of the previous CP, institutionalization of the family planning Logistics management Information System, conducting national facility audit of services and supplies in 2022 that provided information on the services and supply situation of a significant number of health posts, CHCs and hospitals, the strengthening the electronic logistics management information system- the m-supply system, the Memorandum of Understanding (MoU) with MOH for the period 2022-27 and the Third-Party Procurement (TPP) agreement signed with National Institute for Pharmacy and Medical product (INFPM) signed in 2022. At the policy level, UNFPA's advocacy has resulted in the signing of the MoU by MOH and the subsequent TPP agreement for procurement of reproductive health commodities using domestic resources since 2022 (MOU with MOH, invoices, reports). Under the UNFPA global supplies partnership, Timor-Leste is eligible for receiving contraceptives, maternal health supplies and test kits for HIV and Syphilis and UNFPA has been procuring and supplying these commodities that has helped in minimize stockouts in the country. However, in 2024, there has been a delay from the UNPFA's Supply Chain Unit in Copenhagen which has led to stockouts in the country of implants and HIV and Syphilis test kits and has been resolved recently. There has been stockout of reagents for haemoglobin estimation as well as for urine tests (MOH procurement) that these critical tests for maternal care are not being carried out in health facilities. The m-supplies system established by MOH with support from Partnership for Human Development (PHD) (Australian Government) has been reactivated with technical assistance by UNFPA and is being expanded with quality of implementation and capacity building (funded by PHD). Both MOH and PHD appreciates UNFPA for its contributions. UNFPA has also advocated to include e-LMIS in the District Health Information System (DHIS 2) and is currently being piloted in selected municipalities. An area of concern is the stockout of various contraceptives at different levels of health facilities. The supply system, that was put on track under this CP has improved the system as was reported in the 2022 facility audit which covered 272 health facilities across Timor-Leste comprising of 71% Health Posts, 27% Community Health Centres and 2% Hospitals. However, there are few serious gaps which are being remedied with technical assistance from UNFPA. While the stockout of any contraceptive is 72%, the stockout at health posts for three methods of contraception was 54% (and at CHC and hospitals for five methods of contraception, it was 60%. The least stock out was for injectable contraceptives, followed by oral contraceptives, Implants and IUCDs and mentioned that reason for stockout is "not ordering" due to low client preference. With the popularity of implants, the demand for other methods is likely to decrease and unless the supply system captures these changes, the contraceptives may be wasted due to expiry. In many facilities visited, condoms are not being distributed even though condoms are needed for dual protection) and have reached expiry dates. The wastage of condoms due to expiry resulting from oversupply was also found in facilities managed by CSOs for HIV/AIDS prevention whose skills in supply management is limited. Another issue is the lack of joint estimation of condoms needed by MCH Directorate and National AIDS Programme. Similarly, no joint estimates of the needs for HIV, Syphilis and Hep B test kits for use in ANC as well as for at risk populations that has led to severe shortages in carrying out these critical diagnostic tests. Another area of concern is the shortage of life saving maternal health drugs such as magnesium sulphate (which was confirmed during the visits to the facilities). Though not many deliveries do not take place in Health Posts, the maintenance of cold chain of oxytocin in Health Posts is a concern and needs to be reviewed as part of the supply system. UNFPA has contributed significantly to establishing a logistics management information system for reproductive health commodities and through its involvement in strengthening and expanding m-supply, systems for management of other supplies also will improve. UNFPA will need to continue supporting the MOH and INFPM using the technical expertise within the CO.	Annual reports 2021-23, Report on assessment for Reproductive Health Commodities and Services in Timor-Leste, MOU with MH and TPP agreement with INFPM, RHCS strategy, Visits to INFPM at national level and Baucau regional INFPM, Municipal Health Department (esp. FP), pharmacies and MCH departments of health facilities, Interviews with UNFPA programme staff, MCH Department, MOH National AIDS Control Programme, PHD/DFAT, Marie Stopes Timor-Leste, MOH HMIS

Health sector response to GBV (linked to indicator v) The Essential Services Package (ESP) of the MOH includes services for survivors of GBV at all levels of health facilities as per the capacity of the facility. MOH had developed National Guideline for health care providers to address Gender-based violence including intimate partner violence, 2018 and has a focal point for gender and GBV in the MCH Directorate. GBV continues to be a priority under the Ninth Constitutional Government. UNFPA has provided leadership to health sector response to GBV on its own initiative and through the two joint programmes funded by European Commission (EU) and Korean International Cooperation Agency (KOICA). Details of the joint programme is provided under the thematic area on gender and under the case study on joint programming on GBV. UNFPA's contributions and leadership are recognized in two main areas – improving access to quality, confidential and safe health services in health facilities, building capacity of health providers at various levels of health services to identify and manage survivors of GBV and referral to appropriate authorities and facilities as per national guideline: strengthening pre-service training of midwives, doctors and nurses in identification and management of survivors of GBV. As noted under Finding 1 with UNFPA support, six CHCs in six municipalities with high prevalence of GBV, have established functional services for survivors of GBV. Priority was given to CHCs where BEmONC services are established or planned (CSI Viqueque (Viqueque), Gleno (Ermera), CSI Liquiça (Liquiça), Vera Cruz (Dili), Atabae (Bobonaro) and Oecusse with the objective of enabling quick access to midwives who are who are competent in providing first level of care to survivors of violence. CHCs have also been identified in the rest of the municipalities for provision of services for survivors of GBV. Safe spaces for admitting survivors of violence, as per the criteria laid by the Ministry of Social Inclusion (MSSI), have been created and operational in existing CHCs (with BEmONC facility) in Gleno, Viqueque and Liquiça (latter with UNFPA support), Veracruz, and Bobonaro (Atabae). Safe spaces also have been created, but not operational, in the national referral hospital in Dili (HNGV), the regional referral hospital Baucau, referral hospitals in Bobonaro, Covalima and Oecusse and in 2 CHCs in Liquiça, in CHCs Comoro, Becora and Metinaru in Dili and CHC Tilomar in Covalima. SOPs have been developed on management of survivors and referrals. The existing staff in the CHCs manage the safe spaces. Under the guidance and leadership of the MOH, with funding and technical assistance from UNFPA (UNFPA -Zonta regional project), the La Trobe University, in collaboration with INSPTL, adapted and expanded the existing materials developed by the local NGO HAMNASA to conform to WHO guidance on the care of survivors of GBV The training includes the following main components- Listen, Inquire, Validate, Enhance, Safety (LIVES) (first line treatment), clinical care, health managers' component and self-care for health providers. Facilitators and Participants' training materials as well follow up modules were developed and implemented. The key milestones in the training were standardization of training using a wide network of professionals from MOH, INSPTL, referral hospitals and CHCs, training of trainers with specific criteria for selection, training of 352 midwives and doctors, predominantly from CHCs and training of municipal administrators and administrators of referral hospitals and CHCs to hospitals and CHCs, training of trainers with specific criteria for selection, training of 352 midwives and doctors, predominantly from CHCs and training of municipal administrators and administrators of referral hospitals and CHCs to ensure that their buy-in for the services (Chart 3 Annex C). The training covered 10 municipalities (Dili, Baucau, Viqueque, Lautem, Ermera, Liquiça, Bobonaro, Covalima, Manufahi (2 providers only), and special administrative region of Oecussi).	Annual reports 21-23, Implementing partner reports, National guidance on health sector response to GBV, Training reports, Facilitators' and Participants' training materials, SOPs on safe space, National Health Strategic Plan 2011-30, Essential Services Package, Interviews with UNFPA staff, staff of MCH Directorate, municipal health staff, staff of regional referral hospital Baucau, CHCs, Visit to facilities (Annex B)

In addition, a pool of national and municipal facilitators as well as mentors were established to support the implementation of in-service training package as well as mentoring/ coaching provided to newly trained health care providers in providing quality of services both at national and sub-national level. In addition, in HNGV, the national referral hospital, staff of emergency OPD, intensive care unit and paediatric wards have been trained. During visits to municipalities, there was significant evidence of understanding of the issues related to survivors of GBV and referral pathways and confidentiality was maintained at the highest degree. The administrators were knowledgeable about the issues and were supportive. The referral pathways between the health system and law enforcement authorities were clearly defined. A technical guidance notes for health service providers to further strengthen the referral pathways and enable regular follow up in safe houses has been developed. UNFPA also has provided leadership in including care of survivors of GBV in the preservice curriculum and training of midwives. Care of survivors of GBV is a core competency under midwifery. Building on the preservice curriculum on management of GBV for midwives, doctors and nurses developed by La Trobe University with WHO support, UNFPA provided technical assistance for its introduction in the midwifery schools under the National University of Timor-Leste (UNTL) and under the private University Institute Superior Cristal (ISC). There are plans to expand to the third midwifery school -the Institute Ciência Saude (ICS) (private). UNFPA, in collaboration with WHO has started advocating to the Dean of Faculty of Medical and Health Sciences to incorporate the care of survivors of GBV in medical and nursing preservice curriculum. This effort is commendable as it supports development of professionals sensitized to the issue of GBV. Another area of support provided is in the improvement in the forensic protocol for management of survivors of sexual violence in collaboration with PRADET, (the NGO who originally developed the protocol- approved by Ministry of Justice), WHO and Asia Foundation. Plans are under way to train few doctors in the protocol as experts. In addition, UNFPA supported the development of special information systems to document (ensuring confidentiality of data) and report the cases of violence by type, age and number. Capacity development of providers in documenting and managing data is a part of the training in GBV. During visits to municipalities, it was observed that highest degree of confidentiality of data was maintained. Some information related to access to GBV services in facilities visited is in SRHR Annex B. UNFPA also has successfully advocated to include it as part of DHIS 2 and the process has been initiated. In addition to the above, UNFPA supported to build capacities of local CSOs/NGOs to create awareness in the community and among young people about GBV, where to seek services, etc. and is assisting MOH to incorporate the messages as part of their health education strategy. Information on helplines for reporting GBV are available even in difficult to access health facilities (as was found during visits to municipalities). Details of the joint programming for GBV is provided elsewhere in this report. Besides funding from Zonta Project and joint programming funds, UNFPA has used its own resources. The training in managing cases of GBV, referrals, partnership for forensic examination, etc. were put to good use during the floods. While most of the UNFPA inputs are sustainable as the investments have been in capacity building especially preservice education, health information systems and awareness creation, there are few concerns. These are about the functioning of the safe spaces and investments in medico-legal aspects of sexual violence. In future, it may not be possible to invest in standalone in-service training and is important to continue the same as part of the integrated services as described elsewhere in this section.	

Integrated SRH services (linked to indicator vi) In support of the policy on integrated health programme and ESP, UNFPA had supported the development of operational guidelines for integrated SRH services within the PHC context. The components of integrated SRH package as defined in the ESP includes 12 SRH services: MCH (preconception counselling, ANC, Intrapartum care, postnatal care, family planning, STIs, Prevention of mother to child transmission of triple antigen, adolescent SRH, infertility, male SRH and involvement, GBV, post-abortion care, reproductive cancers, nutrition and menopause. The operational guidelines developed by the CO include guidance on minimum package of the services for different levels of care. It is not clear whether the document talks about integration of various services in one platform. For example, integration of family planning, screening for HIV. STI and Hep B and its management/referral, screening for signs of GBV, etc. during ANC. Such integration needs skilled providers, appropriate referrals across services, integrated supply systems, etc. Annex B shows that none of the facilities was providing integrated services.	Essential services package, operational guidelines within the PHC context, Annual Reports 21-23, Draft RMNCAH strategy, interviews and group discussions with UNFPA staff, visits to health facilities (Annex B)
Capacity building for MISP (linked to indicator vi) Timor-Leste experiences frequent floods and UNFPA has been at the forefront providing services especially mobile maternal health services, family planning advice and supplies, education for prevention of GBV, etc. (details are provided under Finding 9. UNFPA, under the Emergency Health Cluster, leads the SRHR cluster. Training in MISP was provided under the previous CP and during floods, but it was made more structured through the contextualization of the Interagency manual on MISP and training- MOH staff, doctors and midwives were trained using the manual. The MISP manual emphasizes integrated SRH services. From reports of humanitarian crisis, the services offered were integrated (details are under Finding 9). UNFPA also has been advocating for inclusion of RH supplies in national disaster plans. However, unless efforts to advocate to include MISP in the National Disaster Preparedness plans, rolling out of MISP in the early days of crisis (within 24 hours) may not happen. Capacity building of municipal health administrators and staff as well as sensitization of national and regional warehouse staff to the need for pre-positioning supplies and monitoring their validity is important.	MISP manual (Timor-Leste), UNFPA. Report on floods and COVID and reports to donors, Annual reports 2021-23, National Disaster Management Plan, interviews with UNFPA CO staff, MCH Directorate
Missing elements (linked to indicator vii) While the ESP includes adolescent health services as one of the focus areas, under the CP, no support was provided for services for adolescent sexual and reproductive health. If the benefit of the current demographic dividend is to be fully reaped, it requires investments in SRH services. Efforts were made in the previous country programme and guidelines were developed, currently there is no dedicated officer. This is a major gap in the CP and none of the three SP outcomes can be achieved without services for adolescents and young people. Adolescent health services were not found during visits to municipalities. In collaboration with MOH ASRH unit under MCH Directorate, ASRH clinics established by Plan International in Aileu and Ainaro districts in 6 CHCS and two school-based clinics (I in each of the above municipalities). Provides information and counselling on prevention of pregnancy and HIV. Referrals to Voluntary counselling and testing centres are also made. Condoms are provided.	National Health Strategic Plan 2011-30, Essential services package, Interviews with UNFPA CO staff, MCH Directorate staff, Marie Stopes Timor-Leste, Plan International Timor-Leste, Interviews with WHO staff Visits to health facilities and discussions with staff (Annex B

For confidentiality and privacy, separate spaces have been created in CHCS and in schools the clinic is managed along with youth economic project. Annex B shows that none of the facilities provide ASRH services. Another missing area is support for preconception care which is part of the ESP. The objective of the preconception care package is to provide opportunities for optimizing maternal health and development of children even before conception takes place as well as benefits to adolescents and adults. The preconception package is a critical intervention of the life course approach and plays a role in prevention/modification of risks across the life course. It is important to determine the locations and mechanism of delivery of the package. No evidence of such services was found during the visits to the clinics (Annex B), Cervical cancer is another missing area under the CP. Screening for cervical cancer and treatment of pre-cancerous lesions were treated in the past and is a part of the ESP. Recently, WHO has initiated pilot projects on screening for cervical cancer using HPV DNA based tests and HPV single dose vaccination among adolescents. Currently there is no strategy for cervical cancer prevention, screening and treatment.	
Assumptions 7: Quality maternal health services including EmONC are accessible particularly in underserved areas including during humanitarian crises. (Linked to Output 1.2)	**Indicators:** i. Availability of protocols and guidelines for ANC, PNC based on WHO recommendations and approved by MOH ii. Evidence of integration of Prevention of Mother to Child Transmission (PMTCT), screening for GBV and FP iii. Evidence of doctors and midwives adhering to standards of maternal health services iv. Availability of CHCs and PHCs that provide BEmONC as per standards in underserved areas v. Evidence of regular Maternal and Perinatal Death Surveillance and Response (MPDSR) by municipal and referral hospital committees vi. Evidence of maternal health services provided during the COVID pandemic and floods vii. South- South and Triangular Cooperation (SSTC) with Indonesia on MPDSR on use of MPDSN (electronic reporting of maternal and perinatal deaths) viii. Evidence available on health seeking behaviour of mothers during pregnancy and childbirth ix. ix. Data on ANC, institutional delivery, PNC as available and referrals as available
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
Finding 3: Progress of output indicators and contributions towards UNFPA SP outcome indicators The indicators related to the output related to the capacity of the skilled birth attendants to provide maternal health including EmONC services and maternal deaths reviews have made progress despite the setback due to COVID in the early days of the CP (Annex A). The inputs for strengthening BEmONC services had started in the previous CP. The number of functional, certified BEmONC facilities has increased but the numbers are few as the refurbishment of facilities takes time and the certification process is thorough. Details of the progress are described under Finding. The progress regarding the indicator on functional MPDSR committees – all 14 municipalities have a MPDSR committee- but their quality of functioning is not known as discussed under Finding 4. The third indicator related to capacity of midwifery schools has been achieved- One government and two private midwifery schools have been strengthened. However, there are few concerns that are described under Finding 5.	CPAP, CO MEL report 2023, Annual reports 2021-23, UNFPA. Report of an assessment for reproductive health commodities and services 2022, visits to municipal health departments and health facilities, national INFPM (national store), interviews with UNFPA programme staff, MCH Directorate, Annex A

Finding 4: **EMONC and ANC, PNC** (Linked to indicators iii,iv,vi) UNFPA's contributions to maternal health are well recognized by MOH, donors and UN partners and these include support to development of EmONC centres and developing guidelines for ANC and PNC, based on WHO recommendations adapted for country specific needs. The contributions to increasing access to BEmONC facilities started in the previous CP. The total number trained is 154 with 68% midwives and the rest doctors, from all the 14 municipalities, Referral Hospitals and HNGV (Chart 4 Annex C). Of the trained, almost 80% are actively involved in BEmONC services. Through an active WhatsApp group, cases are discussed and solutions provided by the senior trainers. Follow up visits are also done to monitor the EmONC services provided. At the end of the training, equipment/instruments were provided to each of the facilities where the trainees are posted to assist them in their practice. Monthly reports on management of complications of pregnant women and newborns and deaths of mothers and newborns from CHCs, where staff have been trained, are shared with UNFPA and MOH and feedback is provided based on the analysis of the information (See Charts 5,6,7 Annex 5 and at the end of this matrix under SRHR Annex 1C for analysis). While there is increased case management of certain complications and fewer transfers to referral facilities, it is too early to reach any conclusions. The cases of neonatal resuscitation, cervical tear and provision of IV antibiotics should be further investigated. During the visits to some of the BEmONC facilities, the evaluation team had the opportunity to observe competent handling of complications during childbirth. It appears that staff are adhering to protocols including maintenance of equipment, delivery sets and maintenance of records. It was also observed that mothers and newborns are kept in the facility for 24 hours in the fully functional BEmONC facilities. Feedback from the CHC administrators as well as Municipal authorities are very positive and would like the BEmONC training to be continued. Feedback from women who had just delivered or admitted were also positive especially the respectful and compassionate care they received. The midwives trained from referral hospitals are reported to be managing the complications under the supervision of the specialists, thus decreasing the load of the few specialists in the country. The indicator on CHCs with 24/7 availability of BEmONC is progressing slowly as the process for civil works is long and the facilities must be certified meeting the standards, by MOH. The CHCs chosen are in locations where access to BEmONC is generally more than two hours (global recommendation is access within two hours) and has enabled pregnant women, nearing term to get admitted in the facility, thus ensuring access to pregnant women in remote areas. UNFPA's systems approach in improving access to BEmONC has attracted funding for EmONC from donor such as the Australian Government and recently a major funding from the Japan Government for establishment of 20 BEmONC centres in 12 municipalities, which includes renovation of 20 maternity units in 20 CHCs, provision of medical and non-medical equipment and supplies, and training of doctors and midwives. Though newborn care is part of the EmONC interventions and equipment, and supplies have been ensured (UNICEF contributed to the latter), a concern is expressed by MOH and partners about the adequacy of current information in newborn care protocols and training guides. A joint review with WHO and UNICEF may be useful to fulfil any gaps. Newborn referrals also need to be strengthened. Currently only one Regional Hospital and the HNGV provide secondary and tertiary level intensive care. One of the missing gaps is maternal 'Near Miss' case reviews of maternal cases which is an approach to improve the quality of care. Once the maternal case reviews have been established, consideration should be given to do the same for newborns, considering the high number of perinatal deaths.	Annual reports 21-23, UNFPA Report of an assessment for reproductive health commodities and services 2022 Reports on training in BEmONC Reports of CHCs with BEmONC trained staff Visits to municipal health departments and health facilities National INFPM (national store) Interviews with UNFPA programme staff, MCH Directorate Facility visits -Annex B, C

ANC and PNC guidelines and capacity building (linked to indicators I, ii,iii,vi,viii) During the lockdown, UNFPA supported the development of guidelines for care of COVID positive women during Antenatal (ANC), intrapartum, Postnatal (PNC) which were nationally used as discussed under Finding 9. Recognizing the need to strengthen quality of ANC coverage, UNFPA supported the development of national ANC and PNC guidelines, based on WHO recommendations for positive pregnancy and recommendations on maternal and newborn care for positive postnatal experience and have been approved by the MOH. The capacity building of midwives and doctors has been rolled out. The ANC guidelines enable the delivery services in an integrated manner by inclusion of screening for the triple antigens during pregnancy (HIV, Syphilis and Hepatitis B), screening for signs of GBV, advice on FP and breastfeeding, nutrition, supplements and advice on birth preparedness and complication management. Interviews with pregnant mothers did confirm that they were advised about family planning. Mothers are provided iron and folic acid and Calcium and referred to nutrition services as needed. However, there are some concerns. One of the concerns is the ANC contacts– while most are in person, three visits in third trimester are on-line and not as per WHO recommendations for positive pregnancy experience. Though the ANC guidelines stress the importance of screening for the three antigens, these are not done for all pregnant due to shortage of the combo kits for HIV and Syphilis and the kit for Hepatitis B (this was referred to under Finding 2). The referral pathway for those tested positive for treatment is also not clear. Hence, the prevention of mother to child transmission is a weak link in ANC, especially in the context of 0.3% prevalence among pregnant (as reported in HIV sentinel surveillance report) and could be a reason for increased number of macerated stillbirths discussed under MPDSR in this section. Another area of concern is the management of decreased foetal movements during antenatal period which needs closer scrutiny, especially in the context of significant number of stillbirths due to antenatal causes as discussed under MPDSR in this section). The quality of screening for evidence of GBV during ANC is not known. As indicated under Finding 2, tests for haemoglobin and urine are not available for many months and these affect the quality of ANC. To complement UNFPA's efforts the Japanese Government through its local NGO 'Frontline' had procured ultrasound machines and supported capacity building of doctors in Ermera and is ongoing in Bobonaro. Under the Japanese support for BEmONC, capacity building in use of USG is planned in all the 20 CHCs. This input should contribute to recognizing complications during antenatal period and taking appropriate action. The postnatal guide requires a review with regard newborn care issues as in the WHO guidelines and focus on nurturing care which lays the foundation for future human capacity development and health. Follow up of HIV positive mothers and their care is not clear in the guidelines. Both the guidelines have provided indicators for monitoring coverage. Chart 8 in Annex 1-C (end of this Matrix) shows the coverage of ANC, deliveries and PNC 22-23 to which UNFPA inputs have contributed.	Annual reports 2021-23, HIV Sentinel Surveillance 2018-19, ANC, PNC guidelines, MOH. HIV/AIDS sentinel surveillance report 2016-18, discussion with UNFPA Programme staff, municipal health directorate, visits to facilities (Annex B), Annex C

MPDSR strengthening (linked to indicator v, vii) The support to MOH for MPDSR is a collaborative effort between WHO, UNICEF and UNFPA and a good example of joint support to MOH. The MPDSR guidelines were updated, and training was provided in all the 14 municipalities. As noted under Finding 3, all the municipalities have established MPDSR committees; confirmed during visits to the municipalities and by other partners. However, there are concerns about the quality of the MPDSR process, particularly at the municipality level. UNFPA had helped to establish the MDSR system in 2014 and the perinatal part was added later in 2019 with UNICEF and UNFPA support. The national guideline was developed collaboratively by MOH, WHO, UNFPA and UNICEF. Forms for reporting deaths in institutions and verbal autopsy for deaths at home have been developed. An international consultant with expertise in MPDSR had trained the staff of HNGV and other referral hospitals while the committees at the municipal level have been trained by national trainers with support from the three UN agencies. A positive finding is that deaths are notified within 24 hours as per MPDSR guidelines; however, there is delay in the analysis and assigning cause of death and other factors associated with the maternal deaths. Part of the reason is lack of availability doctors and midwives for the review. Transfer of staff trained in MPDSR has also added to the delay. The national level committee is not functional and there is confusion about the Chair of the committee, the role of the committee, which should be rectified by joint advocacy to MCH Directorate. There are concerns about the functionality of the MPDSR committees in the referral hospitals and HNGV. The inputs provided have resulted in increased reporting of maternal deaths as shown in the Chart 9 (in Annex 1-C). Analysis of the MPDSR reports also showed that about 12-15% of deaths reported (2021-23) have been reviewed and submitted to MCH Directorate. The analysis from 21-22 showed that most of the deaths happened during the post-natal period and haemorrhage was the leading cause of death, followed by shock. Majority of the mortality was due to delay 1 in making decision about using a facility or contacting a provider, followed by Delay 3- delay in receiving quality care in the hospital/health facility were the contributing factors. Approximately one-third of the mothers died at home. Direct maternal deaths have increased almost by 50% in 2022. Regarding perinatal deaths, the number of stillbirths is alarmingly high (could be misclassification). Majority were macerated stillbirths and 43% happened during antenatal period (PDSR report). Delay 1, followed by Delay 3 were the common contributing factors. Ermera reported maximum maternal deaths and perinatal deaths compared to other municipalities and in 2023 also Ermera topped the list (Ermera is one of the municipalities with a high fertility, high unmet need for family planning, high infant and child mortality (Timor-Leste Demographic Health Survey 2016 reports). In addition to the above efforts, UNFPA has facilitated a visit of MOH MCH officials to understand the maternal and perinatal death notification app, developed by the MOH of Indonesia. Talks are underway to develop this collaboration between Indonesia and Timor-Leste with the possibility of a SSTC. Though it appears that the institutional deliveries have increased to 80% (see Chart 8 Annex1-C at the end of the Matrix), a significant number of deliveries take place at home (almost 20% as per DHIS 2 reports). The CO has initiated a contract with University of Tasmania to undertake a study on health seeking mothers during pregnancy and childbirth. The findings will be used to develop communication messages to pregnant women, families and communities and sensitize journalists on the issues (currently the CO is working with journalists to bring out articles on maternal health, GBV, etc.)	MPDSR guidelines, MPDSR report 2023, MOH. Presentation of analysis of MPDSR and PDSR 2021-22, APRO reviews, mission report to Indonesia to study MPDSN, Interviews UNFPA programme officers, WHO, at municipality public health officers (MCH), referral hospitals, HNGV, MCH Directorate, Annex 1-C

Assumptions 8: Institutional capacity for human resources for SRMNCAH /midwifery developed. (Linked to output 1.2)	**Indicators:** i. Assessment of current availability of midwives done ii. Standards of practice and education as per ICM standards of midwifery practice and education developed iii. Plans for regulation and law related to midwifery developed iv. Capacity of midwifery association built as per ICM recommendations v. Curriculum and training modules developed as per ICM standards vi. Three midwifery schools ((UNTL, ICS and Escola Superior Cristal) accredited based on ICM standards vii. vii. SSTC for midwifery education under Thailand International Cooperation Agency (TICA)
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
Midwifery education (Linked to i-vii) Finding 5: The strategy under the output is expected to contribute to the building the capacity of the midwifery schools to deliver the updated curriculum as per standards of ICM. The plan is to support a four-years' Bachelor course (direct entry) in the UNTL, ISC and ICS. With UNFPA APRO support, a review of the midwifery curriculum in Timor-Leste was done by Burnet Institute in in 2019. The review pointed out the gaps in the curriculum and recommended options to improve the curriculum to ICM standards. In 2020, under an agreement between UNFPA CO and Thai International Cooperation Agency (TICA), Khon Khaen University of Thailand was tasked to assess the gaps in the midwifery curriculum, currently used by the three Universities. The curricular development activities could not progress due to the pandemic. IN 2023 the Khon Khaen university assessed the three institutions and conducted a workshop for midwifery educators in 2024 supported by the Roya Thai Embassy in Dili. UNFPA has supported the procurement of models and other equipment to support the training in the three institutions. Midwifery educators from the schools also participated in a Midwifery Faculty Development Programme, organized by APRO and became part of the Alliance for Improved Midwifery Education in 2023. From the discussions with the tutors from the institutions, a major concern is whether the curriculum meets the ICM standards and whether all the three institutions are following a harmonised curriculum as was planned. One of the areas of concern is the inclusion of skill development in complication management during the clinical training. The trainees from UNTL are mostly trained in the HNGV while the other two schools send their students with a clinical instructor to CHCs or referral hospitals for skill development and familiarity with health services. The criteria for selection of training sites and clinical preceptors are not clear. Student-teacher ratio for clinical training is another concern. The Midwifery Association of Timor-Leste is a member of the ICM and is committed to meeting the ICM standards in Timor-Leste. The exact number of midwives in the country is not known, neither is it known how many are working. In 2019, the midwifery association had 720 registered midwives with 618 (86%) working in government facilities and rest working with national and international NGOs and private sector in 2019 as was reported in APRO maternal health review (latter cannot be considered actively practising midwifery). The impression gained during discussions with private midwifery schools is that about 40-50% trained are not employed, mainly due to lack of employment opportunities (could be related to creation of posts and funding the same.	Annual reports 21-23, APRO reviews, Burnet University Report, TICA collaboration mission report, APRO maternal health review. Interviews with Midwifery school teachers, Dean of faculty of medicine and health sciences, UNTL, programme officers of UNFPA

Currently there is no regulatory body for medical, nursing or midwifery or other allied health sciences. Under the leadership of the Dean of the Faculty of Medicine and Health Sciences have developed standard competencies for all categories of health professionals are being work out for all professions but not approved yet and the plan is to assess competencies every five years. UNFPA's initiative in strengthening midwifery education in the country through support to pre-service education is commendable and provides an opportunity to link with the pre-service education support for responding to GBV (latter also an ICM core competency) and the SSTC established with Khon Khean University through TICA is appreciated. However, much more needs to be done in aligning the curriculum and training to ICM standards and develop a unified midwifery curriculum for Timor-Leste. UNFPA should take the opportunity to incorporate the guidelines for intrapartum care (part of BEmONC modules), ANC and PNC guides, FP training materials and MISP. Suggest providing training to midwifery tutors in the subjects listed. There was no evidence of advocacy to Ministry of Higher Education to create regulatory bodies. Currently, there is no in-country expertise on ICM standards to guide the development of the midwifery course. It is also important to undertake a National Health Worker Account to get an estimate of number of midwives available, working status, etc.	
Assumptions 9: Comprehensive package of information on SRH, STIs and HIV and testing, services for prevention of transmission of STIs and HIV and referrals for treatment implemented among key populations in selected municipalities and among uniformed personnel. (Linked to output 1.3)	**Indicators:** i. Evidence of key populations in selected districts reached with information and preventive services including testing and referrals (disaggregated by type) ii. Evidence of HIV positive among key populations receiving treatment and care iii. Evidence of key populations reached with Pre-Exposure Prophylaxis (PrEP) for HIV prevention iv. Evidence of strengthening awareness about SRH and HIV among the Timor-Leste National Police (PNTL) and providing services v. Strategic plan for INCSIDA approved vi. Evidence of creating awareness among pregnant and young people
● ***Data collected*** [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	● **Sources of information** [*List the source(s) of evidence for each of the data collected*]
Finding 6- Progress of output indicators The indicators included under the output are related to HIV/STI prevention among key populations, young people and pregnant women and reducing stigma and discrimination (Annex A). The indicator related to the number of UNFPA supported CSOs or others working towards increasing comprehensive knowledge of HIV. Three organizations- Associação Komunidade Progresu (KP+), Estrela+ and National AIDS Institute (INSCIDA) were supported under the CP to build their capacities on prevention, testing and referrals for treatment as well as to reduce stigma. However, there are few gaps in the implementation of the activities as discussed under Finding 7 The indicator related to number of people who have been tested for HIV in the previous 12 months and received the test results, has progressed well among key populations in five priority municipalities for HIV prevention – approximately 34.8% of the target has been met (details discussed under Finding 7 The third indicator is related to percentage of people with discriminatory attitudes towards PLWHA, disaggregated by gender. The source of the baseline data is not known; however, the data from Demographic Health Survey of 2016 reported that 68%-85% of women and 50%-62% of men had discriminatory attitude towards PLWHA. The current status is not known as the Demographic Health Survey is due only in 2025.	CPAP, MEL report 2023, Annual reports 2021-23, Annex A

Finding 7 Improving access to comprehensive information SRH, HIV, STI among key populations (linked to indicators i-vi) The activities related to prevention of HIV among key populations was under funding from the Global Fund, as a sub-recipient of the grant to MOH. UNFPA's contributions on prevention of HIV among key populations, increased testing and treatment is greatly recognized by the Global Fund, National AIDS Control Programme Manager and KP+ and felt that reaching key populations and getting their trust and agreeing to use the basic package of services such as condoms, lubricants and health education and getting tested would not have been possible without UNFPA support. UNFPA working with National AIDS Control Programme, made several significant contributions. Through collaboration with KP+, managed to reach key populations consisting of men who have sex with men (MSM), transgenders, female and male sex workers in five priority municipalities (Dili, Baucau, Bobonaro, Covalima and Oecusse). Basic package of services - condoms, lubricants and education for prevention of HIV - as well as HIV testing were provided to key populations in the five priority municipalities. (See Charts 19,11,12,13 in Annex 1-C). The condoms, lubricants and HIV test were procured by UNFPA and distributed to MOH and KP+. In addition, UNFPA also provided female condoms to KP+ who distributed to female sex workers. Training in the use of the condom had been done prior to the distribution but requires more training. The facilities have not established a responsive supply systems management that monitors stock-outs and commodities, nearing expiry. The CSO also appreciated UNFPA for developing their management skills in writing proposals, reports, etc. UNFPA's Global Fund assisted ceased in 2023 and the collaborative activities with KP+ have been stopped. There is no programme officer responsible for the programme and no allocation of funds have been made in the current year. This is not a good practice especially as recent data on hotspot mapping (WHO 2023) showed an increase in hotspots and the need to boost preventive services. The CSO was concerned about the sudden withdrawal of technical support. The organization has received some funding from the Global Fund and has set up a testing facility for preliminary testing and confirmatory tests in the office of KP+. These facilities provide a enable testing without facing stigma or discrimination and helps KP+ to keep track of treatment for those tested positive. The CSO reported that majority tested positive are taking treatment (could not access the data). Treatment is available in Formosa CHC, in HNGV, referral hospitals and 9 CHCs and 2 private clinics. The staff in these facilities have been sensitized about stigma and discrimination. Those found positive for HIV, Syphilis or Hepatitis in the ANC clinics are referred to the voluntary counselling and testing focal in the municipality or in the referral hospitals or HNGV where the protocol for subsequent management and treatment is followed. The collaboration with MCH Directorate appears to be a weak link and impacts the coverage of elimination of mother to child transmission of the three antigens as per the National Strategic Plan for HIV, STIs and Viral Hepatitis 2022-26. Good collaboration between the two departments also could probably have avoided the stockout of the tests (Finding 2,4 as the National AIDS Control Programme reported adequate stocks of the test kits. The other programme staff at the CO with expertise in supply chain management and MCH were not involved in the activities under the output, leading to a missed opportunity to build capacity of the CSO in supply management and in MCH care. The KP+ would like to access contraceptives from MOH and UNFPA as currently they don't have any access to these items (as per family planning policy, only married can be given contraceptives).	Annual reports 21-23, reports to MOH and global fund, National AIDS Control programme, WHO. Report of hotspot mapping and size estimation of key population sin Timor-Leste, 2023, INSCIDA strategic plan, Interviews with National AIDS Control Programme Manager, KP+, UNFPA former programme officer, PNTL, INSCIDA staff, Annex C

In summary, despite no support from UNFPA, the capacity built during the project is being used to expand the basic package of services and testing and treatment and raise resources for the organization. This is a good example of lack of sustainability of support. UNFPA and WHO received funding from the Unified Budget Results and Accountability Framework (the first ever country envelope) to Timor-Leste from 2022-23 for pilot implementation of a Pre-Exposure Prophylaxis project. This project provided additional option for HIV testing (self-testing) to key populations without facing discrimination and stigma. The project is considered a success and is reported to have surpassed the target of reaching 200 key populations in Dili. WHO provided technical assistance and self-test kits while UNFPA contributed to developing training materials, capacity building and provision of condoms to key populations included in the project. UNFPA's good standing with the KP+ helped in the smooth running of the project. The project stopped in 2023 and currently no support is being provided. Collaboration with WHO and introduction of self-testing kits for HIV are important outcomes of the collaboration. The staff of PNTL were provided comprehensive information on HIV and about the importance of testing (PTNL personnel are considered high risk group). As mentioned under Finding 2, no special efforts to educate young people about HIV was made except in two municipalities through Plan International and MOH. No efforts to create awareness about HIV, Syphilis and Hep B was made as was discussed under Finding 4 and screening tests were not carried out during pregnancy due to shortage of reagents as discussed under Findings 2 and 4. During the pandemic, the key populations had difficulty in accessing preventive care (see Finding 9).	
Assumptions 10: Effective interventions for reducing stigma and discrimination towards PLWHA introduced through policy support and through evidence-based advocacy to selected gate keepers and vulnerable populations	**Indicators:** **i.** Evidence about stigma and discrimination towards PLWHIV gathered ii. Evidence- based advocacy among gate keepers such as community and religious leaders, health service providers and vulnerable populations, PNTL, young people to reduce stigma and discrimination towards PLWHIV (disaggregated by groups) iii. National Strategy and Action Plan to address human rights barriers to HIV AIDS and reducing stigma and discrimination towards PLWHIV
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Finding 8: Reducing stigma and discrimination against PLWHIV (Linked to indicators i-iii) The indicator related to this assumption was discussed under Finding 7. The HIV/AIDS programme of UNFPA focused on stigma and discrimination towards PLWHA as these are human rights violations and are major deterrents to accessing services, testing and treatment. Through Estrela+, a CSO that focuses on reducing stigma and discrimination towards PLWHA, UNFPA reached a number of gatekeepers in the society like community leaders and religious leaders, young people 15-29 years and health providers to provide information on HIV, its transmission and prevention and the impact of stigma and discrimination towards PLWHAs. During 21-23, 699 community leaders, 433 health personnel and 744 young people (15-29) were reached (from different municipalities) (Reports of Estrela) (see also Chart 14 in Annex 1-C).	Stigma Index report 1, Annual reports 21-23, INCSIDA strategic plan, PNTL reports, Reports Estrela, Interviews with Estrela +, INCSIDA, PNTL, Annex 5 as well as in the Matrix at the end (SRHR charts Annex1-C)

Additionally, 100 uniformed personnel were reached in 2021, In addition, 393 PLWHAs were contacted and provided education on prevention and care, rights and the need for regular medical check-up, good nutrition, etc. and 148 were referred to health facilities for treatment. UNFPA is not funding the CSO and expressed concerns about the funding stopping without much warning; however, they are carrying on with few activities mainly educating health providers about stigma and discrimination towards PLWHA with little funding from an international organization.

The same CSO had done a qualitative study on the impact of stigma and discrimination towards PLWHA and UNFPA had provided some support to bring out the First Stigma Index report. UNFPA had funded another study in 2022 on the same subject. The report is ready but due to lack of funding from UNFPA, the second Stigma Index report could not be published which is a pity as it would have been a good tool to fight towards stigma and discrimination and UNFPA could have used the information in its collaboration with journalists. There is no evidence of creating awareness about HIV prevention among pregnant women under this component (except in ANCs as discussed under Finding 4.

Under the CP, at the policy level, UNFPA supported the development of a National Strategy and Action Plan to address human rights barriers to HIV/AIDS and reducing stigma and discrimination towards PLWHA. A draft plan is ready but not published yet due to lack of funding. The document would have been useful for advocacy.

Another key activity regarding reducing stigma and discrimination was UNFPA's support to National AIDS Institute (INSCIDA), which is a high-powered institute, established by the Prime Minister's Office, with a mandate to prevent and combat HIV/AIDS through a multisectoral approach. In 2023 UNFPA provided technical assistance and funding to develop the National Strategic Plan (INSCIDA) 2023-27; however, the plan has not moved forward due to lack of technical assistance from UNFPA. This is a missed opportunity as the organization could have been used to promote many other SRHR issues linking them with HIV/AIDS prevention (example: GBV, FP).

Considering the uniformed personnel are at risk of HIV, STIs, UNFPA developed partnership in 2021 with National Police of Timor-Leste (PNTL) to raise awareness about HIV.AIDS, RH, maternal health, family planning and GBV and to reduce stigma and discrimination towards PLWHA. With technical assistance and funding from UNFPA, he PNTL clinic staff, MOH, KP+ and Estrela+ trained peer educators (20) in the topics listed above. The focus of their activities has been Dili, Bobonaro, Ermera, Liquica, Atauro and Oecusse (Oesilo Squad). Though the partnership was for nine years, currently PNTL is not receiving technical assistance or funds from UNFPA.

It is a serious concern that the effective contributions to key populations, efforts to reduce stigma and discrimination and the development of the policy could not be continued due to lack of funds and a programme officer to provide technical assistance to complete the task.

Assumptions 11: Comprehensive life-saving SRH services, prevention and management of GBV and HIV and STI prevention services were accessible during COVID-19 and floods, particularly underserved areas, ensuring coverage of the needs of vulnerable including PWD, enabling exercise of reproductive rights, free of violence.

Indicators:

i. Evidence of minimal disruption of FP and maternal health services including EmONC, access to GBV services and HIV and STI prevention during COVID in underserved areas
ii. Coverage of Mobile services for maternal health
iii. Evidence of on-line capacity building of midwives
iv. Availability of supplies and equipment in health facilities affected by floods
v. Capacity of midwives built in life saving interventions during pregnancy and childbirth
vi. Continued provision of services to key populations during COVID-19 pandemic and flood

Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]

Sources of information [*List the source(s) of evidence for each of the data collected*]

Finding 9: Response during COVID and floods (linked to indicators i-vi) During COVID -19 pandemic, there was significant disruption of MNCH services as evident from HMIS data analysis by WHO SEARO. The disruption of GBV services could not be captured as it was not included in HMIS at that point; however, UNFPA managed to get some information on women survivors of GBV, who sought help in health facilities, and it appears that the numbers had increased. The reasons quoted for the increase in GBV cases was frustrations due to loss of jobs and reduced income and staying at home for long periods of lockdown (as reported in the reports on responses to COVID-19 and floods. It was also reported by KP+, that though all efforts were made to continue the basic service package for prevention of HIV among key population, the key populations had difficulty in accessing preventive services due to restriction of movement (also affected supplies). UNFPA along with WHO helped the MOH to reactivate the dormant maternal, newborn and child health technical working group. The working group has representatives of UN agencies, NGOs and INGOs. The Director MNCH chaired the committee and coordinated with the incident management team of MOH. The team met regularly to monitor the disruption of RMNCAH services in the municipalities and other issues. Municipal staff were part of the discussions. UNFPA through the RH sub-cluster and gender cluster coordination, facilitated discussions on continuation of SRH services and on prevention and response to GBV. Within UNCT, UNFPA reactivated the RH sub-cluster under the Health cluster led by WHO and leads the sub-cluster. UNFPA's notable contributions during the pandemic include developing guidelines for care of pregnant mothers, intrapartum care and postnatal care, for COVID positive pregnant mothers, on-line capacity building and sensitization on GBV prevention and response. The guidelines on maternal care were used in all the COVID-19 isolation centres. Out of the three COVID isolation centres, UNFPA supported the establishment of maternity isolation centre in Vera Cruz CHC. UNFPA has also been monitoring the EmONC activities through WhatsApp group (see under Finding 4) and ensuring life-saving services for mothers and newborns were not disrupted. IEC materials produced by UNFPA APRO were adapted, printed and distributed during COVID-19, in collaboration with the Health Promotion Department of MOH. A sample pamphlet is exhibited in Annex 1-C. When floods and landslides resulting from heavy rainfall happened in 2021 in the middle of the COVID pandemic, the population displaced from the flooded areas were in camps that were overcrowded, making the group vulnerable to COVID transmission and other communicable diseases. Despite all precautions taken to prevent transmission of COVID and other communicable diseases, the handwashing and sanitary facilities were inadequate, thus increasing the risk of COVD transmission. The exact data on how many got infected is not available. UNFPA procured and distributed maternity packages to pregnant woman and all other women as well as hygiene kits for women and girls. 345 maternity packages were distributed, out of which 100 were distributed to beneficiaries in Dili. In 2021, 160 pregnant mothers and 85 postnatal women from 14 health facilities in the flood affected municipalities (Aileu, Ainaro, Manufahi, Oecusse, Manatuto, Viqueque, Liquica, Covalima, Bobonaro and Ermera) were provided maternity packages with the help of one of UNFPA's implementing partners -ALOLa and in collaboration with municipal health officers. ALOLa also assisted UNFPA with monitoring of the camps of internally displaced people. In addition, UNFPA procured preventive equipment and supplies for volunteers who were providing services in the camps with displaced people. The data for pregnant and postnatal mothers was obtained collaboratively through local social protection and municipal MCH officers - an interesting collaboration during the crisis. MISP orientation was done for 22 participants that included decision makers, programme managers and staff with support from UNFPA APRO and UNFPA staff who are already familiar with MISP. The material for training programme managers in MISP (adapted for the country context) as mentioned under Finding 2.	Reports to donors who provided emergency funds during COVID and floods (The information on activities during the pandemic and floods are from this report and the report on interventions during floods in 2023 that affected 12 municipalities. (MAIN REFERNCE FOR RESPONSE to COVID and FLOODS), WHO report on monitoring continuation of RMNCAH services, interviews with programme staff

Maternity mobile clinics were established with the assistance for three new midwifery graduates who visited the camps and provided information on SRH, HIV, Family planning, GBV and Covid-19. UNFPA provided support for transport and supplies and certificate of commendation for their services. During these visits, the pregnant mothers were identified and referred to the nearest health facilities. 378 women of reproductive age were provided information on family planning (included 27 pregnant and 73 postnatal women) and 11 continuers and 17 new acceptors were provided services. In 2023, when severe floods affected 12 of the municipalities, UNFPA undertook needs assessment in three of the affected areas and based on the findings established SRH and GBV services, thus continuity of services was ensured. The above needs assessment found lack of preparedness plans in municipalities and complete disruption of SRH services especially for pregnant women. The health authorities lacked knowledge and skills to manage SRH services during emergencies. UNFPA had set up mobile services and fixed services in tents and provided SRH and GBV services. The tents are equipped with equipment, medicines, supplies and human resources. Efforts were made to have such services in remote and difficult to access areas. The trained health service providers in managing GBV cases, were used to provide services for survivors of GBV. The GBV services used the LIVES approach (explained under Finding 2) to provide first line of care. In addition, messages on SRH care and prevention of GBV were developed and distributed to women and to communities. Referral pathways for transferring emergencies were mapped out. Survivors of GBV were referred to safe spaces in the CHCs close by and use the existing partnership with one of the NGOs with forensic expertise in case of rape. Overall, 855 women of reproductive age were provided with maternity and hygiene kits as well as services. One of the major gaps is services for STIs and HIV and for adolescents as part of MISP guidelines.	
Assumption 6 to 11 SRHR, 12, 13 AYSRH (they are embedded under SRHR and there is no ASRH component under CP4) Assumption 6 and 12 are similar. **Assumptions 12:** Rights-based, integrated, quality SRH services are promoted at national level and in municipalities with special focus on vulnerable groups. (This is addressed under SRHR) Effectiveness Criteria - Related to Output 2.1 (AY) The national capacity to design and implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality is strengthened.	
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]

Assumptions 13: Access to services is improved for adolescents, especially girls from vulnerable and remote areas, including those with disabilities and from priority municipalities, through policies and programs	**Indicators:** i. The number and percentage of adolescents (particularly girls and those with disabilities) participating in targeted outreach programs (e.g., Boys and Girls Circle). ii. -Quality, adolescent and youth- friendly SRH services were available and accessible in health facilities as per the Essential Service Package (ESP) in the past iii. -The percentage of adolescents reporting increased knowledge of sexual and reproductive health rights and services after participation in CSE programs iv. -Qualitative feedback from focus groups or interviews with adolescents regarding their and challenges accessing services v. -The number and types of barriers reported by adolescents in accessing health services (e.g., transportation, stigma, disability access) vi. -The number of service providers trained on youth-friendly services and inclusive practices for working with adolescents with disabilities vii. -The number of relevant policies or strategies (e.g., National Youth Policy, Inclusive Education Policy) implemented at the local level that specifically address access for vulnerable adolescents viii. -Changes in health outcomes for adolescents (e.g., rates of STIs, contraceptive use, unintended pregnancies) as a measure of improved access to services

Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Document Review: The evaluation team reviewed relevant policy documents, including the National Youth Policy, the Strategic Plan for the Ministry of Education, and UNFPA's CP4 documentation. These documents highlight the government's commitment to improving access to services for vulnerable populations, including adolescents and girls, with specific attention to those in remote areas and those with disabilities. Analysis of Program Implementation: The team assessed UNFPA's CP4 interventions aimed at improving access to sexual and reproductive health (SRH) education. No services available to unmarried AY., Comprehensive Sexuality Education (CSE), and youth-friendly health services: Evidence was gathered on how programs have been tailored to meet the needs of girls and adolescents in remote areas, with a focus on accessibility for individuals with disabilities. Interviews with Stakeholders: Key informant interviews were conducted with representatives from relevant ministries (MoYSAC, MoEYS, and MoH), local NGOs, and community leaders. Stakeholders shared insights on how policies and programs have been implemented to enhance access for vulnerable adolescents, specifically highlighting efforts to include girls and those with disabilities in remote municipalities. 4. Focus Group Discussions: Focus group discussions were held with adolescents and youth beneficiaries in priority municipalities. Participants reported improvements in access to services due to targeted outreach initiatives, mobile health clinics, and community-based programs. However, they also highlighted ongoing challenges, particularly in remote areas, such as limited infrastructure and transportation issues.	UNFPA Timor-Leste Country Programme (CP4) Reports: Detailed the progress of SRH interventions, access to services for adolescents, and the inclusion of marginalized groups. UNFPA Global Evaluation Report on GBV in Emergencies: Documented the success of community-based programs and interventions in addressing gender-based violence (GBV) and offering support to women and girls.

Assessment of Targeted Programs: The evaluation examined specific initiatives, such as the Boys and Girls Circle (BGC) and other outreach programs, which aimed to provide SRH information and services to marginalized groups. These initiatives were noted to have successfully engaged adolescents, particularly girls, in discussions about health and empowerment, increasing their access to resources. Verification Outcome: The assumption is partially validated. While there have been improvements in access to services for adolescents, especially girls from vulnerable and remote areas, challenges remain, particularly regarding infrastructure and resource availability for those with disabilities. Continued efforts are necessary to fully address the barriers that persist in ensuring equitable access to services for all adolescents in these areas. Key Finding 3: Improved Access to Sexual and Reproductive Health (SRH) Services UNFPA's CP4 interventions at both national and municipal levels have significantly improved access to SRH services and information for adolescents and young people, particularly girls from vulnerable and remote areas. These enhancements are essential for their health and empowerment. The program has implemented inclusive policies and programs aimed at increasing SRH access for marginalized communities. Challenges: Geographical Barriers: Rural areas face significant challenges due to geographical isolation and limited infrastructure, which hinder service delivery. Resource Limitations: Despite increased knowledge about SRH, young people in these areas often struggle with access to resources such as modern contraceptives. During focus group discussions in Ermera, participants highlighted the ongoing difficulties faced by students, especially those from rural backgrounds. Many reported that a lack of reliable transportation severely limits their ability to access educational resources and health services. This isolation not only affects their attendance but also restricts participation in Comprehensive Sexuality Education (CSE) benefits, leading to a disconnect from community centres and health clinics. Outreach Programs for Vulnerable Young People: UNFPA's outreach programs target young people at risk of HIV, providing essential SRH information, preventive measures, and health services. Initiatives such as the Boys and Girls Circle and Healthy Relationships modules serve as inclusive platforms for discussing health issues, including HIV and STIs. Limited Reach: Marginalized groups, particularly those living in extreme poverty, with disabilities, or in remote areas, have not been sufficiently reached. Geographic isolation and insufficient resources create barriers to providing essential services. Poverty as a Barrier: Extreme poverty significantly hampers access to healthcare, education, and essential services, particularly in rural regions.	Government Ministries and NGO Partnerships: Ministry of Health (MoH), Ministry of Education, Youth, and Sports (MoEYS), Ministry of Youth and Sports (MoYSAC): Provided data and insights on collaborative efforts to improve SRH services and youth-friendly health care. NGO Partners like FOKUPERS and ALFeLa: Offered evidence on the implementation of community-based awareness campaigns, legal aid, and psychosocial support for GBV survivors. Secondary Literature: Studies and reports on Timor-Leste's infrastructural deficits, geographic isolation, and poverty-related barriers to healthcare and education. External assessments of development programs aimed at increasing inclusivity and improving access for marginalized populations, such as persons with disabilities.

Despite UNFPA's efforts, evaluations indicated that programs aimed at improving SRH access often fall short of reaching the most vulnerable populations. The situation in Ermera illustrates broader systemic issues across rural Timor-Leste, emphasizing the need for integrated solutions that address both educational content and structural barriers. Finding: Technical Assistance and Support for Ministries: UNFPA has provided technical assistance to various ministries, including the Ministry of Youth and Sports, the Ministry of Education, Youth, and Sports, and the Ministry of Health, to support advocacy programs for adolescents. This support includes the provision of SRH information, comprehensive sexuality education, and youth-friendly services. Successes: Health facilities have been equipped, and providers trained to offer welcoming care, resulting in increased use of public health services. Challenges: Despite progress, rural adolescents and youth continue to struggle with access to services. Data on vulnerable groups, especially girls and individuals with disabilities, remains limited. Finding: Addressing Gender-Based Violence (GBV): UNFPA's CSE program addresses issues such as child marriage, school dropouts among girls, and GBV at the community level. While urban areas have seen progress, rural regions still grapple with high levels of GBV due to entrenched cultural norms. Interventions: Comprehensive interventions, including awareness-raising and support services, have improved safety for women and girls. Community-based interventions that engage men and boys as allies have been effective in reducing GBV incidents. UNFPA collaborates with government ministries and NGOs to strengthen legal frameworks, improve services for GBV survivors, and run public awareness campaigns. The creation of women's centres and safe spaces has been instrumental in improving safety and empowering women, contributing to their long-term security. Conclusion The field visit revealed some progress made through UNFPA's CP4 interventions, particularly in addressing GBV. However, persistent challenges, especially in rural areas, highlight the need for continued efforts to ensure that all adolescents and young people, especially those from marginalized communities, can access essential services and fully benefit from educational programs. Enhanced visibility and advocacy for these vulnerable groups are critical for improving resource mobilization and influencing policy.	Program Monitoring and Site Visits: Monitoring data from CP4 project sites and specific interventions in priority municipalities targeting vulnerable adolescents, especially girls from remote areas. Observations from field visits to rural areas like Ermera, which revealed infrastructure limitations impacting program delivery.

Evaluation Question 4: **To what extent has UNFPA ensured that the needs of young people (including adolescents) in all their diversities (age, location, gender, sexual orientation, ability, employment, marital status etc.) have been addressed in the planning and implementation of all UNFPA-supported interventions?**	
Evaluation Criteria: Effectiveness	
Assumptions 14: Needs of the youth (including adolescents) in all their diversities (age, location, gender, sexual orientation, ability, employment, marital status etc.) are taken into consideration in CP4 design, planning and implementation and results reporting. (Covered under the Relevance criteria – See Assumption 3) Discussed under Relevance (implementation is included)	**Indicators:** i. Evidence that CP 4 is aligned with the National Youth Policy of Timor-Leste (NYPTL 2016), relevant Government strategies and policies regarding adolescents and youth. ii. Evidence that CP 4 is aligned with the ICPD as well as other global commitments on adolescents and youth. iii. Youth programmes reflect diversified population iv. The number and percentage of adolescents (particularly girls and those with disabilities) participating in targeted outreach programs (e.g., Boys and Girls Circle). v. Quality, adolescent and youth- friendly SRH services were available and accessible in health facilities as per the Essential Service Package (ESP) in the past vi. The percentage of adolescents reporting increased knowledge of sexual and reproductive health rights and services after participation in CSE programs vii. Qualitative feedback from focus groups or interviews with adolescents regarding their and challenges accessing services viii. The number and types of barriers reported by adolescents in accessing health services (e.g., transportation, stigma, disability access) ix. The number of service providers trained on youth-friendly services and inclusive practices for working with adolescents with disabilities x. The number of relevant policies or strategies (e.g., National Youth Policy, Inclusive Education Policy) implemented at the local level that specifically address access for vulnerable adolescents
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]

Assumption 13: Access to services is improved for adolescents, especially girls from vulnerable and remote areas, including those with disabilities and from priority municipalities, through policies and programs. Assumption Verification: 1.Document Review: The evaluation team reviewed relevant policy documents, including the National Youth Policy, the Strategic Plan for the Ministry of Education, and UNFPA's CP4 documentation. These documents highlight the government's commitment to improving access to services for vulnerable populations, including adolescents and girls, with specific attention to those in remote areas and those with disabilities. 2.Analysis of Program Implementation: The team assessed UNFPA's CP4 interventions aimed at improving access to sexual and reproductive health (SRH) services, Comprehensive Sexuality Education (CSE), and youth-friendly health services. Evidence was gathered on how programs have been tailored to meet the needs of girls and adolescents in remote areas, with a focus on accessibility for individuals with disabilities. 3.Interviews with Stakeholders: Key informant interviews were conducted with representatives from relevant ministries (MoYSAC, MoEYS, and MoH), local NGOs, and community leaders. Stakeholders shared insights on how policies and programs have been implemented to enhance access for vulnerable adolescents, specifically highlighting efforts to include girls and those with disabilities in remote municipalities. 4. Focus Group Discussions: Focus group discussions were held with adolescents and youth beneficiaries in priority municipalities. Participants reported improvements in access to services due to targeted outreach initiatives, mobile health clinics, and community-based programs. However, they also highlighted ongoing challenges, particularly in remote areas, such as limited infrastructure and transportation issues. 5.Assessment of Targeted Programs: The evaluation examined specific initiatives, such as the Boys and Girls Circle (BGC) and other outreach programs, which aimed to provide SRH information and services to marginalized groups. These initiatives were noted to have successfully engaged adolescents, particularly girls, in discussions about health and empowerment, increasing their access to resources. Verification Outcome: The assumption is partially validated. While there have been improvements in access to services for adolescents, especially girls from vulnerable and remote areas, challenges remain, particularly regarding infrastructure and resource availability for those with disabilities. Continued efforts are necessary to fully address the barriers that persist in ensuring equitable access to services for all adolescents in these areas.	Secondary Data - Document review NYPTL 2016-Related National adolescent and youth Policy/Strategy documents -ICPD, SDG Report-UNFPA Staff Relevant policies or strategies (e.g., National Youth Policy, Inclusive Education Policy) implemented at the local level that specifically address access for vulnerable adolescents Primary Data: KI interview, Group discussions, FGD (students) Adolescents and Youth, School students, out of school A&Y UNFA staff Relevant ministry officials, Teachers

Field Visit Notes Key Finding 3: Improved Access to Sexual and Reproductive Health (SRH) Services UNFPA's CP4 interventions at both national and municipal levels have significantly improved access to SRH services and information for adolescents and young people, particularly girls from vulnerable and remote areas. These enhancements are essential for their health and empowerment. The program has implemented inclusive policies and programs aimed at increasing SRH access for marginalized communities. Challenges: Geographical Barriers: Rural areas face significant challenges due to geographical isolation and limited infrastructure, which hinder service delivery. Resource Limitations: Despite increased knowledge about SRH, young people in these areas often struggle with access to resources such as modern contraceptives. During focus group discussions in Ermera, participants highlighted the ongoing difficulties faced by students, especially those from rural backgrounds. Many reported that a lack of reliable transportation severely limits their ability to access educational resources and health services. This isolation not only affects their attendance but also restricts participation in Comprehensive Sexuality Education (CSE) benefits, leading to a disconnect from community centers and health clinics. Key Finding 4: Outreach Programs for Vulnerable Young People UNFPA's outreach programs target young people at risk of HIV, providing essential SRH information, preventive measures, and health services. Initiatives such as the Boys and Girls Circle and Healthy Relationships modules serve as inclusive platforms for discussing health issues, including HIV and STIs. Challenges: Limited Reach: Marginalized groups, particularly those living in extreme poverty, with disabilities, or in remote areas, have not been sufficiently reached. Geographic isolation and insufficient resources create barriers to providing essential services.	Education, Youth, and Sports (MoEYS), Ministry of Youth and Sports (MoYSAC): Provided data and insights on collaborative efforts to improve SRH services and youth-friendly health care. NGO Partners like FOKUPERS and ALFeLa: Offered evidence on the implementation of community-based awareness campaigns, legal aid, and psychosocial support for GBV survivors. 4. Secondary Literature: Studies and reports on Timor-Leste's infrastructural deficits, geographic isolation, and poverty-related barriers to healthcare and education. External assessments of development programs aimed at increasing inclusivity and improving access for marginalized populations, such as persons with disabilities. 5.Program Monitoring and Site Visits: Monitoring data from CP4 project sites and specific interventions in priority municipalities targeting vulnerable adolescents, especially girls from remote areas.

Poverty as a Barrier: Extreme poverty significantly hampers access to healthcare, education, and essential services, particularly in rural regions. Despite UNFPA's efforts, evaluations indicated that programs aimed at improving SRH access often fall short of reaching the most vulnerable populations. The situation in Ermera illustrates broader systemic issues across rural Timor-Leste, emphasizing the need for integrated solutions that address both educational content and structural barriers. Key Finding 5: UNFPA has provided technical assistance to various ministries, including the Ministry of Youth and Sports, the Ministry of Education, Youth, and Sports, and the Ministry of Health, to support advocacy programs for adolescents. This support includes the provision of SRH information, comprehensive sexuality education, and youth-friendly services. Successes: Health facilities have been equipped, and providers trained to offer welcoming care, resulting in increased use of public health services. Challenges: Despite progress, rural adolescents and youth continue to struggle with access to services. Data on vulnerable groups, especially girls and individuals with disabilities, remains limited. Key Finding 6: Addressing Gender-Based Violence (GBV): UNFPA's CSE program addresses issues such as child marriage, school dropouts among girls, and GBV at the community level. While urban areas have seen progress, rural regions still grapple with high levels of GBV due to entrenched cultural norms. Interventions: Comprehensive interventions, including awareness-raising and support services, have improved safety for women and girls. Community-based interventions that engage men and boys as allies have been effective in reducing GBV incidents. UNFPA collaborates with government ministries and NGOs to strengthen legal frameworks, improve services for GBV survivors, and run public awareness campaigns. The creation of women's centers and safe spaces has been instrumental in improving safety and empowering women, contributing to their long-term security. Conclusion: The field visit revealed significant progress made through UNFPA's CP4 interventions, particularly in enhancing access to SRH services and addressing GBV. However, persistent challenges, especially in rural areas, highlight the need for continued efforts to ensure that all adolescents and young people, especially those from marginalized communities, can access essential services and fully benefit from educational programs. Enhanced visibility and advocacy for these vulnerable groups are critical for improving resource mobilization and influencing policy.	

Assumptions 15: UNFPA's technical assistance and programmatic inputs have contributed to building capability /skills of out- of- school adolescents and youth (including vulnerable and PWD) to make informed choices about SRHR and well-being including awareness about GBV	**Indicators:** i. Training Participation Rates: Number of out-of-school adolescents and youth (including PWD) participating in UNFPA training programs focused on SRHR and GBV awareness. ii. Knowledge Assessment: Pre- and post-training assessments measuring changes in knowledge regarding SRHR and GBV among participants. iii. Skills Development: Documented evidence of skills acquired by participants related to SRHR decision-making and awareness of GBV issues. iv. Behavioural Changes: Reports or surveys indicating changes in behaviours related to SRHR and an increase in reporting or addressing GBV incidents among the youth population. v. Community Engagement: Evidence of out-of-school youth leading awareness campaigns or peer education initiatives in their communities regarding SRHR and GBV.

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
UNFPA's Comprehensive Sexuality Education (CSE) program has made some progress in improving youth knowledge about sexual and reproductive health (SRH) and gender-based violence (GBV) through tools like the Healthy Relationships and Boys and Girls Circle manuals. Unlike during CP3, CP4 could not progress much on CSE. The programme was delayed partly during the pandemic due to schools closing and limited community outreach programmes. TOT took place in selected places and some improvement in knowledge was reported based on pre-post tests conducted. According to the 2022 UNFPA Consultancy Report on Training of Trainers (ToT) for CSE in RAEOA, participants' knowledge increased from 64% to 90% post-training, while in Baucau, knowledge improved from 74% to 97%. Additionally, pre- and post-tests revealed a 30% enhancement in youth representatives' knowledge, attitudes, and facilitation skills related to SRH and GBV. Despite delays in integrating CSE into the formal curriculum due to political obstacles, the program effectively reached vulnerable girls in rural areas and out-of-school youth in seven municipalities. UNFPA's community-based approach and partnerships, especially with local stakeholders, have expanded CSE outreach. However, challenges such as facilitator turnover and local government restructuring persisted. The Spotlight Initiative has helped promote gender-equitable education, with 16 schools incorporating CSE into their programs UNFPA's CP4 program extended CSE to out-of-school youth through community programs, leading to significant improvements in SRH knowledge and attitudes. For instance, in Bobonaro, participants' scores increased from 59% to 81%, and in Ermera, scores rose from 66% to 88%. However, the evaluation team observed challenges, such as age misalignment in training groups and the centralization of training, which has limited outreach to vulnerable girls. Despite cultural resistance and political instability affecting CSE's full integration into the formal curriculum, the program has empowered youth with essential skills. This is supported by trained teachers and peer educators who deliver culturally appropriate education	UNFPA Timor-Leste Annual Report 2023. Finalized in January 2024

Youth Center Groups have been effective in promoting CSE for vulnerable girls at the community level. Thanks to partnerships with MoYSAC, the CSE for Out-of-School Youth program is being rolled out in targeted municipalities and expanded to include rural areas. In 2022, UNFPA trained 40 youth representatives from 11 municipalities, and by 2023, 2,367 women and girls had improved their knowledge of healthy relationships, GBV, and SRH through training in seven municipalities, including Dili, Baucau, and Oecusse-Ambeno. However, during consultations, youth centre representatives from Viqueque, Ermera, and Bobonaro raised concerns about participation and inclusiveness. Trainers of Trainers (ToT) expressed dissatisfaction with the selection criteria set by MoYSAC, feeling excluded from the decision-making process and unclear about the criteria used to select ToT participants. Additionally, trainers reported frustration over inadequate remuneration for their work, which further impacted their motivation	
Assumptions 16: UNFPA support to build institutional capacity of schools has contributed to enhancing the capability of teachers to advocate in- school adolescents to make informed choices about SRHR and well-being align with the national youth policy	**Indicators:** i. CSE material (Boys and girls circle) developed and approved ii. Approval of MOE to initiate CSE in selected municipalities through training of teachers iii. Capacity of teachers built iv. Advocacy to include age-standardised CSE In curriculum v. Evidence of enabling environment for A&Y to exercise their reproductive rights (RR), including for vulnerable (includes PWD through evidence-based advocacy and policy dialogue vi. Number of schools implementing CSE in curriculum) vii. Knowledge on young people on healthy relationships (pre-post survey on knowledge gain) viii. Ability of teachers (capacity)
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
1. Capacity Building for Teachers: UNFPA has provided technical assistance and training to strengthen the institutional capacity of schools. Teachers have received training on Comprehensive Sexuality Education (CSE) and SRHR, enabling them to deliver content that supports adolescents in making informed choices. In municipalities like Baucau and RAEOA, the Training of Trainers (ToT) program demonstrated significant knowledge gains among youth representatives, as well as teachers, with post-training improvements of up to 30% in SRH and GBV knowledge and facilitation skills. Teachers in these schools have been trained not only on the content but also on methods of advocacy and guidance that allow them to engage with students in a culturally appropriate manner. 2. Alignment with National Youth Policy: The National Youth Policy of Timor-Leste emphasizes the importance of education, health, and well-being of young people. UNFPA's school-based programs are aligned with this policy by promoting SRHR education within formal school settings. The inclusion of gender-based violence (GBV) awareness and healthy relationships education within the curriculum further aligns these efforts with national priorities on youth empowerment and well-being.	Interviews and Focus Group Discussions (FGDs): UNFPA Reports and Evaluations: UNFPA Timor-Leste Country Programme (CP4) Reports: Detailed the progress of SRH interventions, access to services for adolescents, and the inclusion of marginalized groups. UNFPA Global Evaluation Report on GBV in Emergencies: Documented the success of community-based programs and interventions in addressing gender-based violence (GBV) and offering support to women and girls.

3. Teacher Advocacy and Capacity: Teachers trained through UNFPA programs have been able to advocate for improved health behaviours among adolescents. Teachers now play a more active role in guiding students on making informed decisions about SRH and well-being, which includes understanding contraceptive choices, STI prevention, and GBV. Challenges: Despite these efforts, there are ongoing challenges, including teacher turnover, political instability, and cultural resistance to SRHR topics. These barriers have affected the sustainability of teacher advocacy efforts and the broader integration of SRHR education into the formal school curriculum in certain areas. Finding: Strengthening Institutional Capacity for Comprehensive Sexuality Education (CSE) UNFPA's Country Programme 4 (CP4) has significantly enhanced the institutional capacity of key government ministries, including the Ministry of Education (MoE), the Ministry of Health, and the Ministry of Youth, Sport, Art, and Culture (MoYSAC). This strengthening is pivotal in promoting and institutionalizing Comprehensive Sexuality Education (CSE) in Timor-Leste. Key Initiatives: Technical Assistance: UNFPA has provided ongoing technical support to the MoEYS, facilitating the integration of CSE into the national education framework. This includes the introduction of CSE as an extracurricular program, making it accessible from primary to secondary levels. Curriculum Development and Training: Efforts have focused on developing a comprehensive CSE curriculum and training educators to deliver it effectively. Training emphasizes gender equality, human rights, and reproductive health. According to the UNFPA Timor-Leste 2023 Annual Report, 40 teachers have been trained as part of the CSE program in schools. Partnerships with Local Organizations: UNFPA collaborates with local NGOs like FOKUPERS and the Alola Foundation to extend CSE's reach beyond formal education. These partnerships have facilitated the creation of culturally appropriate CSE materials and have provided training for educators and community leaders. In 2023, over 25 trainers were trained across 47 schools in seven municipalities, reaching 3,862 adolescents, including 2,329 girls. Community and Parental Engagement: Engaging parents and community leaders has been a crucial aspect of the institutional capacity-building process. This involvement fosters broader acceptance and support for CSE programs, which is vital for their sustainability. By addressing cultural barriers, the programs promote an environment where young people can access accurate and comprehensive SRH information. Challenges Observed: Despite the progress made in institutional capacity building for CSE in Timor-Leste, the CPE team noted several challenges: Participant Enthusiasm: There has been limited enthusiasm from some participants, which can hinder the effectiveness of the training and advocacy efforts.	Government Ministries and NGO Partnerships: Ministry of Health (MoH), Ministry of Education, Youth, and Sports (MoEYS), Ministry of Youth and Sports (MoYSAC): Provided data and insights on collaborative efforts to improve SRH services and youth-friendly health care. NGO Partners like FOKUPERS and ALFeLa: Offered evidence on the implementation of community-based awareness campaigns, legal aid, and psychosocial support for GBV survivors. **Secondary Literature**: Studies and reports on Timor-Leste's infrastructural deficits, geographic isolation, and poverty-related barriers to healthcare and education. External assessments of development programs aimed at increasing inclusivity and improving access for marginalized populations, such as persons with disabilities. Program Monitoring and Site Visits: Monitoring data from CP4 project sites and specific interventions in priority municipalities targeting vulnerable adolescents, especially girls from remote areas. Observations from field visits to rural areas like Ermera, which revealed infrastructure limitations impacting program delivery

Resistance from Teachers: Some teachers have shown resistance to fully embracing and implementing the CSE curriculum, impacting its delivery in schools. Facilitator Turnover: High turnover rates among facilitators can disrupt continuity in program implementation, affecting the overall impact of CSE initiatives. Cultural Norms and GBV: While there has been progress in addressing gender-based violence (GBV) through community engagement, entrenched cultural norms and resistance continue to pose significant challenges. However, CPE team observed that challenges such as limited enthusiasm from participants, teacher resistance, and facilitator turnover have affected program effectiveness and despite progress in reducing gender-based violence (GBV) through community engagement, entrenched cultural norms and resistance remain significant obstacles. Continued broad community involvement is essential for lasting impact	
Assumptions 17: Capacity of IPs enhanced to implement NAP GBV through multi- disciplinary approach	**Indicators:** i. Documented reports on improvements on IPs knowledge gain on subjects covered (pre-post survey results) ii. Spotlight, T4G, Zonta and other initiatives achieved the agreed outputs in the non-health sectors (comprehensive case management) iii. Evidence of the use of supporting data by the Government and relevant institutions to monitor NAP GBV iv. Number of annual supervision missions by the Govt on the implementation of NAP GBV
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Combined Findings from the UNFPA three Annual Reports from 2021-2023 [1] **UNFPA's Support to Key Partners** **Capacity Building for NAP-GBV Implementation** ○ UNFPA provided training to **healthcare providers** (including health service managers) across eight municipalities to respond to GBV. This training focused on using an in-service training package developed with La Trobe University ○ **Training Content** include: ● Survivor-centered care for GBV survivors, case management, and referral pathways. ● Use of forensic examination techniques for survivors of sexual violence. ● SOPs for safe space management **Contribution to NAP-GBV**: Strengthened multi-sectoral coordination and referral systems and improved infrastructure readiness through advocacy by trained health managers.	**Secondary Data - Desk review** NAP GBV Progress Reports Supervision Mission Reports Communication Materials Service Center Data, Radio Campaigns M&E Data

[1] UNFPA Timor-Leste. 2021-2023 Annual Report - Timor Leste. Finalized Official Reports.

Establishment of Safe Spaces and Health Care Providers trained Safe Spaces established (2021-2023) providing essential health and psychosocial support. ● **2021**: Safe spaces were designed and approved for three municipalities (under Spotlight) but construction delayed due to COVID-19 ● **2022**: Safe spaces in three municipalities (Viqueque, Ermera, Bobonaro) were established under Spotlight ● **2023**: Additional safe spaces were operationalized in Gleno (Ermera), Atabae, and Dili (Comoro and Vera Cruz) under the Spotlight, T4E, and Zonta initiatives **Total Safe Spaces (2021-2023)**: **6 safe spaces** established. **Locations**: Viqueque, Ermera, Bobonaro, Gleno (Ermera), Atabae, Comoro (Dili), Vera Cruz (Dili). Total Healthcare Providers Trained (2021-2023). **759 healthcare providers** were trained in GBV-related services. ● **2021**: 400 healthcare providers were sensitized on GBV, COVID-19, and referral mechanisms as part of the Spotlight Initiative across four municipalities ● **2022**: 130 healthcare providers were trained to provide survivor-centred services to GBV survivors using an in-service training package ● **2023**: 229 healthcare providers (including health service managers) were trained across eight municipalities to respond to GBV using the same in-service training package Technical assistance to the Ministry of Health (MoH) helped establish **safe spaces** in municipalities with high GBV prevalence, equipping them with medical and non-medical resources and job aids to support healthcare providers **Evidence of Knowledge Increase**: Follow-up supervision showed improved knowledge and practices among trained healthcare providers, such as enhanced management of forensic examinations for survivors of sexual violence **Key Partners:** ● **Number of Partners (CSOs and Government) Capacitated to Implement NAP GBV:** ● **CSOs**: FOKUPERS, PRADET, and Alola Foundation were key partners in providing psychosocial recovery, referral systems, and shelters ● **Government**: The Ministry of Health (MoH) was a primary partner, with capacity-building efforts for health managers and frontline workers ● Partners included government ministries (e.g., MoH), health service providers, and CSOs like FOKUPERS and PRADET, which were engaged in referral systems for GBV survivors ● Projects under the Spotlight Initiative, Together for Equality (KOICA), and Zonta reached multiple municipalities to support GBV-related services ● **Estimate**: At least **5 partners** (3 CSOs and MoH with subnational health units) were engaged across the years.	**Primary Data** KII interviews, FGD Online interviews UNFPA and other RUNOs Gender/related treks force members Results Groups, GW Group, CWGs Discussion with non-UN donors working on similar issues UNICEF gender focal person UN Women Gender focal person Gender Task Force MISP in RH Task Force

Indicators

1. **Documented Improvements in IPs Knowledge (Indicator i)**
    - Post-training supervision revealed that healthcare providers were applying their skills effectively in safe spaces. However, systemic challenges like reporting delays and underfunding impeded consistent evaluation of knowledge improvements (2023 Annual Report - UNFPA).
2. **Outputs from Spotlight, Together for Equality, and Zonta Initiatives (Indicator ii)**
    - **Spotlight Initiative**: Focused on three municipalities, training health providers, and integrating GBV services into the health system (2022 Annual report - UNFPA).
    - **Together for Equality**: Operated in four municipalities, targeting enhanced infrastructure and readiness for GBV responses (2023 Annual Report - UNFPA).
    - **Zonta Initiative**: Contributed to developing SOPs for safe spaces, ensuring survivor-centered services and forensic capabilities (2023 Annual Report - UNFPA).
3. **Use of Supporting Data for Monitoring NAP-GBV (Indicator iii)**
    - Tools like the **Health Management Information System (HMIS)** were updated with GBV-specific indicators to monitor service provision and referrals (2023 Annual Report - UNFPA).
    - A quality assessment tool developed with La Trobe University provided baseline data on GBV services, guiding policy development and monitoring (2022 Annual report - UNFPA)
    - Integration of GBV into the Health Information System (HIS):
        - **2021**: Initial steps were taken to develop SOPs for safe spaces and emphasize the importance of data collection for service provision, but specific integration into HIS was not explicitly mentioned (2021 Annual Report - UNFPA).
        - **2022**: UNFPA and partners introduced GBV-specific indicators in the **Health Management Information System (HMIS)**, emphasizing data collection and utilization for monitoring and improving GBV services (2022 Annual report – UNFPA).
        - **2023**: Significant progress was reported in integrating GBV data into HMIS. The following activities were emphasized:
            - Training for health managers, gender-based violence (GBV) focal points, and maternal and child health professionals on GBV data collection, management, and reporting.
            - Development of supervision tools and integration of indicators related to GBV services into HMIS (2023 Annual Report - UNFPA).
4. **Government Supervision Missions on NAP-GBV (Indicator iv)** - Regular supervision missions by MoH ensured the integration of GBV services in selected health facilities, although delays and challenges in coordination affected the implementation (2022 Annual report - UNFPA)

Findings from UNFPA CO GBV Consultant and APRO GBV Consultant Mission Reports[2] **Capacity of IPs enhanced to implement NAP GBV through a multidisciplinary approach.** i. **Documented reports on improvements in IPs knowledge gain on subjects covered (pre-post survey results)**: Pre-post test results from the training on the national GBV curriculum showed significant improvement in knowledge and attitudes among participants. However, sustaining this knowledge and addressing specific tendencies (e.g., "telling survivors what to do") requires ongoing follow-up and individual attention ii. **Spotlight and other initiatives achieved the agreed output in the non-health sectors (comprehensive case management)**: There is a focus on multi-sectoral coordination through facilitated meeting, with various ministries and organizations, including justice Ministry of Justice, Defensoria Publica, and ALFELA, police, and social services, for comprehensive case management. However, there are identified gaps in high-level government commitment, HR allocation, and survivor-supportive attitudes within institutions iii. **Evidence of the use of supporting data by the Government and relevant institutions to monitor NAP GBV**: The integration of HMIS tools for GBV tracking into the TLHIS-2 (Timor-Leste Health Information System) platform marks a significant step in enhancing data monitoring capabilities for the government. Comprehensive data protocols have been developed to support this This data protocol aligns with international standards to enhance the GBV data management system iv. **Number of annual supervision missions by the Govt on the implementation of NAP GBV**: While direct evidence of supervision missions was not detailed, the collaboration with the Ministry of Health (MoH) and the finalization of GBV data collection tools suggest active government engagement. However, advocacy is needed to enhance government ownership	

[2] Rodrigues, U. M. S. (2024). *Individual Consultant Report: Reporting period 15 January – 14 February 2024*. UNFPA, Timor-Leste
Airoldi, G., & Rejinders, M. (2022). *Mission Report of APRO GBV Specialist - Q4 (13-17 November 2022)*. UNFPA APRO, Timor-Leste

Findings From the Spotlight Initiative Timor-Leste Cumulative Report 2024[3]

Policy and Institutional Strengthening

NAP-GBV Advocacy and Ratification:

- UNFPA supported the Secretariat of State for Equality (SEI) in finalizing and launching the National Action Plan on Gender-Based Violence (2022–2032) with other UN sister UN Agencies such as UN Women. This included technical assistance for gender-responsive budgeting and multi-sectoral coordination
- Advocacy efforts resulted in the adoption of laws and policies addressing workplace harassment and domestic violence, expanding legal protections under NAP-GBV

Health Sector Integration:

- Developed Standard Operating Procedures (SOPs) to institutionalize GBV response within health facilities, linking service providers with law enforcement and community leaders
- Facilitated the establishment of safe spaces and integrated SRH services in healthcare settings for comprehensive support to survivors
- The establishment of safe spaces within health facilities in Viqueque, Bobonaro, and Ermera provided survivors with medical, psychosocial, and legal support. These spaces served as one-stop centers for survivors, ensuring a comprehensive and confidential service delivery model
- Between 2020 and 2023, the number of women accessing healthcare services in these municipalities increased significantly, from 119 survivors in 2021 to 468 survivors in 2023

Capacity Building and Technical Support

Training and Knowledge Building:

- UNFPA, under the Spotlight Initiative and in collaboration with other UN agencies, implemented extensive training programs for government stakeholders and CSOs. These efforts focused on building capacity to address GBV through legal, social, and health system frameworks.
- Development and dissemination of over 73 knowledge products, including technical manuals, policy briefs, and strategic frameworks, to enhance stakeholders' capacity for NAP-GBV implementation
- Targeted training of healthcare providers to improve data collection, case management, and survivor-centered service delivery
- Capacity building wasprovided to strengthen the capacities of governmental and CSO data producers to analyze and disseminate VAWG data, fostering national ownership of GBV monitoring systems

[3] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative

Monitoring and Evaluation:

- The Secretariat of State for Equality (SEI) and local CSOs have significantly improved their ability to monitor NAP-GBV due to the enhanced knowledge and tools provided through UNFPA's interventions. As of 2023, multiple quarterly and annual monitoring activities were conducted, facilitated by updated data systems and guidance documents developed under the Spotlight Initiative
- At least **four quarterly and two annual reviews** of NAP-GBV implementation were completed during the program period. These reviews involved government and civil society stakeholders to assess progress, identify gaps, and propose policy-level actions
- Monitoring included data from service providers (healthcare, law enforcement, and social services) and survivor feedback, providing a multi-sectoral perspective.
- However, gaps remain in ensuring comprehensive geographic coverage and consistent feedback mechanisms from marginalized communities due to limited staff availability, inadequate funding, and logistical constraints in remote areas hinder comprehensive and frequent monitoring activities. Despite these challenges, the collaboration between SEI and local CSOs fostered a culture of evidence-based advocacy and decision-making

Civil Society Engagement and **Capacity Building for CSOs** include:

Training Provided:

- Development of skills in participatory monitoring, program design, and implementation related to NAP-GBV.
- Use of tools for GBV data collection, analysis, and dissemination in line with international standards.
- Workshops on survivor-centered approaches for service delivery and advocacy on GBV-related issues

Institutional Strengthening:

- Financial management and proposal-writing workshops enabled CSOs to secure additional funding from national and international donors
- Formation of a consortium of 23 CSOs strengthened collective advocacy and networking for NAP-GBV implementation

Outcomes and Improvements:

- Participating CSOs reported a 45% increase in their understanding (knowledge and skills) of GBV prevention and response mechanisms, enabling more effective implementation of community-based interventions
- Enhanced capacity allowed CSOs to conduct localized monitoring and advocacy, contributing directly to quarterly and annual reviews of NAP-GBV. Community outreach activities led by CSOs under the Spotlight Initiative reached over 74,000 individuals, raising awareness about GBV services and prevention.
- Partnerships with 21 CSOs, including local grassroots organizations, facilitated participatory monitoring and the inclusion of marginalized groups in NAP-GBV implementation. This approach ensured that marginalized voices were considered in policymaking and program evaluation

Healthcare Worker Training:

- The expansion of Partnerships and collaboration with the Ministry of Health (MoH) led to over **500 healthcare workers** trained under the Spotlight Initiative, focusing on:
    - Survivor-centered care and case management, incorporating psychological first aid and medical response.
    - Standard Operating Procedures (SOPs) for integrated SRH and GBV services, including mechanism for referral and multi-sectoral support
    - Integration of GBV response (GBV indicators) into the Data and Monitoring Systems of Health Management Information System (HMIS), ensuring better tracking of GBV cases and service delivery. This has progressed data availability and usage for evidence-based decision-making and monitoring.
- Training resulted in improved identification and referral of GBV cases, with health facilities reporting a 30% increase in survivor access to services. In addition, integration of GBV data into HMIS provided reliable datasets for monitoring and decision-making. Participants gained technical knowledge in managing complex cases and working collaboratively with law enforcement and social service providers.

Coordinating Healthcare Referrals in Law Enforcement and Justice Sector Training:

- **60 police officers** from the PVPU and legal personnel received capacity-building support to improve survivor-centered approaches in case handling, and coordination and referral pathways between police, healthcare providers, and social service agencies. This included specific training on the Law Against Domestic Violence (LADV) and relevant related legal frameworks/provisions under NAP-GBV.
- Report do not mention how many % of police officers have increased/improved their understanding survivor-centered approaches in case handling.

<u>Strengthening Multi-Sectoral Coordination and Referral Pathways</u>

Governance Structure:

- The establishment of governance structures such as the **National Steering Committee** and the Civil Society Reference Group (CSRG) enhanced multi-stakeholder engagement. These platforms facilitated regular strategic discussions on NAP-GBV implementation and sustainability
- Regular meetings of national and sub-national coordination mechanisms facilitated the integration of GBV services into broader social protection frameworks
- The Interministerial NAP-GBV Commission and Gender Working Groups included representatives from marginalized communities, ensuring inclusive and participatory decision-making

<u>Challenges and Lessons Learned</u>

Monitoring Challenges: Despite progress, consistent monitoring across all municipalities was difficult due to resource constraints and logistical challenges. Limited coordination among stakeholders occasionally delayed reporting timelines

Sustainability: Continued capacity-building efforts and financial support are needed to sustain the outcomes of the Spotlight Initiative and ensure consistent implementation of NAP-GBV in the future. **Pandemic and Natural Disaster**: Natural disasters and the COVID-19 pandemic, especially in 2021-2022, disrupted program activities, requiring adaptive measures such as virtual training and revised communication strategies. Despite these challenges, capacity-building initiatives continued and were expanded.

Findings From Together for Equality Endline Survey Report [4]

Capacity Building:

- The capacity of Civil Society Organizations (CSOs) and public institutions to monitor activities related to the National Action Plan on Gender-Based Violence (NAP-GBV) was enhanced through workshops, training sessions, and the implementation of a standardized framework.
- Skills in gender budget analysis and tracking of gender-based violence (GBV) were strengthened among SEI personnel.
- A total of 42 CSOs were engaged and trained on government policies and budgets associated with NAP-GBV, resulting in an increase in their knowledge from 46.2% (18 out of 39 CSOs) at baseline to 100% (42 CSOs) by the end of the program.
- As part of the "Together for Equality" (T4E) program, UNFPA supported the development and training of stakeholders on Standard Operating Procedures (SOPs) for integrated sexual and reproductive health (SRH) and GBV services aimed at assisting GBV survivors and facilitating GBV referrals.
- These SOPs were implemented in 34 health facilities across four municipalities: Dili, Baucau, Covalima, and Oecusse, which included Community Health Centers (CHCs), CSOs, and hospitals.
- Managers and health professionals from these 34 facilities received training on survivor-centered care, which emphasized dignified and confidential support for GBV case management, medical forensics, respectful treatment of survivors, and improved coordination among health facilities, shelters, and authorities.
- Workshops and training sessions were conducted for CSOs and public institutions to strengthen coordination between health facilities and shelters. This initiative aimed to streamline referrals and provide comprehensive care for survivors while enhancing the overall capacity to monitor NAP-GBV activities.

Health Facility Improvements:

- Establishment of **three Safe Spaces** in Dili, Baucau, and Covalima for survivors of GBV, providing immediate psycho-social support and referrals. Improvements in health facility staff attitudes and awareness of GBV were reported, facilitated better coordination between health facilities and shelters, strengthening the referral network, leading to better survivor experiences

Multisectoral Coordination and Referral Institutional Support:

- Supported research on Administrative Data Mapping for Violence Against Women and Girls in Timor-Leste that provided insights on standardizing data collection, clarifying agency roles, enhancing analysis capabilities, and ensuring data privacy
- Key Government Partners involved Secretary of State for Equality and Inclusion (SEI), Ministry of Health, Ministry of Justice, Ministry of Education, Ministry of Youth, Sports, Arts and Culture, and other relevant line ministries, Municipal authorities and the Ministry of Public Works participated in gender-responsive budgeting and infrastructure planning.
- Key Civil Society Organizations include local/national organizations such as Alola Foundation, FOKUPERS, and Rede Feto.

[4] Sung, S. (2024). *Together for Equality (T4E) "Preventing and Responding to Gender-Based Violence in Timor-Leste 2020-2024": Endline Survey Result Report (Final Version)*

- **Partnerships/collaboration with Key Government Institutions**:
    - **Police Vulnerable Persons Unit (PVU)**: Improved handling of GBV cases by law enforcement through the creation of pocket guides and structured guidelines on GBV case management.
    - **Ministry of Social Solidarity and Inclusion (MSSI)**: Supported the coordination of survivor assistance, including legal aid, psycho-social support, and reintegration services.
- A total of **1,345 GBV survivors** received multisectoral support, with a **182.6% increase** in clients served annually compared to the baseline
- Expanded the number of institutions monitoring NAP-GBV implementation from 12 to 33, including government departments, universities, NGOs, and sports organizations.
    - 21 new institutions included, such as 14 universities and other specialized bodies include: Ministry of Higher Education, Civil Protection Agency, PNTL (Polícia Nacional de Timor-Leste), PNTL (Polícia Nacional de Timor-Leste), BEE TL (National Water Utility in Timor-Leste), Federation of National Basketball Timor-Leste (FNBTL), Plan International.

Expansion of Referral Networks: The number of service providers in the referral network expanded from **4 to 14**. This includes: 10 institutions offering specialized GBV services, 3 safe spaces (established by UNFPA and partners) and 1 service provision at the National University of Timor-Leste (UNTL).

- These additions expand the monitoring framework to include a broader range of institutions, both government and non-government, ensuring diverse perspectives and expertise are incorporated into the implementation and tracking of NAP-GBV activities. This step was part of the efforts to enhance multisectoral engagement and strengthen the overall capacity to respond to GBV effectively
- Facilitated Women's Safety Audit Walks (WSAW) across 24 locations, engaging 1,570 participants, leading to budget commitments for public space renovations.
- UNFPA, in collaboration with UN Women and UNICEF, supported the development of a national 24/7 multisectoral hotline to provide survivors with immediate access to services and referrals (in progress).
- The multisectoral GBV response system integrates health-sector-centric referrals, non-health sector pathways, and community engagement. Health facilities provide immediate links to psychosocial counseling, safe spaces, and legal services, while facilitating forensic examinations as per SOPs. Non-health sector referrals involve police and local authorities directing survivors to medical care and forensic documentation, with social services offering reintegration support. Community leaders play a crucial role in identifying and referring GBV survivors, especially in remote areas, and collaborate with local authorities and service providers to enhance survivor safety and access to justice

Capacity Building in Emergency Situation and Disaster-Prone Areas:

- Training efforts under the program included building the capacity of local authorities and community leaders in disaster-affected areas to better identify and refer GBV survivors
- Efforts were made to strengthen disaster response systems with a gender-sensitive approach, ensuring that GBV survivors have access to services even during crises.
- Partnerships with the Civil Protection Agency and local authorities were fostered to incorporate GBV response measures into emergency preparedness and mitigation strategies.
- Despite these efforts, the report highlights challenges in reaching remote areas during emergencies and sustaining consistent service provision. It recommends further investment in mitigation planning and enhanced coordination between sectors to address these gaps effectively

Evidence of Increased Knowledge **Public Institutions and CSOs**: ● Training efforts led to 100% of CSOs reporting increased knowledge of government policies and budgets related to NAP-GBV, compared to 46.2% at baseline. ● Significant improvement in public institutions' capacity to monitor and implement NAP-GBV activities. **Participants of Training Programs**: ● A total of 1,335 individuals participated in economic empowerment and entrepreneurship training, with a focus on integrating GBV prevention. ● Participants reported improved knowledge and skills in financial management, leadership, and advocacy. **Limitations and Challenges** ● Despite the progress, the endline report noted the absence of a formal NAP-GBV monitoring report, limiting the ability to fully evaluate the implementation ratio of NAP-GBV activities. ● Continued challenges in gender-responsive budgeting and full government support were also highlighted ● Limited resources and entrenched patriarchal norms hinder the expansion of referral pathways to rural areas. ● High staff turnover within ministries and inconsistent application of protocols impacts the sustainability of the referral systems.	**KIIs with GBV Stakeholders**[5]

[5] **UNFPA CP4 Evaluation Team.** *Key informant interviews with stakeholders, including UNFPA CO GBV Team, UN Women T4E and Spotlight Coordinator, DG-SEI, MSSI DG-GBV, FOKUPERS, Belun, Midwives and Doctors in Dili, Baucau, Ermera, Viqueque, and Liquica, as well as representatives from Alola, HAMNASA, KOICA, and EU.* Conducted between July 1 and July 26, 2024

KIIs with GBV Stakeholders[6]

Capacity Building and Knowledge Enhancement:

UNFPA, through initiatives like the UN-EU Spotlight Initiative and KOICA-UN Together for Equality (T4E), has selected and empowered/capacitated key IPs such as HAMNASA, Belun, ALOLA Foundation, and FOKUPERS and others by leveraging their localized expertise. These organizations were chosen for their local experience in grassroots advocacy and community-based activities related to GEWE and GBV prevention and response. The capacity building efforts (mainly through workshops) have been comprehensive regarding the implementation of NAP GBV through a multisectoral approach, covering: Effective advocacy and campaign material development, sensitization on the Domestic Law Against Domestic Violence and CEDAW, Case management for GBV through a multisectoral approach involving stakeholders from national to suco levels in its implementation led/coordinated by the Ministry of Social Solidarity and Inclusion (MSSI), tools and mechanisms for effective community awareness activities.

IPs acknowledged that they gain knowledge from post-workshop on subjects covered. Evidence of knowledge gain is demonstrated through pre-post survey results conducted by UNFPA in every workshop. For instance, the participants responded that after the workshop, their knowledge on GBV particularly on its definition, types of GBV, magnitude and scope of GBV, health impact of GBV, and health care providers' role to respond to GBV is improved and enhanced. However, in our interviews they expressed the need for and the importance of continued training/capacity building, the establishment of safe space with equipment, guidelines, protocols, and trained health care providers with in-service training packages, in addition to the work of other important non-health sectors.

Implementation of NAP GBV and Multisectoral Approach:

Spotlight and other initiatives achieved the agreed outputs in the non-health sectors (comprehensive case management). The programme has strengthened the multisectoral response to GBV by:

- Enhancing coordination within the health system and other sectors (from the revision of the NAP GBV to the implementation and monitoring of the NAP-GBV)
- Improving referral networks from national to suco levels through the coordination of all important stakeholders
- Engaging diverse community members, including elders, men, women, and youth and other marginalized groups (could be more)
- Strengthening healthcare providers' participation in GBV referral pathways to provide health services to survivors
- Conducting workshops/capacity building on multisectoral approaches involving government stakeholders from health, justice, and social sectors
- CSOs, in turn, work to raise awareness and empower local leaders and youth groups, enabling them to carry on the advocacy efforts at the grassroots level and expand the reach of the intervention.
- The case management system, led by MSSI, has achieved agreed outputs, demonstrating effective implementation of the NAP GBV that includes support for shelters for survivors and the use of consistent Standard Operating Procedures (SOPs) for case management across all municipalities. MSSI has established GBV focal points at every administrative level (municipality level), facilitating support for GBV survivors and coordinating with partners in referral pathways. This comprehensive approach ensures a coordinated response to GBV cases, from initial reporting through to providing necessary support and services. Additionally, this response system is bolstered by collaboration with the Vulnerable People Unit of the National Police and legal aid NGOs, all operating within a legal framework established to address domestic violence. During emergencies, MSSI partners with municipal authorities to conduct real-time surveys to identify individuals in need of social assistance.

[6] **UNFPA CP4 Evaluation Team.** *Key informant interviews with stakeholders, including UNFPA CO GBV Team, UN Women T4E and Spotlight Coordinator, DG-SEI, MSSI DG-GBV,*

<table>
<tr><td>Assumptions 18: Increased focus on GBV prevention and access to GBV services for vulnerable people including PWDs have resulted in an increase in the help-seeking behaviour among the women who experience violence</td><td colspan="2">Indicators:
i. Availability of services to people in areas access is difficult (coverage of vulnerable people including PWDs)
ii. Gender and social norms: Number of girls and women who have access to SRH information that included violence against women
iii. Evidence in change in pattern of help seeking women (those who now report violence)</td></tr>
<tr><td colspan="2">Data collected [must be strictly linked to the assumptions and corresponding to the above-indicated indicators]</td><td>Sources of information [List the source(s) of evidence for each of the data collected]</td></tr>
<tr><td colspan="2">Findings from UNFPA Annual Reports from 2021-2023[7]
Increased Focus on GBV Prevention
Indicator i: Availability of Services in Hard-to-Access Areas (Including Vulnerable Populations and PWDs)
● 2021:
○ Spotlight Initiative targeted four municipalities for GBV-related services and referral mechanisms but limited specific data on PWDs or LGBTQ populations (2021 Annual Report - UNFPA).
● 2022:
○ Safe spaces were established in three municipalities (Viqueque, Ermera, and Bobonaro) and designed to provide services to vulnerable groups, including women and girls with disabilities. Inclusivity was emphasized during the design phase of these spaces, making them accessible for PWDs (2022 Annual report - UNFPA).
○ Mobile health clinics provided 544 clients (including women in remote areas) access to SRH services, which included GBV components, ensuring continuity of services in rural and remote areas (2022 Annual report - UNFPA).
● 2023:
○ Expanded access to safe spaces in six municipalities (Viqueque, Ermera, Bobonaro, Atabae, Comoro in Dili, and Vera Cruz in Dili), all equipped to serve PWDs and survivors of violence. Sensitization training on accessibility and inclusiveness was conducted for health workers managing these spaces (2023 Annual Report - UNFPA).
○ Mobile clinics and targeted outreach expanded coverage, addressing SRH and GBV services in remote and underserved areas (2023 Annual Report - UNFPA).
From 2021-2023, services expanded to cover hard-to-reach areas, particularly through safe spaces and mobile clinics. Inclusivity for PWDs was a consistent focus, especially in 2022 and 2023, although it was limited.</td><td>UNFPA Annual Reports from 2021-2023</td></tr>
</table>

FOKUPERS, Belun, Midwives and Doctors in Dili, Baucau, Ermera, Viqueque, and Liquica, as well as representatives from Alola, HAMNASA, KOICA, and EU. Conducted between July 1 and July 26, 2024

[7] UNFPA Timor-Leste**.** 2021-2023 Annual Report - Timor Leste. Finalized Official Reports.

Indicator ii: Gender and Social Norms – Access to SRH Information (Including Violence Against Women) ● **2021**: ○ Training and sensitization on GBV prevention and SRH were conducted for **400 healthcare providers** under Spotlight, indirectly increasing community awareness through service providers (2021 Annual Report - UNFPA). ● **2022**: ○ Comprehensive sexuality education (CSE) initiatives were expanded to **47 schools** across seven municipalities, reaching **3,862 adolescents and youth**, including girls, with modules on SRH and GBV prevention (2022 Annual report - UNFPA). ● **2023**: ○ Over **735 survivors** received essential GBV and SRH services in safe spaces. Awareness sessions were conducted as part of referral pathways, indirectly improving knowledge of SRH and violence prevention (2023 Annual Report - UNFPA). ○ Spotlight Initiative, Together for Equality (T4E), and Zonta initiatives emphasized addressing harmful gender norms and raising awareness on GBV through community-level programs (2023 Annual Report - UNFPA). ***Indicator iii: Change in Help-Seeking Behaviour (Women Reporting Violence)*** ● **2021**: ○ Limited data on reporting trends, though efforts under Spotlight focused on improving referral pathways and case management, which likely encouraged reporting (2021 Annual Report - UNFPA). ● **2022**: ○ A **quality assessment** indicated gaps in reporting but emphasized a growing recognition of health facilities as access points for GBV survivors. This included training of 30 health providers on survivor-centred care (2022 Annual report - UNFPA). ● **2023**: ○ Help-seeking behaviour increased as **358 GBV cases** were identified and managed across health facilities in Dili, referred by Vulnerable Persons Units (VPUs), shelters, and other partners (2023 Annual Report - UNFPA). ○ Safe spaces recorded **735 survivors** accessing services, demonstrating improved help-seeking behaviour among women facing violence (2023 Annual Report - UNFPA). ○ Advocacy from trained health managers improved referral systems and service readiness, directly addressing barriers to help-seeking behaviour (2023 Annual Report - UNFPA).	

Findings From the Spotlight Initiative Timor-Leste Cumulative Report 2024[8]	Spotlight Initiative Timor-Leste Cumulative Report 2024[9]
The capacity building and technical support provided to CSO and Government partners to implement NAP GBV has resulted in these Outcomes and Challenges. **Key Outcomes**: ● **Increased Service Utilization**: A coordinated referral network resulted in over **23,713 survivors accessing quality GBV services** by the end of 2023 The establishment of **safe spaces within health facilities** in Viqueque, Bobonaro, and Ermera provided survivors with medical, psychosocial, and legal support. A total of **three safe spaces** were established under the Spotlight Initiative. These safe spaces are located in the municipalities of **Viqueque, Bobonaro, and Ermera.** These spaces served as one-stop centers for survivors, ensuring a comprehensive and confidential service delivery model ● Between 2020 and 2023, the number of women accessing healthcare services in these municipalities increased significantly, from 119 survivors in 2021 to 468 survivors in 2023. This reflects the growing trust in and utilization of these integrated services. ● **Policy and Budget Alignment**: Ministries reported increased budget allocations for GBV-related services, reflecting a commitment to sustaining NAP-GBV outcomes ● **Community Awareness**: Outreach programs and referral information dissemination led to an increase in survivor help-seeking behavior. **Challenges**: ● Despite progress, the **limited geographic coverage** of referral services in remote areas restricted access for some marginalized groups. ● Resource constraints and weak digital infrastructure affected the ability to monitor and scale referral networks effectively **i. Availability of Services to People in Hard-to-Reach Areas (Including Vulnerable Groups like PWDs)** ● **Coverage for Vulnerable People**: ○ **Safe Spaces Established**: Three safe spaces were operationalized in Viqueque, Bobonaro, and Ermera municipalities. These facilities provided comprehensive GBV services, including medical care, psychosocial support, and legal assistance. Between 2020 and 2023, the number of women and girls accessing services in these facilities increased significantly, with **119 survivors accessing services in 2021**, rising to **468 survivors in 2023** ○ **Inclusive Referral Networks**: The program worked closely with organizations representing marginalized groups, including persons with disabilities (PWDs) and LGBTI individuals, to ensure referral networks were accessible and inclusive ● **Challenges in Rural Access**: Despite progress, gaps remained in reaching rural communities due to logistical barriers and limited resources, which hindered service accessibility for some vulnerable populations	

[8] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative

[9] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative

ii. Gender and Social Norms: Access to SRH Information Including VAW ● **Number of Beneficiaries**: ○ Through campaigns and sensitization programs, the Spotlight Initiative reached over **1,000,590 individuals**, including women and girls, with information on GBV, SRH, and related topics ○ **Access to SRH and VAW Information**: By the end of 2023, **23,713 women and girls** reported increased knowledge of essential GBV services, including recovery and SRH services ● **Behavior Change and Social Norms**: ○ Community campaigns significantly influenced gender-equitable attitudes. Examples include the "Connect with Respect" initiative in 15 schools across three municipalities, involving teachers, students, and parents to promote healthier relationships **iii. Change in Pattern of Help-Seeking Behavior** ● **Increase in Reporting**: ○ Over the program's duration, **9,830 women and 1,296 girls** reported experiencing violence and sought help from formal services, representing a marked increase compared to baseline figures ○ More than **23,713 survivors accessed quality GBV services** by the end of the program, including safe spaces and health facilities ● **Increased Knowledge of Services**: ○ **12,680 women and 1,149 girls** gained knowledge about essential GBV services, while **656 women** and **288 girls** reported improved understanding of recovery services within the past year ● **Community Feedback**: ○ Testimonials from program participants highlighted increased awareness and confidence in reporting violence. For example, a female community member in Atabae stated, "I now know how to report violence and access legal services" after participating in a campaign	

Findings from UNFPA CO GBV Consultant and APRO GBV Consultant Mission Reports[10]	UNFPA CO GBV Consultant and APRO GBV Consultant Mission Reports[11]
Increased focus on GBV prevention and access to GBV services for vulnerable people, including PWDs, has resulted in increased help-seeking behavior among women experiencing violence **Indicator i:** Availability of services to people in areas where access is difficult (coverage of vulnerable people, including PWDs) ● Disability inclusion was integrated into the national curriculum for healthcare providers. The training specifically included adaptations for GBV and disability and emphasized survivor-centered care. Visits to Safe Spaces like the one in Gleno demonstrated targeted efforts to ensure accessible services ● A **field visit to a health facility-based Safe Space** in Gleno, Ermera Municipality, assessed the availability and readiness of GBV services, including considerations for disability inclusion **Indicator ii:** Gender and social norms: Number of girls and women who have access to SRH information that included violence against women ● The GBV awareness campaign during International Women's Day 2024, which included community engagement and the launch of Safe Spaces, reflects an increase in outreach efforts aimed at breaking harmful social norms and improving access to information ● The report highlights a **national GBV curriculum** adapted for Timor-Leste, incorporating specific disability considerations. Cascade training has reached health care providers, equipping them to address GBV cases more effectively **Indicator iii:** Evidence in the change in the pattern of help-seeking women (those who now report violence) ● The rollout of **Safe Spaces** and improvements in GBV response infrastructure (e.g., training and case management tools) are expected to encourage help-seeking behavior. However, the reports suggest that survivor-blaming attitudes remain a barrier and highlight the need for ongoing social norm changes and community interventions ● Survivor-blaming attitudes and harmful norms persist, as highlighted in pre-training assessments. Nevertheless, the post-training results suggest gradual changes in attitudes, which could foster a more supportive environment for survivors to seek help. Monitoring changes in reporting patterns was flagged as a follow-up priority.	

[10] Rodrigues, U. M. S. (2024). *Individual Consultant Report: Reporting period 15 January – 14 February 2024*. UNFPA, Timor-Leste
Airoldi, G., & Rejinders, M. (2022). *Mission Report of APRO GBV Specialist - Q4 (13-17 November 2022)*. UNFPA APRO, Timor-Leste

[11] Rodrigues, U. M. S. (2024). *Individual Consultant Report: Reporting period 15 January – 14 February 2024*. UNFPA, Timor-Leste
Airoldi, G., & Rejinders, M. (2022). *Mission Report of APRO GBV Specialist - Q4 (13-17 November 2022)*. UNFPA APRO, Timor-Leste

Also from the Spotlight Initiative in Timor-Leste, there is significant evidence of the program's engagement with male community members, particularly through activities designed to promote awareness, transform harmful masculinities, and foster supportive roles in GBV prevention and response. **Key Findings:** 1. **Engagement in Awareness Campaigns**: o The initiative partnered with CSOs representing men and boys, such as **Mane ho Vizaun Foun (Men with a New Vision)**, to implement the "Connect with Respect" program. This program engaged **teachers, students, and parents, including male participants**, across 15 schools in three municipalities (Viqueque, Bobonaro, and Ermera). It emphasized building healthy relationships in schools and at home o Over the course of the program, the Spotlight Initiative partnered with **five CSOs representing men, boys, and faith-based groups** to transform ideas and practices around gender roles and GBV prevention 2. **Shifting Attitudes and Behaviors**: o Campaigns targeting harmful masculinities included direct engagement with men in workplaces, communities, and educational institutions. One such message, "EVAWG is a Whole-of-Society Effort," highlighted the responsibility of men and boys in ending violence against women and girls (VAWG), effectively amplifying their role in community-level prevention efforts. o Social norms change programs reported increased recognition among male participants about the impacts of GBV and their roles in addressing it. Testimonials, such as those from male community leaders, reflected these shifts. For example, the Chief of Aldeia Haupo stated, “We grew up under a culture of fear, but now we know, we must report all violence against women and girls to the police,” after participating in sensitization sessions 3. **Reach and Scale**: o Awareness campaigns, including those focused on positive parenting and respectful partnerships, reached **1,979 male participants in 60 remote villages** across three target municipalities o Broader campaigns on GBV prevention, which included men and boys as a target audience, utilized social media, radio, and community events to disseminate key messages effectively **Outcomes:** ● **Improved Male Participation**: Men and boys increasingly participated in campaigns and educational activities, resulting in tangible commitments to the prevention of GBV. ● **Increased Reporting**: Community leaders and male participants actively promoted GBV reporting mechanisms within their communities following awareness activities.	

Findings From Together for Equality Endline Survey Report [12]	Together for Equality Endline Survey Report [13]
i. Availability of Services to People in Areas Where Access is Difficult (Coverage of Vulnerable People Including PWDs and LGBTQ Community): ● **Expansion of Service Coverage:** o UNFPA, through the "Together for Equality" (T4E) program, established **three Safe Spaces** in Dili, Baucau, and Covalima, providing immediate psycho-social support and referrals for GBV survivors. o The number of service providers in the referral network expanded from **4 to 14**, including 10 institutions offering specialized GBV services, 3 safe spaces, and 1 service provision at the National University of Timor-Leste (UNTL). ● **Inclusion of Vulnerable Populations:** o The program ensured that services were accessible to vulnerable groups, including PWDs and the LGBTQ community, by training service providers on inclusive practices and establishing facilities equipped to accommodate diverse needs. o Outreach initiatives targeted remote and underserved areas, facilitating access to services for populations in regions where access was previously challenging. **ii. Gender and Social Norms: Number of Girls and Women Who Have Access to SRH Information That Included Violence Against Women:** ● **Educational and Awareness Programs:** o The T4E program conducted **awareness campaigns** and **educational sessions** reaching over **10,000 individuals**, focusing on SRH information that included components on violence against women. o Collaborations with local schools and community centers facilitated the dissemination of information to girls and women, promoting awareness and understanding of GBV and available support services. o Focus on Disaster-Prone Areas: The T4E program emphasizes reaching adolescent girls, boys, young women, and men in disaster-prone areas, ensuring they have access to GBV services and awareness programs ● Inclusion in Safe Spaces and Outreach Programs: o Safe spaces established by the program in Dili, Baucau, and Covalima include outreach components designed to serve populations in remote and disaster-prone regions. o Community engagement initiatives, such as training local authorities and leaders, aim to improve GBV prevention and response in areas susceptible to disasters. ● **Integration into Health Services:** o SRH services were integrated with GBV prevention information, ensuring that women accessing health services received comprehensive education on violence prevention and response mechanisms.	

[12] Sung, S. (2024). *Together for Equality (T4E) "Preventing and Responding to Gender-Based Violence in Timor-Leste 2020-2024": Endline Survey Result Report (Final Version)*

[13] Sung, S. (2024). *Together for Equality (T4E) "Preventing and Responding to Gender-Based Violence in Timor-Leste 2020-2024": Endline Survey Result Report (Final Version)*

iii. Evidence in Change in Pattern of Help-Seeking Among Women (Those Who Now Report Violence): ● **Increase in Reporting Rates:** ○ The number of GBV survivors seeking assistance increased by **182.6%**, with **1,345 survivors** receiving multisectoral support, compared to the baseline figures. ○ **A multisectoral hotline is still in the development process "ongoing development of national hotline services with support by UN Women"** . Its establishment with operation in **24/7 is both timely and highly appropriate in supporting these efforts.** consolidated 24/7 information hub to enhance accessibility and streamline assistance, it will provided survivors with immediate access to services, contributing to the more increase in reporting and help-seeking behavior. ● **Enhanced Community Engagement:** ○ Community leaders and local authorities were trained to identify and refer GBV cases, leading to improved community-level reporting and support for survivors. ● **Improved Service Provider Capacity:** ○ Training of health professionals and service providers in survivor-centered care resulted in more women feeling confident to report incidents, knowing they would receive respectful and confidential support. These findings demonstrate that targeted interventions focusing on GBV prevention, inclusive service provision, and community engagement have effectively increased help-seeking behavior among women experiencing violence, particularly among vulnerable populations.	

KIIs with GBV Stakeholders[14] Increased Focus on GBV Prevention and Accessibility & Availability of Services GBV services are now accessible and available in all health facilities, with healthcare professionals trained in GBV response. Agreement with La Trobe University has helped develop an in-service training package for health service providers on health sector response to GBV, based on WHO curriculum. This training, along with multi-sectoral approach training for stakeholders, has significantly improved the capacity to address GBV issues. Additionally, Health facilities have made significant strides in supporting survivors of gender-based violence (GBV) by creating dedicated safe spaces, some were established with the financial support of the Donor-supported UNFPA program. These areas provide immediate, confidential, and secure environments for survivors seeking GBV services, ensuring their privacy and safety. While these spaces are intended for short-term support, they play a vital role in offering initial medical attention, counselling, and assistance. Healthcare providers are trained to assess cases and make appropriate referrals to additional services, including police, social services, or shelters for long-term support. After receiving care, survivors are often referred to shelters operated by civil society organizations (CSOs) like Casa Vida, which provide comprehensive services to help them recover and rebuild their lives. The establishment of these safe spaces within health facilities represents a significant step forward in addressing GBV, encouraging reporting, and ensuring that survivors receive the necessary care and support. Community awareness programs on prevention and response to GBV, as well as prevention of early pregnancy, sexual reproductive health have been implemented in selected municipalities, extending to post-administrative and village levels, reaching even remote communities often lacking information about GBV and available services. However, coverage for GBV survivors with disabilities remains low due to factors such as infrastructure limitations and mobility issues. For example, in 2023, 2,267 women community leaders and members have shown improved knowledge on gender equality, human rights approaches, GBV prevention, and sexual reproductive health and rights across several municipalities. Another example, in 2022, community awareness activities in four villages of Liquica Municipality resulted in at least 75% of people having increased awareness and knowledge on these topics. Village councils are now aware of their roles in sensitizing communities and supporting survivors to access services.	**Secondary data - Desk review** Progress Reports Supervision Mission Reports Communication Materials Service Center Data Radio Campaigns M&E data **Primary Data:** KII interviews, FGD Online interviews UNFPA and other RUNOs Gender/related treks force members Results groups, GWgp, CWGs UNICEF gender focal person

[14] **UNFPA CP4 Evaluation Team.** *Key informant interviews with stakeholders, including UNFPA CO GBV Team, UN Women T4E and Spotlight Coordinator, DG-SEI, MSSI DG-GBV, FOKUPERS, Belun, Midwives and Doctors in Dili, Baucau, Ermera, Viqueque, and Liquica, as well as representatives from Alola, HAMNASA, KOICA, and EU.* Conducted between July 1 and July 26, 2024

Positive Changes in Reporting and Attitudes

There has been an observed increase in GBV reports to the Vulnerable Persons Unit (VPU) from communities where awareness sessions were held, indicating that women and vulnerable groups are more informed about available assistance and are seeking help. Community members now report violence directly to the VPU, showing progress in breaking the cycle of violence and victim-blaming.

The participation of local authorities, youth organizations, community-based organizations, and women's rights organizations is crucial in promoting gender-equitable attitudes and reducing GBV incidence. For example, in Liquica municipality, local authorities actively participate in GBV referral pathways and case management systems, playing an important role in promoting gender equality, preventing violence, and supporting survivors' access to available services.
HAMNASA, an implementing partner, for example, has developed effective strategies for GBV prevention and response. They conduct 6-month reviews involving all stakeholders (in the post-administrative to suco/village level) to assess progress and share information with the community. Together do final evaluations/assessment to identify GBV cases and address cultural issues or report to the Vulnerable Persons Unit (VPU).
Furthermore, they also organized Learning Lab sessions, featuring a film on domestic violence followed by discussions and information sharing on available assistance for survivors. These sessions aim to ensure that community members, especially women and vulnerable groups, know where to seek help when experiencing violence. There has been an observed increase in GBV reports to the Vulnerable Persons Unit (VPU) from communities where awareness sessions were held. Community members now report violence directly to the VPU, showing progress in breaking the cycle of violence and victim-blaming. HAMNASA has noted a shift in attitudes towards GBV, especially among men who previously thought violence was normal but now understand it is unacceptable and a crime.

Despite these achievements, some challenges persist:

- Data disaggregation: GBV data is currently disaggregated only by sex, with limited information about people with disabilities, age categories, and other vulnerable groups such as LGBTQ+ communities as well as sex workers (FOKUPERS, previously accommodated human trafficking survivors in their shelter. However, they found themselves unable to adequately address the unique safety concerns and specific needs of these survivors, which differed significantly from those of other shelter residents).
- Harmonization of interventions: Different organizations use varying modules and strategies for raising community awareness, creating disharmonized messages. Efforts are needed to standardize modules, messages, and interventions on GBV prevention.
- Long-term behavioural change: One-off activities are insufficient to improve and change gender-equitable attitudes. Sustained and evidence-based interventions are required for the prevention of violence against women and girls
- IPs like HAMNASA, Alola Foundation, and FOKUPERS face difficulties in balancing quality and sustainability of the projects and maintaining staff resources due to funding delays and short-term contracts
- Some IPs express the need for more capacity building in effective advocacy, integrating gender transformative approaches
- Case management: MSSI faces resource limitations at post-administrative and village levels, with plans to enhance human resources by recruiting additional officers for GBV management, vulnerable people's cases, child protection, and coordination

UNFPA focuses on one off event and a key inform requested not to spend funds on one off event that do not leave lasting a message, instead to do something that can be followed up closely and the people remember the message (long-term impact/effect).		
Assumptions 19: UNFPA CP4 supported PD (population and development) interventions contributed to strengthen the planning and implementation of national development policies and strategies (refers to all programmes across CP4) Relevant to other programme areas as well (include relevant and applicable thematic areas)	**Indicators:** i. Number of professionals and units trained to apply integration methods and tools ii. Demographic/Population Studies released iii. Database for public policies established and available to the public (trends) - Disaggregated data produced, analysed, and utilized at national and sectoral levels in a timely manner (with UNFPA support) - -surveys had disaggregated data that was used for more in-depth vulnerability analyses iv. Evidence that the above analyses informed policies and programmes. Number of national and sectoral plans incorporating population, reproductive health and gender issues (with UNFPA support) v. Data supported by UNFPA contributed to the development of national policies and strategies vi. Mechanisms for policy analysis and dissemination of policy briefs	
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]		**Sources of information** [*List the source(s) of evidence for each of the data collected*]
UNFPA, during CP4 was successful in extending its technical assistance to INETL to complete the Census 2022 and support to publish six thematic reports and six other publications are in progress. These will provide data for evidence-based planning by the government and other development agencies. CP4 mobilized resources to enhance the capacity of INETL staff. Some delays were experienced in getting the DHS implemented due to COVID-19 and in turn other studies that depended on DHS data. UNFPA support to enhance data generation and mapping is highly commended by INETL as well as other development community. Census and DHS data are the credible data sources used for planning, monitoring and as indicators in progress measuring. As part of the Census data collection exercise, UNFPA has provided training to municipal statistical staff through Census training of trainers (TOT) and data literacy programs funded by the EU. This training, while not specifically focused on CRVS, has proven highly beneficial for their routine data collection tasks, including those related to CPI and CRVS. CP4 also supported with sex disaggregated data for evidence –based planning and policy making on gender issues. Capacity building on data literacy or GBV related issues helped monitor NAP-GBV. Given the country's demographic profile with the window open for the demographic dividend, UNFPA is engaged in the dialogue with the government, and this will be an optimum timing for UNFPA to be a leader in the driver seat for steering the path to make it happen.		**Secondary Data - Document Review:** ● AWPs and workplan progress reports, including of annual reports from needs assessments, evaluation and monitoring reports ● Planning and programming documents issued during the reference period ● P&D project reports, monographs, thematic reports ● Administrative data

The thematic reports cover population projection, fertility, mortality, migration, education, and evaluation of age and sex data (List is available in Annex 5 Additional Information). The remaining five reports, still in the process of finalization, will address housing characteristics and amenities, youth, gender, disability, and the labour force, along with a census atlas. Timor-Leste had a comparative advantage of having a state M&E system linked to SDG indicators and budget planning and realization. That system is no longer in place to track the progress of the outcomes' indicators directly through the national M&E system. The viable alternative to explore joint efforts to track progress towards high-level SDG indicators is the National Institute of Statistics of Timor-Leste (INETL), co-founded by UNDP back in 2000 and receiving continuous support from UN Agencies. Census (2022) Thematic reports completed – UNFPA supported INETL (Table is attached to Annex xx on Additional Information) ● Demographic evaluation of census to include reported age displacement, age heaping due to digit preference, the ratio of males to females by areas of residence, and administrative divisions. ● Fertility Levels – adolescent fertility rates, general fertility rates for women, age at first marriage, age-specific marriage rates, marriage patterns ● Mortality levels – Infant Mortality and under-five Mortality rates, Maternal Mortality Rates, life expectancy by sex ● International and Internal Migration such as migration between municipalities, international migration rates presented for a one-year and 5-year duration since migration. ● Population projections at national and sub-national levels for the next 50 years by different age groups and sex ● Education status such as school attendance rates, school completion rates, field of study, and literacy rates by Socio-economic Groups and by Areas of Residence By UNFPA ● Analysis of the Disabilities and Differences according to Age, Sex, Education, Social Groups, and Area of Residence (completed) ● Children and Youth Analysis and Demographic Dividend Analysis are in progress	**Primary Data - KI interviews:** ● UNFPA P&D Team ● MOH, MOYAC, SEI, MSSI (Data related) and publications ● UN results groups (for data availability) ● Past training participants (capacity building related) ● Implementing partners working at the municipality and sub municipality and suco level
Assumptions 20: UNFPA contributed to strengthening institutional capacities to produce and use data to map out inequalities and emerging population dynamics to inform CP4 interventions and country policies to enable targeting of key populations and marginalized populations to reap intended benefits. (same to be applied in development, humanitarian setting and emergency preparedness.)	**Indicators:** i. Capacity of national staff to produce maps and disaggregated data for planning purposes (national, sub-national and local level). ii. References made to data for targeting marginalized populations in planning. iii. Evidence of data- utilization for policy and decision- making iv. Contribution of data for policy and strategy implementation (e.g. NAP GBV, Youth strategy, CSE planning v. Evidence of data contributing to the improvements in access to services
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]

Notes: (same to be applied in development, humanitarian setting and emergency preparedness.) Capacity development: In 2023, UNFPA Timor-Leste continued its capacity development work with the Timor-Leste National Institute of Statistics (INETL, ex-GDS) to reduce gaps in data generation capacity and data availability. UNFPA supported training to 15 of INTEL staff in the areas of administration, finance, human resources and procurement to enhance the administrative capacity of INETL. In addition, twenty-five junior professional and technical staff were trained successfully on tabulation, thematic report writing, data analysis, data editing and population forecasting/projection in Dili and six were trained in Bangkok. As a result, the trained staff were assigned to analyse the thematic report of the Census "***Fó fila fali"*** which was published and disseminated in July 2024. In addition, fourteen INTEL staff were trained to support post-census activities and INETL completed and published six thematic reports with UNFPA technical support. Capacity development and technical support of UNFPA would have contributed to the successful completion of these reports (Thematic reports on education, fertility, mortality, population projections administration) and the production of other thematic reports on are in progress (children and youth, gender, labour and economics among others). CP4 has plans to advocate census data to be used by government programs for evidence-based planning. Evidence that the above analyses informed policies and programmes. Data supported by UNFPA contributed to the development of national policies and strategies: The ministries and other stakeholders' reference to census data (previous census 2015 and 2022) in the national policies and strategies indicate the use of census data for planning and preparing policies and strategies. In TL, DHS is in the process of implementation and up to now most of the ministries, UN and national stakeholders use data from the 2016 DHS. This validates the credibility of the data and the use of it for the planning purposes. Data and evidence for policy design and intervention: By supporting the collection and analysis of gender-related data (UNFPA Timor-Leste supports the piloting of GBV data for policy with the HMIS to collect GBV data from several targeted municipalities), CP4 enables evidence-based policy-making and targeted interventions. This focus on data strengthens the overall response to GBV and helps in monitoring progress towards gender equality goals. Data and Monitoring: UNFPA also supported Government in the use of supporting data to monitor NAP GBV efforts to improve data collection and utilization for NAP GBV monitoring includes: Capacity building on data literacy for GBV-related issues in four municipalities, with 125 persons participating from line ministries, CSOs, National Police of Timor-Leste, GDS (now INETL – Institute of National Statistics of Timor-Leste), capacity building on strengthening GBV data production to increase knowledge and understanding of the current situation of GBV and data production in Timor-Leste; integration of GBV data into supervision tools like the Health Management Information System (HMIS) to a standardized reporting format across all municipalities (starting with 5 municipalities – started the data collection for this); and the development of HMIS indicators for GBV (remain discussion about the key indicators to better facilitate HIMS officers in GBV data analysis). These efforts have resulted in improved initial data collection and utilization by the government and relevant institutions to monitor NAP GBV implementation.	**Secondary data - Document Review:** Relevant programme, project and institutional reports of stakeholders UNFPA Annual reports, policy papers, reports, Monographs, thematic reports **Primary Data - KI interviews:** UNFPA CO staff GoTL, and IPs INETL selected staff

There is some limitation in data disaggregation: GBV data is currently disaggregated only by sex, with limited information about people with disabilities, age categories, and other vulnerable groups such as LGBTQ+ communities as well as sex workers.
Support to INETL to improve the range, quality and consistency of prevalence and administrative data on violence against women and girls

On data literacy, as part of Spotlight Initiative, CP4 strengthened the capacity of government and non-government institutions to access, utilize and disseminate data on violence against women and girls (VAWG) for planning and designing interventions. Training was offered enhancing knowledge of data producers from civil society, government institutions, and local organizations on gender-based violence (GBV) related data. 256 people from 27 institutions across 4 municipalities (Ermera, Bobonaro, Viqueque, and Dili) were trained on data literacy to produce prevalence and/or incidence data on VAWG. UNFPA also supported an Administrative Data Mapping project as part of efforts to improve quality and reliable data on VAWG. At municipal level, chiefs of municipal (INETL staff) were given TOT for census and the data literacy on GBV was accomplished at the same time under the funds from EU SI (by EU/ spotlight Project).

Population Dynamics and Data:

- CP4 supports the collection, analysis, and use of sex-disaggregated data, crucial for evidence-based policymaking on gender issues.
- The programme assists in strengthening national capacity to conduct gender analysis of demographic data, informing policies that address gender disparities.
- Specific focus is given to improving data collection and analysis related to GBV, helping to better understand the scope and nature of the issue in Timor-Leste (ie. piloting of the integration of GBV data collected from health facilities in targeted municipalities).
- Support for gender-responsive budgeting initiatives ensures that national resources are allocated in ways that promote gender equality (direct advocacy and through the IPs such as FOKUPERs and Women's Network (REDE FETO).

Data and Monitoring:
UNFPA also supported Government in the use of supporting data to monitor NAP GBV efforts to improve data collection and utilization for NAP GBV monitoring include:

- Capacity building on data literacy for GBV-related issues in four municipalities, with 125 persons participating from line ministries, CSOs, National Police of Timor-Leste, GDS (now INETL – Institute of National Statistics of Timor-Leste)
- A national workshop/capacity building on strengthening GBV data production to increase knowledge and understanding of the current situation of GBV and data production in Timor-Leste
- Integration of GBV data into supervision tools like the Health Management Information System (HMIS) to a standardized reporting format across all municipalities (starting with 5 municipalities – data have started to be collected)
- Development of HMIS indicators for GBV (remain discussion about the key indicators to better facilitate HIMS officers in GBV data analysis)
- These efforts have resulted in improved initial data collection and utilization by the government and relevant institutions to monitor NAP GBV implementation.

Demographic Dividend: CP4 PD theory of change includes planned intervention to raise awareness on population dynamics and Demographic Dividend. Two national workshops and one regional workshop have been organized to address the demographic dividend. These workshops aimed to provide in-depth analysis and discussion on the opportunities and challenges associated with leveraging demographic changes for economic growth. The national workshops focused on engaging key stakeholders at the country level to align strategies and policies, while the regional workshop brought together participants; academics and experts from multiple countries to share experiences and best practices.

Currently, among the total population, 35 percent is below the age of 15, and 6 percent is 65 and over. This implies a dependency ratio of 68, which means that 100 persons in the active age groups in Timor-Leste must support 68 persons in the dependent age groups. Compared to the 2015 census, the dependency ratio has declined from 81 to 68 dependents for every 100 people in the active age group, which is significant.

According to the 2022 Census, Timor-Leste's demographic dividend is 1.16 percentage points per year between 2015 and 2030, which is the highest among the 13 Asian economies. Demographic dividend is not automatic. To reap the benefits of the youth bulge and the declining dependency ratio, favourable conditions must be created with good education, healthy people, decent employment, and gender equality among other factors, to create a productive economy. If the interventions are not directed at this segment of population, the country is at risk of missing this window of opportunity. CP4 mentions the use of data to assess the demographic shifts to optimize investments for demographic dividend. This will be a good opportunity for UNFPA to initiate a joint UN project, for the youth in coordination with relevant UN agencies, to reap the benefits of the demographic dividend as a development strategy.

The analysis of the village report, "Census of Fila Fali," was carefully designed to deliver detailed insights into small-area estimations. This approach allows for a nuanced understanding of local population dynamics and conditions. The primary objective of this analysis is to provide critical information that supports effective policy development and strategic planning. By focusing on granular data, the report aims to address specific needs and challenges at the community level, thereby enhancing overall population well-being. The detailed findings are intended to inform targeted interventions and resource allocation, ensuring that policies and programs are well-suited to the unique circumstances of each area. This level of detail is crucial for developing responsive and effective strategies that improve living conditions and meet the needs of local populations effectively.

Support to CRVS: The issues of Civil registration and vital statistic are very important component that help the country to record vital information such as births, deaths and other vital events for individual to claim identity, civil status and ensuing rights. At the municipal level, INETL staff are responsible for collecting data on births, deaths, marriages, and maternal deaths. As part of the Census data collection exercise, UNFPA has provided training to municipal statistical staff through Census training of trainers (TOT) and data literacy programs funded by the EU. This training, while not specifically focused on CRVS, has proven highly beneficial for their routine data collection tasks, including those related to CPI and CRVS. However, the reliability of data at the suco and aldeia levels has been questioned, often due to issues such as double counting. The objective of civil registration and vital statistics is to ensure that we “GET EVERYONE IN THE PICTURE,” as emphasized in the ministerial declaration. By improving the quality of CRVS data—particularly concerning maternal deaths, stillbirths, neonatal mortality rates (NMR), infant mortality rates (IMR), and under-five mortality rates—the ability to plan and target essential services effectively could be enhanced.

<table>
<tr><td colspan="3">Evaluation Question 5: To what extent did UNFPA get the value for money for its intervention vis-à-vis the results achieved?</td></tr>
<tr><td colspan="3">Evaluation Criteria: Efficiency
Common for all programme areas (SRHR, AY, Gender, & PD) in both development and humanitarian context</td></tr>
<tr><td>Assumption 21: CO had sufficient human resources with relevant expertise to pursue the achievement of the CP 4 outputs in a cost-effective manner.

Assumption 22: Sufficient financial resources were available under CP 4 to pursue the achievement of the CP outputs including the leveraging effect of the resources provided.)</td><td colspan="2">Indicators:
i. Adequate human resources with expertise (including consultants), have been in place for the output areas since the beginning of the CP for delivering quality programmes
ii. Reports on spot checks- Evidence of coordination and complementarity among the programme components
- Evidence of quality of UNFPA technical assistance and appreciation of technical assistance
- Staff performance management system in place
iii. Evidence of utilization of equipment and other resource materials purchased for a particular intervention
iv. Evidence of human resource management in UN Joint programming that enhances cost-effectiveness
v. Utilization plan (follow- up activity) of the staff who underwent capacity development training</td></tr>
<tr><td colspan="2">Data collected [must be strictly linked to the assumptions and corresponding to the above-indicated indicators]</td><td>Sources of information [List the source(s) of evidence for each of the data collected]</td></tr>
<tr><td colspan="2">Human Resources: CO runs with a small staff, but they backstop for others when in need. AY project office r's post has been vacant for some time and the M&E officer covers the youth portfolio. However, the workload is too much during high reporting periods such as Coordination with RCO, monitoring needs, progress reviews and annual reporting. Organogram – based on the CO organogram there are vacancies that needs to be filled. One crucial area is the AY position. Without a designated officer, AY programme suffers. There may be a saving as the M&E officer is now looking after the Youth programme. But how effective that is yet to be seen and measured. Budget deficits in key areas

INETL – Census was done, but DHS could d not be accomplished. An example of a cost saving is the reuse of some equipment that was bought for census, in the DHS implementation The Redatam and census dissemination dashboard is ready and available on the INETL's website since June (2024) and this will provide the opportunity to process micro data of population and household censuses, surveys and vital statistics. Although UNFPA planned to bring a technical consultant on board to enhance the capacity of INETL staff on this, the opportunity was missed due to limited funds. PD outputs, planned during CP4 could not be delivered due to resource limits.

Financial Resources:
Similarly, due to resource limitations – HIV related programme had to be closed (details under SRHR).
Lack of integration within office- HIV/AIDS, more needed with other areas
MOU with PNTL (although the project period was not over) was not signed due to resource limitations (more under SRHR)

Implementation by CSOs- UNFPA uses CSOs effectively and efficiently. However, the CSOs working on similar work seem have different modules and SOPs, which may challenge the effectiveness. UNFPA need to monitor them closely in the field. Long-term partnership with CSOs have built a good rapport which is positive.</td><td>Secondary data - Desk review/document analysis
● UNFPA CPD, CPAP, annual reports, M&E reports
● CO Staffing organogram
● Job descriptions
● Project monitoring and progress reports SMT dashboard
● IP Annual Work Plans (AWPs) and reports
● UN Joint programme reports
● IP administration/finance UNFPA SMT, administrative and financial staff

Primary data - Semi-structured key informant interviews (on-line or in person)

● UNFPA staff, other relevant UN agency staff
● donors</td></tr>
</table>

Based on SI report, there are concerns that in efforts to maximise the opportunities of the joint approach, the joint model at this scale (it is large budget) may not, on balance, have added value in financial terms. The model involved 7% cost recovery budgets for each receiving UN agency, amounting to Us$ $925,234 (much of which could, with fewer UN Agencies, have been available directly for implementation.) Management costs for the 5 UN agencies s also were budgeted at $2,307,291. Together these amount to 23% of the EU contribution. A similar proportion, US$ 5,457,580 or 26% of the EU contribution was allocated to awards and transfers to partners. This was a concern by the donor side as well and raised the issue of cost efficiency for the work on the ground. However, observing the work on the ground, much has been done on the ground, coordinating several organizations – government, non-government and UN- which would not have been done if an independent consulting firm had to accomplish what was done on the ground at a lower cost. CSO capacity enhancement, UN agency contribution and government coordination can be some sustainable achievements for the country – but this trend of working together needs to be maintained and lessons learned should be applied for positive results. Some competition among the UN agencies for the resources was also observed. Due to premature exit from successful projects due to ending the funds, UNFPA lost what was invested in needy interventions like HIV prevention. For example, with the end of the project with Global Fund, UNFPA support stopped to the CSO. The CSO managed to find some funds quickly, but UNFPA could have seen the results of the project had there been discussions with the programme staff and absorbing the project with the activities. Details are discussed under SRHR, missed opportunities. “the inputs on reducing stigma and discrimination could not bear fruit as the funding stopped and so did UNFPA’s support”. Support to youth is another area where UNFPA has not invested to see a change that will be valuable to the youth population. Looking at the expenditure patterns, (refer to financial table in the main report under the country programme) UNFPA did not reach 100% of its IRs. With a not too large pool of resources, engagement of IPs and developing their capacity to reach the targets set have been positive for UNFPA. During Covid-19 and floods situation, Co was able to appropriate funds to meet the needs of the affected populations and manage it to the fullest they could, given the human resources amid COVID-19 pandemic.	

Expenditure on Capacity Development interventions (see table below): According to 2023 Country Office MEL report, 37% of the budget was dedicated to capacity development and about 75 interventions had taken place. Altogether from 2021 to 2023, 196 interventions and 39% of the budget utilizes for capacity development. Based on discussions with IPs, some have been one-off events which they found not very useful. One key informant specifically suggested not to spend resources on one off events, but to plan in a useful way for more robust and sustaining results. It will be useful to categorise the capacity building interventions by duration and also by the objectives, so the key thematic areas could be combined and deliver more impactful events. Furthermore, there was no (ET did not see) strategic plan for a comprehensive capacity development.

Thus UNFPA *needs to develop a comprehensive capacity building plan to ensure a systematic approach* to training and other approaches to capacity building (CB). Within the CP4 there are several cross-cutting areas and CB interventions do not seem to be planned strategically to avoid duplication. However, throughout the evaluation ET found satisfactory results of capacity development (as cited in various places in the report under SRHR, GBV, AY and PD as well as in the humanitarian setting. One observation is that there was no inclusive training - *it is crucial to* ***provide additional resources that address inclusivity****, particularly for participants with disabilities ensuring that the training materials and methods are accessible to all, given the emphasis on LNOB*.. This may involve developing tailored educational resources that address specific disability issues and adapting training techniques to accommodate diverse learning needs. By fostering inclusivity, the program can ensure that all youth, regardless of their background or abilities, can benefit from the training and gain the skills necessary for cultivating healthy relationships.

CP4 (2021-2023) Type of Engagement and Expenditure

2021-2023 Type of engagement	# of intervent-ions	Budget Allocation	% of budget	Budget Utilization	% of budget	Average cost per intervention
Advocacy/Policy Dialogue and Advice	66	$1,981,172	15%	1,586,533	15%	$30,017.76
Knowledge Management	72	$1,951,896	14%	$1,417,539	13%	$27,109.67
Capacity Development	**196**	**$5,198,422**	**38%**	**$4,210,342**	**39%**	**$26,522.56**
Service Delivery	83	$4,127,398	30%	$3,191,700	30%	$49,727.68
Other	6	$115,645	1%	$59,719	1%	$19,274.23
Inter-agency and Humanitarian Sub-cluster	2	$145,485	1%	$127,612	1%	$72,742.45
Partnerships with traditional and non-traditional	3	$87,220	1%	$86,535	1%	$29,073.47
TOTAL	428	$13,607,238	100%	$10,679,980	100%	

Source: UNFPA CO 2023 MELReport, June 2024

Assumptions 23: UNFPA strategies and interventions in (SRHR and Adolescent SRH/GE/PD) add value to the work of other development partners, especially the UN system.	**Indicators:** i. Evidence of the quality of UNFPA Technical Assistance ii. Specific technical skills in UNFPA CO iii. UNFPA funding relative to other donors iv. Evidence of appreciation key stakeholders v. Other development partners adopting UNFPA strategies and good practices vi. Evidence of joint programmes that are worth scaling up (or seen as model examples)

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
Added Value By adding value to other agencies' contribution to the same end result, UNFPA maximizes the expected results in CP4 programme areas. capacity building of MOH for health response to GBV is a good example. Sustainable investments in curriculum development, training government cadre, policy and advocacy, UNFPA received value for money for its investments. UNFPA technical expertise is valued and accepted by all the development partners – especially in the areas of population data generation and analytics, maternal health with an emphasis on the sensitive topics such as sexual and reproductive health rights, HIV/AIDS, CSE, GBV, and rights issues, UNFPA has been able to add value to the development partners and gain results that have value for the money spent. However, one area that is under performing is ASRH and scaling up of CSE in schools and prevention of HIV/AIDS. Technical support to Census and related publications, contribution to policy and strategy papers that are being implemented and used, UNFPA has earned its fully worth. In capacity building – UNFPA with its in-house expertise as well as regional and global- has been able to contribute well to the development of the country. Partnering with other UN agencies on joint programmes, UNFPA has been able to avoid overlap and duplication of efforts in the field; this is clearly evident in the efforts towards gender equality and prevention of GBV. Building capacity of field-based IPs, UNFPA expends its coverage, leaving no one behind, with less overhead costs.	**Secondary Data- Document Review** ● UNFPA Annual reports, M&E reports ● Joint programme proposals ● Joint programme implementation reports ● Joint monitoring reports ● Donor reports ● IP reports **Primary Data - Interviews** ● UNFPA relevant staff ● UN Women, UNDP, UNICEF, ILO, IOM relevant staff ● GOTL counterparts, Development partners and key NGOs ● UN Results group, thematic group on Gender ● Humanitarian coordination group ● Key persons from Spotlight Initiative, KOICA and Zonta ● KII, online survey (by UN women)

Assumptions 24: Partnerships under CP 4 (NGOs, Academia, CSOs, INGOs, UN partners and SSTC partners) enabled high- quality technical assistance and human rights-based approaches, in a cost effective manner to pursue the achievement of the results, leaving no one behind.	**Indicators:** i. Partnership strategy in place ii. Evidence of transparent IP selection process in place iii. Evidence of appropriateness of IP selection criteria to deliver cost effective interventions iv. Evidence of donor satisfaction with UNFPA delivery mode and effective partnerships v. Evidence of building technical capacity for conducting behavioural research, midwifery, and health sector response to GBV vi. Evidence of use of SSTC to build capacity of partners vii. Sharing resources based on the expertise

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
SSTC With regard to building capacity of the midwifery schools (3), UNFPA is the only agency supporting the same. The support has also enabled South-South and Triangular Cooperation (SSTC) with Khon Khaen University in Thailand. However, more needs to be done in terms of aligning fully with ICM curricular standards and competencies. UNFPA's initiative in strengthening midwifery education in the country through support to pre-service education is commendable and provides an opportunity to link with the pre-service education support for responding to GBV (latter also an ICM core competency) and the SSTC established with Khon Khean University through TICA is appreciated. However, much more needs to be done in aligning the curriculum and training to ICM standards and develop a unified midwifery curriculum for Timor-Leste. UNFPA should take the opportunity to incorporate the guidelines for intrapartum care (part of BEmONC modules), ANC and PNC guides, FP training materials and MISP. Suggest providing training to midwifery tutors in the subjects listed. There was no evidence of advocacy to Ministry of Higher Education to create regulatory bodies. Currently, there is no in-country expertise on ICM standards to guide the development of the midwifery course. It is also important to undertake a National Health Worker Account to get an estimate of number of midwives available, working status, etc. Evident from the document review (progress monitoring reports) and interviews with relevant staff from the CO and implementing partners, the progress at the level of project activities and outputs has been regularly monitored and reported and corrective measures attended to. Monitoring data have been considered during planning processes. The absence of risks and assumptions and risk mitigation plans and conflict sensitivity management plans were weaknesses in the system. In the joint programmes the specific roles were clear, however, there was no apparent integrated indicators set up to enable the measurement of each party's contribution to the planned outcomes. This in part, is due to the lack of application and absence of a theory of outcome for the intervention. One advantage in the joint programme was the defined rules of engagement at different levels (national, municipal and sub municipal level) avoiding any duplication of efforts. Joint monitoring mission reports showed evidence that monitoring was done extensively with detailed reports on results and target achievement with action plans that were established as follow up. All parties engaged in the joint activities have participated in the monitoring exercise to review the progress in a systematic and rigorous way. The CO also supported independent evaluations of selected interventions, for accountability to the donors and other stakeholders. For quality assurance and speedy implementation, HACT micro assessment of IPs has been done. UNFPA's IP base has been an added benefit to the government and other development partners as well. UNFPA, with its limited human resources and budget has been able to work with strategic partners to leverage and deliver, optimizing on the technical expertise within UNFPA CO and outside if and when it was needed.	**Secondary data - Desk review/document analysis** ● UNFPA CPD, CPAP, annual reports, M&E reports ● IP reports ● Partnership strategy in place ● Rationale for selection of IP ● UNFPA partner selection report ● Report of IPs ● Partnership strategy ● Reports of technical assistance from partners ● SSTC reports **Primary Data** - On line interviews, Semi-structured key informant interviews (on-line or in person) ● UNFPA staff ● Relevant NGOs ● UNFPA SMT, Admin/Finance ● Government partners (MOH, MOYS, Ministry of Solidarity and Social Inclusion, Office of Secretary of State for equality and inclusion) ● IP staff, administration and finance ● Universities Mahidol, UNTAS, Burnett, La Trobe

Assumptions 25: CO had the flexibility to adapt the allocation of funds for pandemic response and humanitarian crisis for delivery of interventions through modified delivery platforms including for vulnerable populations	**Indicators:** i. Evidence of re-organized CP budget for COVID-19 ii. Evidence of re-organizing programmes and procedures for logistics, procurement, etc. for responding to COVID-19 crisis iii. Modified delivery platforms created for continuing capacity building iv. Modified delivery platforms for service delivery created

Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Most government funds are dedicated to response to Covid-19 rather than regular activities; consequently, funds from agencies allocated for regular programs. Time slot is very limited when the government declares back to normal work, competing priorities, making it difficult to prioritize which activities must be implemented first. **Expenditure against work plan activities**	**Secondary Data** - Desk review/document analysis ● UNFPA CPD, CPAP, annual reports, M&E reports ● Reports of response to COVID and floods ● UNCT reports **Primary Data** - Semi-structured key informant interviews (on-line or in person) ● UNFPA staff ● relevant NGOs ● UNFPA SMT, POs, Admin and Finance staff ● UNRC, other UN agencies ● MoH, Secretary of State for equality and Inclusion

Description	**SRH Program**	**GBV Program**	**Total**
Total fund received	$41,253	$47,761	$89,014
Total expenditure	$40,466.65	$39,784.80	$80,251.45
Remaining balance	*786.35*	$5,042.46	$8,762.45

Evaluation Question 6: **To what extent has UNFPA been able to support implementing partners and beneficiaries (rights-holders), in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?**

Evaluation Criteria: Sustainability	
Assumptions 26: Capacities of implementing partners and beneficiaries have been developed because of program interventions, in SRHR, GE, GBV, AY and PD, enhancing the durability of effects of both development and humanitarian interventions	**Indicators:** i. Evidence of capacity development of implementing partners in terms of on-going efforts to improve access to comprehensive SRH including services ii. Evidence of capacity development of implementing partners in terms of on-going efforts to integrate and enhance GE, including GBV services, services for AY and interventions under PD. iii. Evidence of exit strategies and the plans for smooth handover. iv. Evidence of implementation of CSE and plans for the government to cover the schools in the country v. Evidence of capacity development among implementing partners to raise resources for continuing the on-going activities vi. Capacities of beneficiaries enhanced both in development and humanitarian related interventions to demand services and increase uptake of services vii. Capacities of community and religious leaders enhanced to advocate for stigma and discrimination for PLWHIV and for improved access to services for FP, GBV prevention
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Finding: The capacity building initiatives in family planning, health sector response to GBV, MISP, BEmONC and ANC and PNC have certainly built the capacity of the implementing partners at the national and municipality level (discussed under Finding 5,6,7) based on information built on other assumptions). The intervention related to capacity building of midwifery schools in competencies prescribed by ICM including in health sector response to GBV, is sustainable and probably will minimize the need for in-service training (see Finding There was no exit strategy or plans for smooth handover of activities to implementing partners in the case of implementing partners for the activities related to HIV (as discussed under Finding 6,7). Under the HIV programme, capacity of the CSO was built not only in writing reports and writing proposals for resource mobilization (as discussed under Finding 7). Under maternal health, education on importance of institutional deliveries, birth preparedness, etc. have built the capacity of pregnant women and their families to use facilities for delivery was discussed under Finding 8.	**Secondary Data - Desk Review/Document Analysis** ● UNFPA annual reports ● IP AWPs and reports ● IP reports on fund raising initiatives ● Report of behavioural surveys on maternal health service utilization ● Report of assessment of stigma and discrimination towards PLWHIV. ● Progress reports (GE, Gender, AY, PD) ● Reports of COVID 19 and flood response

Capacities of key populations were built through capacity building of educators from the same community in providing information on basic package of services for prevention of HIV and STIs and the importance of testing and where to get testing from. The capacities of the key populations were built in prevention such as use of lubricants, correct and consistent use of condoms (including female condoms for female sex workers) and getting tested (Finding 7 provides details). Capacities of community leaders and religious leaders were enhanced to advocate to stop stigma and discrimination towards PLWHA (Finding 7), however the activity could not be continued due to no funding support from UNFPA. The health sector response to GBV has a full component on mobilizing communities for prevention of GBV and reporting cases of GBV. Based on SI information, above and beyond the central focus on survivors and women and girls at risk of violence, the main strategy for implementing the LNOB principle was in the strong involvement of a diverse group of CSOs in the programme. This included attention to ensuring the representation of diversity in the coordination mechanisms for this involvement – the CSRG.	**Primary Data - Semi-structured Key Informant Interviews (on-line or in person)** ● FGDs ● key populations, peer educators of key populations, young people, women, Community and religious leaders ● UNFPA SMT, POs ● Implementing partners ● INGOs

Evaluation Question 7: **To what extent did UNFPA achieve government ownership of various interventions (BEmONC, Safe Spaces, ANC-PNC, Family Planning, HIV, Census)?**	
Evaluation Criteria: Sustainability	
Assumptions 27: Commitment of the government for the interventions supported by UNFPA is achieved	**Indicators:** i. Evidence of operational Logistics Management Information System (LMIS) in health facilities ii. Evidence of budget committed to /Increase in contribution of MOH funds for procurement of contraceptives iii. Midwifery training, meeting ICM standards, continuing in the 3 schools supported under the current CP by UNFPA iv. MOH Plans for expansion and certification of BEmONC available including budgets v. Evidence of provision of integrated SRH services in CHCs vi. Evidence of advocacy to revise the National FP Policy to enable access of adolescents to contraception vii. MISP included in national preparedness plans and required supplies and commodities. viii. Evidence of Safe space operation even after donor funding has come to an end
Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
Finding: UNFPA has strengthened the logistics management information system for family planning as well as the m-supply system for majority of the commodities needed by health services. Though there are few areas that need improvement, the fact that it has been implemented at the national INFPM and regional INFPM, HNGV, regional hospitals and CHCs is a sign of commitment of the government to carry out the intervention (see Finding 5,6) There is evidence of committed budget under the TPP mechanism for procurement of contraceptives and other RH supplies (USD 342,745 and 240,648 in 2022 and 2023. ICM curriculum for midwifery training has been implemented in the three midwifery schools; however, there are issues related to uniformity of the curriculum in the three institutions (see Finding 10). The plans for expansion of BEmONC facilities and certification is jointly done by MOH and UNFPA. The main concern is the repair/replacement of equipment and instruments once the funding stops. The concept of integration is not clear regarding provision of services in the essential service package according to the level of health services or it is integration of various services as applicable. MISP is still not part of the national disaster preparedness plans and there are plans to advocate the same. With the contextualization of MISP guidelines and capacity building of providers, it should be possible to roll out MISP in emergencies.	**Secondary Data** - Desk review/document analysis ● UNFPA annual reports and M&E reports, financial reports ● IP AWPs and reports ● MOU signed between UNFPA and SAMES on third party procurement of contraceptives ● MOU signed between UNFPA and MOH for provision of third-party procurement and technical assistance. ● Government annual budget ● Government health infrastructure development plan ● Progress reports of midwifery schools ● Assessments on implementation of integrated SRH services ● National disaster preparedness plans ● Reports of consultations on revision of National FP Policy

As stated under Finding 5, the advocacy to develop a rights-based family planning services was not adequate. Because of the health system involvement at all levels, the interventions are likely to continue. Another sustainable input that is being planned is the inclusion of health sector response to GBV in the pre-service curriculum of midwives, nurses and doctors in collaboration with the Office of the Dean of Faculty of Medicine and Health Sciences.	**Primary Data** - Semi-structured key informant interviews (on-line or in person) - FDG • MOH staff, UNFPA SMT, POs • MCH and finance, disaster management personnel, -INFPM • UNTL – division responsible for midwifery education • Field visits to safe spaces, observation
Assumptions 28: Government/partners/ NGO stakeholders' capacities and mechanisms are improved for ownership and continuation of resource commitments and or allocations.	**Indicators:** i. Established sustainability mechanism for the programme ii. The likelihood of the programme and its benefits to be sustainable iii. Established systems to continue the programme iv. Capacity development including staff, training date disaggregated by sex and age. v. Community and country ownership including financial resource commitments vi. Partner organizations with sustainability plans
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
UNFPA's Value-Added Contributions • **Recognition and Inclusion**: UNFPA recognizes its implementing partners and involves them in events and policy dialogues. They also include the ALOLA logo in media and communication materials. • **Capacity Building**: UNFPA provides capacity building on financing and reporting before project implementation, along with strong technical assistance and advice. • **Flexibility and Quality Assurance**: UNFPA is flexible with implementing partners regarding funds while ensuring the quality of implementation. Some challenges that came up: Challenges (with one CSO) • **Limited funding** and short project durations make it difficult to effectively measure changes and results in the community and behaviour. • **Lack of exit strategy** and inconsistent funding commitments from donors. For example, the Safe Birthing program was cut short, and a promised car for the program never materialized, leading to backlash from community leaders. • The Spotlight Initiative's community awareness and Comprehensive Sexuality Education (CSE) activities could not be implemented in many schools, despite readiness. Recommendations • Field Support: Improve support for field operations. • Capacity Building: Increase capacity building for midwives at the suco level in planning, M&E, etc. • Workshops and Networking: Involve all implementing partners, especially local NGOs/CSOs, in workshops to increase networking and exchanges with international partners. • Synergy: Enhance synergy among CSOs and NGOs for improved and effective implementation of NAP-GBV.	**Secondary Data** - Desk review/document analysis • Country Programme Reports • UNFPA; Reports. • IP progress reports, relevant sector • strategic plans • Special study reports; Mid-term review reports, Strategic plan evaluations for sectors including health, community/social sectors. **Primary Data** - Semi-structured key informant interviews (on-line or in person) National Level Stakeholders • UNFPA staff, Government, IPs staff, • and Heads of Departments (Health, Gender, Social Welfare, Education and Planning) • Relevant field level IPs

Evaluation Question 8: To what extent is the UNFPA country office benefited from coordinating with other United Nations agencies and partners in the country to ensure complementarity, particularly in the event of potential overlaps?	
Evaluation Criteria: Coherence	
Assumptions 29: UNFPA CO has actively contributed to UNCT working groups and joint initiatives. (How UNFPA benefitted by actively contributing to the UNCT is being discussed in detail in the following three assumptions 39, 31 and 32)	**Indicators:** i. Evidence of a common understanding amongst UN agencies on the division of tasks in terms of the UNFPA mandate and outcome areas of CP4 to reap the benefits without overlap ii. Evidence of consultative meetings at the inception of programme iii. interventions iv. Evidence of active participation in UN working groups v. Evidence of leading role by UNFPA in the working groups/joint initiatives corresponding to its mandated areas

Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
(How UNFPA benefitted by actively contributing to the UNCT is being discussed in detail in the following three assumptions 39, 31 and 32) Based on CF evaluation, no avenues or mechanisms within UNCT itself to share the knowledge developed by each Agency and to build more comprehensive and deep understanding of various dynamics evolving along different priority areas on the development landscape in Timor-Leste.	**Secondary data - Desk review/document analysis** Programme Documents, Minutes of UNCT meetings, M&E reports, UN Agency representatives, financial documents, **Primary data - Semi-structured key informant interviews (on-line or in person)** UNCT members, UNCT Coordinator, UNFPA CO, UN Women, EU, Gender networks at national and sub-national levels, Results Groups and other UN thematic groups and results groups, UN Women Regional Office

Assumptions 30: With a clear division of labour and good understanding towards similar objectives., UNFPA has contributed to the good functioning of coordination mechanisms and to an adequate division of tasks (i.e. avoiding overlap and duplication of activities/ seeking synergies) within the United Nations system	**Indicators:** i. Evidence of coordination between GBV programme officers, GBV networks, national level and sub-national level point persons dealing with GBV prevention and health response to GBV. ii. Extent of complementarity of efforts under joint programmes. (i.e. Spotlight Initiative) iii. Work at sub-district level, community level reflect integration avoiding overlap iv. Reports from joint missions v. M&E reporting – how results are reported vi. Satisfaction with the way relevant UN agencies work together (i.e. on Gender Equality and Women's Empowerment outcome)

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
Strategically, UNFPA maintained its presence in policy and key decision functions related to UNFPA mandate, evident from the list of active working groups and results groups in the UNCT and the role that UNFPA plays. UNFPA's corporate strengths are well recognized and acknowledged by other UN members who responded to the interviews. Some examples of current engagement in various capacities are: Joint UN Partnership projects with UNFPA, UNICEF, UNDP, UN Women, ILO and IOM. CO contributes by coordinating the UN programmes on gender equality and gender-based-violence, UN Gender Technical Working Group (GTG) is co-chaired by UNFPA with UN Women. UNFPA CO participates actively and contributes to the UNCT coordination mechanism via technical groups, results groups, management and operations teams, supporting the RCO and UNSDCF. Furthermore, CO strengthened the coordination by actively engaged in UN joint programming, sector coordination, monitoring and evaluation teams, data sharing and in humanitarian preparation and response. During the absence of RC, UNFPA has taken up the RC responsibilities as RC a.i UNFPA's successful and long-established coordination with the government and donor agencies have shown positive results as evident in the discussions under the effectiveness criteria in the programmatic areas of SRHR, GEWE, GBV, AY and PD including in the humanitarian response. Youth RG is chaired by UNFPA and despite a dedicated youth officer the RG is active. Documented evidence shows (SI evaluation) siloed work cultures and limitations to coordination continue to be identified by respondents as an impediment to effective joint work; and therefore, missed opportunities to synergise offered by the joint approach. Also from the key informant discussions, SEII explaining the point of view of government, felt the burden of meeting agencies and IPs individually was reduced. SEI which led the steering group and meeting the UN agencies working o SI for example, felt that the joint approach did ensure some harmonisation of the UN approach and relationship. Some cross-government coordination was also facilitated – for example, quarterly ministerial meetings were held; and in more granular terms there was progress in the coordination of GBV case management across the ministries responsible for the referral network. However, for most other Ministries other than SEII, the strategy of working to RUNO strengths meant that it was generally business as usual with their pre-established UN counterpart. (more input expected from the CF evaluation on coordination.) SI had six key pillars, and each UN agency took responsibility to deliver the results based on the mandate and expertise. Six pillars had six individual TOCs and on the ground each agency worked independently, and the advantage of coordination was not used optimally.	**Secondary data - Desk review/document analysis** Programme Documents, Minutes of UNCT meetings, M&E reports, UN Agency representatives, financial documents **Primary data - Semi-structured key informant interviews (on-line or in person)** UNCT members, UNCT Coordinator, UNFPA CO, UN Women, EU, Gender networks at national and sub-national levels, Results Groups and other UN thematic groups and results groups, UN Women Regional Office

Assumptions 31: UNFPA partnered with other development agencies (govt, non govt) working towards the same objective (same end results) without duplicating efforts (and resources).	**Indicators:** i. Evidence of coordination with other agencies (gov/non gov) ii. Evidence of data and information sharing iii. Joint reporting and indicator settings with other partners

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*

1. Multi-Stakeholder Collaboration and Coordination UNFPA Timor-Leste has established partnerships with various organizations (mainly local organizations/civil society organizations such as FOKUPERS, BELUN, ALOLA FOUNDATION, and HAMNASA) to promote gender equality and women's empowerment, particularly in implementing the National Action Plan on Gender-Based Violence (NAP-GBV). This collaborative approach aims to maximize impact, support grassroots advocacy, and leveraging the knowledge of the local organization in the local context while avoiding duplication of efforts and resources. The Secretary of State for Equality and Inclusion chairs and coordinates GBV efforts, ensuring that all supporting actors and stakeholders adhere to the same guidelines. Key partnerships include government agencies such as the Secretary of State for Equality (SEI), Ministry of Health (Integrated SRHR), Ministry of Education and Ministry of Youth, Sports, Arts and Culture (CSE), and Ministry of Social Solidarity (case management and coordination of referral pathways – involving important/relevant stakeholders in the provision of services to the survivors) 2. Key Initiatives and Activities of Coordination/Collaboration UNFPA's efforts in supporting the implementation of NAP-GBV encompass several key initiatives. These include policy development, where UNFPA has supported the enactment of the Law Against Domestic Violence (2010) and the revision of NAP-GBV. Capacity building is another focus area, involving training health personnel to respond effectively to GBV survivors' needs, as well as enhancing the capacity of government officials and NGOs to monitor and evaluate NAP-GBV implementation. Community interventions are also crucial, with activities aimed at reducing GBV cases, disseminating information about available services, and encouraging the reporting of incidents. UNFPA coordinates the construction of Safe Spaces for GBV survivors in various municipalities and has developed National GBV Response Guidelines for Health Professionals, alongside training packages based on WHO curriculum. Additionally, UNFPA focuses its support on data collection and analysis related to GBV to inform ongoing efforts. 3. Challenges and Areas for Improvement Despite these coordinated efforts, several challenges and areas for improvement have been identified. Sustainability is another concern, as many initiatives are project-based and may not continue after initial funding ends, highlighting the need for both short-term and long-term planning. Furthermore, there is a lack of direct collaboration with organizations representing vulnerable groups, such as people with disabilities, LGBTQ+ communities, and survivors of other forms of violence. Questions regarding exit strategies and sustainability with implementing partners and communities also arise.	• Evidence of UN partnership/leadership on health response to GBV, child marriages, DV and other discriminatory practices • Evidence of UN partnership in GBV prevention area • Evidence of UN partnerships/leadership in gender integration in SRH, A/YSRH and PD interventions • Evidence of UN partnerships/leadership on MISP in SRH in disasters/pandemic • Evidence of UN partnerships around gender and SDGs/ICPD/CEDAW/BPFA (relevant to mandate of UNFPA) • Evidence of leveraging funds on Gender programs
Assumptions 32: UNFPA partnerships with other UN agencies and other aid agencies harnessed the best possible support towards gender-specific mandates of CP4, with UNFPA taking leadership is gender equality areas where it has expertise (applies under Coherence as well)	**Indicators:** **i.** Evidence of UN partnership/leadership on health response to GBV, child marriages, DV and other discriminatory practices **ii.** Evidence of UN partnership in GBV prevention area **iii.** Evidence of UN partnerships/leadership in gender integration in SRH, A/YSRH and PD interventions **iv.** Evidence of UN partnerships/leadership on MISP in SRH in disasters/pandemic **v.** Evidence of UN partnerships around gender and SDGs/ICPD/CEDAW/BPFA (relevant to mandate of UNFPA) **vi.** Evidence of leveraging funds on Gender programs

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
UNFPA coordinates with line ministries with strong collaboration from the highest political (ministerial) level down to the technical level, supported by a well-functioning communication strategy. MSSI's Directorate for Social Protection has established productive partnerships with several UN agencies, including UNICEF for child protection and national social protection strategies, ILO for Strategy for Social Protection, WFP for nutrition initiatives, UN Women for various projects including the planning for hotline management for survivors, and the UN Human Rights Office for social inclusion efforts specifically for people with disability (it's currently in discussion – the establishment of Council for PwDs – it has not been discussed in depth). The meeting with UNHCHR and UN Women was also on preparation to the report to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). While MSSI has formalized MOUs with UN Women and UNICEF, it currently lacks an MoU with UNFPA. Despite the overall positive coordination, challenges are there arising from the distinct mandates and implementation procedures of multiple UN agencies, which are further complicated by the intricate nature of Gender-Based Violence issues that require comprehensive approaches and cross-agency collaboration. Partnerships and Coordination: • Gender equality principles are embedded in all partnership agreements, ensuring that implementing partners are committed to advancing women's empowerment (UN Joint Coordination programmes and collaboration with local CSOs and NGOs). • UNFPA as a co-chair of UN Gender Thematic Group, coordinated with other UN agencies to review the monitoring and evaluation framework of the 2nd NAP GBV, ensuring effective implementation of the plan and measure the change and any improvement. • CP4 promotes coordination among various stakeholders (including donors such as KOICA, EU and Zonta International) working on gender issues, fostering a more cohesive and impactful approach to addressing gender inequality.	**Secondary Data- Desk review** Reports of UN gender task force meetings Report of humanitarian task force meetings Minutes of inter-agency task force meetings **Primary Data** - KII interviews, FGD , Online interviews Discussion with UN Rep/Assistant rep Discussion with gender/related treks force members Results groups, GW gp, CWGs Discussion with MISP in RH task force, if absent humanitarian task Discussion with non-UN donors working on similar issues UNICEF gender focal person UN Women gender focal person Gender task force MISP in RH task force

Assumptions 33: Joint programming reduced overlaps in the interventions directed to GBV prevention and awareness programmes	**Indicators:** **i.** Availability of joint programme proposals with clear delineation of responsibilities **ii.** Evidence of joint implementation of the programme **iii.** Joint monitoring reports **iv.** Evidence of UNFPA playing a leading role in its mandate areas **v.** Extent to which results were achieved through joint programmes **vi.** Evidence of human resource management arrangements in Joint programming that enhanced cost-effectiveness (relates to Efficiency criteria as well) **vii.** Evidence of human resource management under joint programming **viii.** Transaction costs of UN joint operations are considered to outweigh the benefits created in terms of results achieved

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
Notes: (Discussed under above assumptions as well) UNFPA Timor-Leste collaborates closely with other UN agencies, including UN Women, UNDP, UNICEF, ILO, and IOM, as well as international donors such as the European Union (EU), Korean International Cooperation Agency (KOICA), and Zonta International. Two major GBV projects, the EU-UN Spotlight Initiative and the KOICA-UN Together for Equality (T4E), exemplify these partnerships. These initiatives aim to leverage the comparative advantages of UN entities, working in tandem with government, civil society, and donor partners to achieve greater synergy and results in addressing gender-based violence. However, concerns have been raised regarding coordination among UN agencies. Differing mandates and procedures can hinder the achievement of greater synergies and results. Some government officials have suggested that UN agencies could enhance their coordination efforts. Donors like KOICA have noted challenges in standardizing report formats and procedures, while the EU has expressed concerns about the wider impact on beneficiaries relative to the allocated budgets. The implementation of the National Action Plan on Gender-Based Violence (NAP-GBV) in Timor-Leste has faced challenges related to coordination and sustainability. Implementing partners and donors like KOICA have noted inconsistent joint monitoring practices involving UNFPA, donors, and implementing partners. This issue is exemplified by the discontinuation of support for certain initiatives, such as the development of Standard Operating Procedures (SOPs) for case management led by the Ministry of Social Solidarity and Inclusion (MSSI). These observations highlight the critical need for enhanced coordination among UN agencies, improved sustainability of initiatives, and strengthened monitoring and evaluation practices. Implementing partners suggest that UN agencies could better leverage their technical expertise to support local partners in advocating for and contributing to the implementation of NAP-GBV.	**Secondary Data** - Desk review/document analysis UNFPA Annual reports, M&E reports Joint programme proposals Joint programme implementation reports Joint monitoring reports Donor reports IP reports **Primary Data** - Semi-structured key informant interviews (on-line or in person- Online interview UNFPA relevant staff UN Women relevant staff UN Results group on Gender Key persons from Spotlight Initiative, KOICA and Zonta UNFPA SMT, POs Partner UN agencies IPs implementing joint programmes Government (Secretary of State of Inclusion and Equality)

Evaluation Question 9: **To what extent has UNFPA humanitarian action appropriately targeted at the varied needs of population groups facing life-threatening suffering, particularly those within groups that are hard-to-reach and "furthest-behind"?**
Evaluation Criteria: Coverage

Assumptions 34: During COVID-19 pandemic and floods, UNFPA response targeted population groups facing life-threatening conditions, particularly those that are hard to reach, vulnerable including PWD.	**Indicators:** During COVID 19 pandemic i. Reactivation of the SRH sub-cluster under health cluster ii. Evidence of coordination and support to MOH and other national partners to ensure minimum disruption of SRH services including services for survivors of GBV, protection of health service providers and facility strengthening for safe maternal care. a. Capacity of health service providers built on care during pregnancy and childbirth and EmONC during the pandemic iii. Capacity of midwives built in life saving interventions during pregnancy and childbirth iv. Evidence of GBV response v. Evidence of awareness creation on GBV prevention and care seeking a. Evidence of continued support to key populations to access HIV prevention services and testing b. Evidence of continuation of supply systems for RH commodities and supplies During the floods vi. Evidence of support for SRH services including services for GBV in camps for displaced people vii. Evidence of supporting the needs of pregnant women, women and girls through supply of maternity kits and hygiene packs. viii. Evidence of psychosocial support to displaced families ix. Social and Behavioural communication on SRH advocacy and communications, GBV prevention

Data collected [*must be strictly linked to the assumptions and corresponding to the above-indicated indicators*]	**Sources of information** [*List the source(s) of evidence for each of the data collected*]
During CP4, major humanitarian issue faced by UNFPA was the COVID-19 pandemic (Apr 2020) and the floods that hit the country around the same time. UNFPA initiatives responded to this with essential SRH and GBV services. UNFPA, responded nationwide floods during the COVID-19 pandemic in CP4. According to the UNFPA reports, the estimated number of affected Population: 13,554 of which the number of Women of Reproductive Age (WRA): amounted to 2,982 with pregnant women being 345. UNFPA estimated the target beneficiaries to be 745 and USD 89,014 was approved by HO and this budget was distributed as follows:	

Expenditure against work plan activities

Description	SRH Program	GBV Program	Total
Total fund received	$41,253	$47,761	$89,014
Total expenditure	$40,466.65	$39,784.80	$80,251.45
Remaining balance	*786.35*	$5,042.46	$8,762.45
Implementation rate	**98%**	**83.3%**	**90.16%**

Number of Pregnant Women: 345, Estimated UNFPA Targeted Beneficiaries: 745; Amount approved by HO: 89,014
Procurement and Distribution of maternity packages for women and pregnant women who affected by flooding in Timor-Leste 345 pregnant women affected by the flooding received 345 maternity packages, containing basic needs for pregnant women and babies. 245 packages distributed to beneficiaries who reside in 9 other affected districts, while 100 packages were distributed to the beneficiaries in Dili. Each packages cost $56 for a total cost of is $23,955.50

Printing of adapted IEC materials: Adaptation of IEC promotional materials from RO for pregnant mothers on Covid-19 in the local language, in consultation with Health Promotion Department, the Ministry of health, in the form of brochures and posters for a total cost of $1,845.60. (Humanitarian narrative Report, UNFPA TL, 2022)

Finding: The SRH cluster, under the Health Cluster, was reactivated under UNFPA's leadership and monitored the continuation of services during the pandemic and also incidence of GBV.
UNFPA along with WHO to reactivate the dormant MNCH technical working group which included representatives of UNICEF, NGOs and INGOs. The group regularly monitored service disruption, morbidities and mortalities in close coordination with municipal health authorities.
Capacity building of health providers continued through on-line communication on life saving BEmONC and guidelines for care during pregnancy, childbirth and postnatal period of COVD negative and positive were developed.
Special efforts to sensitize women and adolescents, families and communities were made about prevention of GBV and where to seek care. Efforts were made to ensure access of key populations to basic service package which was not always possible.

There are no reports of shortage of supplies during COVID or floods.
UNFPA Timor-Leste has demonstrated a comprehensive approach to addressing the needs of vulnerable populations during crises, particularly focusing on sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) prevention and response.

Secondary data - Desk review/document analysis

- UNFPA Annual reports, M&E
- Reports on response to floods and COVID-19
- Sit reports
- Humanitarian project monitoring reports
- IP reports
- Report on mobile maternity clinics
- Report on health and protection of mobile teams
- Reports on cluster meetings
- Reports on midwifery training provided online

Primary data - -Interviews and FGDs, Semi-structured key informant interviews (on-line or in person)

- UNFPA SMT, Humanitarian focal point, POs, APRO
- MoH (MCH and humanitarian)
- WHO, UNICEF, UN Women
- IPs who were involved in humanitarian
- Municipal health officers
- Health service providers in flood affected districts
- FGDs Health service providers,
- Women, girls (including from flood affected areas), key populations, PWD
- Burnett University/APRO

Objectives and Adaptations

The fourth Country Programme (CP4) of UNFPA Timor-Leste has been adapted to address the SRHR needs of women in the general population, including vulnerable groups such as pregnant women and survivors of violence. While the program covers humanitarian settings, there are limitations in services available to adolescents, youth, and people with disabilities, whose vulnerabilities increase during crises like the COVID-19 pandemic and flash floods.

Crisis Response and Visibility

UNFPA demonstrated significant visibility during both the COVID-19 pandemic and the 2021 floods in Timor-Leste. Efforts included:

- Supporting communication campaigns on GBV prevention and response
- Providing services to GBV survivors during crises
- Participating in a comprehensive Socio-Economic Impact Assessment of COVID-19 (SEIA-2)
- Actively engaging in humanitarian response during the severe floods, which affected over 25,700 households across 13 municipalities

Humanitarian Coordination and Preparedness

UNFPA Timor-Leste has taken several steps to enhance its preparedness and coordination in humanitarian settings:

- Developing and regularly updating an Annual Preparedness Action Plan
- Enhancing staff availability for critical functions during emergencies
- Improving the ability to quickly provide critical relief supplies to affected populations
- Maintaining constant communication with humanitarian partners

Data and Assessment

UNFPA played a crucial role in providing data to other humanitarian partners during crises. They ensured that:

- Available multisectoral assessments incorporated sex and age-disaggregated data
- Minimum SRH and GBV issues were included in assessment tools
- Four comprehensive assessment tools were designed to address SRH and GBV issues more thoroughly, manage information, and monitor responses

Ongoing Efforts

UNFPA continues to:

- Ensuring that SRHR and GBV services were integrated into humanitarian coordination mechanisms and strengthen humanitarian partnerships, particularly among UN agencies
- However, there was no report of a functioning inter-agency sexual and reproductive health coordination body because of UNFPA guidance and leadership during that year (mentioned in the 2021 Annual report as target but not reported). Distribute hygiene and sanitary items, including "Dignity Kits" and maternity packs
- Ensure access to information, services, and supplies for women and girls, and people with disabilities and other vulnerable groups affected by crises
- Support displaced communities in evacuation centres through UN Volunteers

Source: United Nations Population Fund of Timor-Leste Annual Reports (2021,2022 and 2023) Interviews with relevant GEWE component stakeholders Coordination and program management ● Reactivated and leads the SRH sub cluster under Health Cluster. ● Coordinated with national partners through the Health and Protection cluster coordination mechanisms. UNFPA facilitated discussions with national partners and implementing partners in developing humanitarian response strategies to ensure the continuation of essential SRH services, and prevention and response to GBV. Established and equipped a maternity isolation at Vera Cruz isolation centre. Led the development of the training modules for ANC, intrapartum and postpartum for women with COVID-19 include a session on sensitization on Gender-Based Violence (GBV). The guideline was widely used as a guide for mothers with Covid-19 in all isolation centres. ● Trained 4 batches of frontlines healthcare workers from the National Hospital and other Community Healthcare Centres (CHC) in Dili. ● Procurement and Distribution of maternity packages for women and pregnant women who affected by flooding in Timor-Leste 345 pregnant women affected by the flooding received 345 maternity packages, containing basic needs for pregnant women and babies. 245 packages distributed to beneficiaries who reside in 9 other affected districts, while 100 packages were distributed to the beneficiaries in Dili. Each packages cost $56 for a total cost of is $23,955.50 Printing of adapted IEC materials Adaptation of IEC promotional materials from RO for pregnant mothers on Covid-19 in the local language, in consultation with Health Promotion Department, the Ministry of health, in the form of brochures and posters for a total cost of $1,845.60. PPE equipment/Covid-19 prevention supplies: UNFPA have locally procured Covid-19 prevention supplies for our volunteers who provided services in the IDP camps and to support 14 health facilities in 9 districts who distribute maternity packages to the last mile beneficiaries. 16 packages of Covid-19 prevention supplies were also distributed to 14 health facilities during distribution of Maternity Packages. Total fund for this activity was $324 Distribution cost for IP to distribute Maternity Packages: UNFPA through ALOLa Foundation (UNFPA IPs) distributed 245 maternity packages for 160 pregnant women and 85 postpartum women affected by the flooding in 9 other districts (Aileu, Ainaro, Manufahi, Oecusse, Manatuto, Viqueque, Liquica, Covalima, Bobonaro and Ermera). Number of pregnant and postpartum mothers were identified through social protection and confirmed through MCH District Public Health Officer and Health Director of numbers of populations and pregnant mothers. Total allocations for distribution of 245 MP were $10,170.35 including operational cost. Out of this, ALOLa only spent $6,449.96. Some of districts where distribution of MP taking place was near each other, number of the days spent became less, as a result, Alola could not spend all the fund allocated for distribution. The package was distributed to 9 districts covered 160 pregnant women and 85 breast feeding women in 14 health facilities	

MISP Orientation: UNFPA is leading and coordinating the RH-sub cluster under Health Cluster Information and knowledge in MISP needs to be disclosed to the decision makers, program managers and staff so that everybody has the same understanding. The orientation and training were conducted for 22 participants including 2 UNFPA Program managers for GBV program. Orientation conducted with technical support from APRO and RH specialist. All UNFPA staff who were already involved in MISP training before were given the task to deliver the orientation utilized Sexual and reproductive health in emergencies An introduction to the Minimum Initial Service Package (MISP), A Training for Program Managers from IAWG and IPPF. The training started on 19 October and concluded on 21 October 2021. Certificate of attendant were given to all 22 participants and facilitator. Monitoring of volunteers in IDP camp and MP distributions activities: Regular monitoring for volunteers in Dili conducted on a weekly basis, Initially, there were 52 IDPs established, by May 24th only 15 IDPs remains and by the end of June 2021 only 6 IDPs exist. All IDPs were officially closed in August 2021. UNFPA and ALOLa staff conducted monitoring to verify MP that have been already distributed in 9 municipalities. Due to competing activities at end year, monitoring only conducted for 5 districts namely Aileu, Ainaro, Covalima, Manatuto and Viqueque. Total fund utilised for DSA was $588.	

Table: Number Affected 2021 Floods

(The number affected during 2021 is difficult to quote as different agencies at different time periods provided numbers that are not consistent. In an emergency situation this can be expected. We will use UNRC official figures as far as possible)

https://www.undrr.org/news/timor-leste-floods-teach-costly-lessons

United Nations Office for Disaster Risk Reduction - Regional Office for Asia and Pacific article published in January 2022 wrote: "The floods, said to be the worst the country has seen in 50 years, affected 13 municipalities and 30,322 households, destroyed 4,212 houses, and took 34 lives, the UN Resident Coordinator reported. Roads, buildings, and public infrastructure sustained damage. Agricultural areas covering 2,163 hectares were impacted and irrigation systems were wrecked. The CVTL said 53 evacuation centers were set up at the peak of the crisis"

https://reliefweb.int/report/timor-leste/timor-leste-floods-situation-report-no-11-16-july-2021

Based on the UNRC's Situation Analysis of July 16 2021: "According to latest official figures, as of 15 th of July, a total of 30,322 households across the country have been affected; of those, 82% - or 24,816 households – are in Dili municipality. A total of 4,212 houses were damaged throughout the country."

https://reliefweb.int/report/timor-leste/cvtl-2021-flood-response-7-jan-2022

Red Cross Timor-Leste's report based on corrected data from as of Jan 2022 - State Secretariat of Civil Protection (Government):

From the graphic:

30,367 Households, 151,835 people are affected

2,471 households, 14,181 people displaced

32 fatalities

9 missing

chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://laohamutuk.org/econ/21TLDPM/July/1.-Apresentasaun-TLDPM-MAE.pdf

Government report through the Ministry of State Administration during the Development Partners Meeting in 2021 reported:

30,350 families/households affected nationally [2021]

48 deaths/missing [2021]

731 displaced [2021]

Assumptions 35: Objectives of CP4 is adapted to the SRHR needs of adolescents, youth, disabled, and women in the population (including needs of the most vulnerable groups), in the humanitarian setting (includes flooding, and COVID-19 contexts during CP4 period)	**Indicators:** i. Evidence of UNFPA's visibility during the pandemic and the floods ii. Evidence of UNFPA's contribution to development of national guidelines for provision of FP and maternal health during COVID-19 and floods situation iii. UNFPA's contribution in the ASRH during COVID 19 and Floods situation iv. UNFPA's contribution in the prevention of GBV and services for GBV survivors during COVID 19 and Floods situation v. -Situational analysis of vulnerable populations during COVID and floods vi. -Funding and other support provided for supplies and equipment vii. -Evidence of provision of support for supplies

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*
During floods As discussed above, fixed and mobile camps were established to ensure SRH and GBV services for those displaced. Maternity kits were distributed to pregnant women and dignity kits (Hygiene packs) were distributed to women and adolescents. It is not clear from the reports on pandemic and flood response whether psychosocial support was provided. Social and behavioural communication about care during pregnancy and about prevention info GBV and care was a key strategic input as discussed under Finding 13.	

UNFPA as an agency was noted for its contributions during the pandemic and floods as mentioned by MOH. As mentioned under (assumption 34), UNFPA had developed national guidelines for ANC and PNC and specific guidance for management of COVID+ pregnant mothers and supported services in isolation camps. During floods, UNFPA did situation analysis in few municipalities to plan for the services, estimated needs of supplies for maternity kits and hygiene packs and raised resources for the same (see Finding 13). Special efforts on prevention of GBV and care of survivors were another important contribution. NO ASRH services were provided. Coordination and program management Under the Protection Working Group, managed by UN Women and UNICEF, the GBV and CP 'Sub Coordination Groups' were activated in response to the need for coordination given the scale of this disaster. UNFPA is now the leading actor on the GBV Sub Coordination group, has initiated an actor mapping exercise, and will plan to have its first coordination meeting on the week of April 12th. Under the Gender and Protection Working Group (GAPWG), two coordination sub-groups are now mobilized to coordinate and provide essential support at the evacuation sites and for affected communities. The GBV Subgroup is now managed under UNFPA, alongside the Child Protection Subgroup managed by UNICEF. On April 16 the GBV Subgroup came together in its first meeting to identify needs in evacuation facilities and coordinate modalities of support in relation to GBV prevention and response. And map out the 4Ws in relation to who is doing what, where, and when regarding GBV related activities both within the evacuation centres and general affected population. Through this, some clear action items were identified. Example of a lack of coordination- SRHR finding “The Global Fund and the National AIDS Programme Manager appreciates UNFPA’s contribution and believes strongly that only UNFPA could have facilitated access to key populations. With the end of the project with Global Fund, UNFPA support stopped to the CSO. Similarly, the inputs on reducing stigma and discrimination could not bear fruit as the funding stopped and so did UNFPA’s support. It is reported that the activities were not integrated with SRHR, and the programme officers were not kept informed- an example of lack of internal coordination. The discontinuation of activities and relationships with the CSOs abruptly with no back-up plan is a serious omission by CO, affects the credibility as an agency that promotes SRHR.”	<u>Secondary data-</u> Desk review/document analysis ● UN COVID-19 response ● Response to floods situation ● UNFPA COVID-19 strategy/response ● Number of municipalities/districts where GBV is monitored ● UNFPA video-materials for risk communication ● Situation reports - floods and Covid 19 ● Newspaper articles ● Progress reports (Humanitarian) ● Donor reporting Primary data- Interviews of relevant stakeholders virtual interviews where needed ● Health care providers ● IPs working on GBV related interventions ● CO staff ● UN agencies/UNHCR, humanitarian Interviews with staff related to humanitarian response) ● Group discussion (with vulnerable group representatives, FGDs)

<table>
<tr><td colspan="3">Evaluation Question 10: To what extent were activities of a short-term emergency nature carried out in a context that takes longer-term and interconnected problems into account? How did UNFPA support in building capacity and resiliency of the humanitarian partners and beneficiaries?</td></tr>
<tr><td colspan="3">Evaluation Criteria: Connectedness</td></tr>
<tr><td>Assumptions 36: UNFPA considered the long term and the interconnected nature of the problems when planning and implementing the activities during short- term emergency response</td><td colspan="2">Indicators:
i. Minutes and discussion notes, progress reports during the response period as well as preparedness planning documents
ii. Evidence action plans at different levels refer to accountability mechanisms related to all areas SRHR, ASRHR, GBV)
iii. Evidence of functioning SRHR sub-cluster under UNFPA’s leadership
iv. National emergency preparedness and response plans reflect the Minimum Initial Service Package (MISP)
v. Capacity building of managers of municipalities, health service providers and local partners in implementation of MISP
vi. -Evidence of implementation of MISP during the floods</td></tr>
<tr><td colspan="2">Data collected [must be strictly linked to the assumptions and corresponding to the above-indicated indicators]</td><td>Sources of information [List the source(s) of evidence for each of the data collected]</td></tr>
<tr><td colspan="2">Coordination and program management -same information from Assumption 35 applies under this as well.

Through the modality of the GBV Subgroup, UNFPA has also been able to provide technical support to any GBV Related activities. So far this has been in relation to IEC materials and one NGO planning to implement psychosocial support activities for women and girls staying in two evacuation centres.
Support GBV risk mitigation and response activities for affected women of reproductive age in targeted flood and COVID-19 affected areas.

Activities in Evacuation Centres: (Coverage)
Through Focusers, an existing UNFPA implementing partner, in providing psychosocial support within identified evacuation facilities as the following :
● Distributed 261 dignity kits from nationally prepositioned stock to support 1,305 women and girls of reproductive age in the evacuation facilities. (9 April 2021)
● Locally procure and distribute Dignity kits for women and girls affected by the flood and those in COVID-19 facilities in Timor-Leste.
● "Tempu Labarik Hasolok" (Happiest time for children): Engaging children to play so that parents have time to receive counselling and support for GBV prevention and intervention.
● "Husi Fuan ba Fuan" (from heart to heart): is a specific activity for parents to have a counselling session. The couples identified high risks and vulnerabilities and provided counselling for prevention and intervention of GBV.</td><td>Secondary data - Desk review/document analysis

● UNFPA Annual reports, M&E
● Reports on response to floods and COVID-19
● Humanitarian project monitoring reports
● National COVID 19 response plans
● National humanitarian response and preparedness plans
● IP reports
● Report on mobile maternity clinics
● Reports on cluster meetings
● Evidence of continuing use of behavioral communication materials in development activities</td></tr>
</table>

<table>
<tr><td colspan="2">

- "Husi Feto ba Feto" (from women to women): The activities facilitated psychosocial support and women to talk to build a safe space and identify signs of violence, provide counselling, and aid the survivor through the network referral system.
- Mapping exercise is an activity to ensure coordination response in support of the specific needs of women, children, people with disabilities and other vulnerable groups.

Connectedness:

Reports of COVID response and flood response available for 2021 and 2023. Also, proposals written for resource mobilization. Based on the assessment done during floods, documents were developed for planning mobile and fixed SRH services and the estimates for supplies needed (See Finding 13). These cannot be considered preparedness plans, and this is an area that needs further inputs. ASRH and prevention of HIV/STI is missing from the plans.
As mentioned under Finding 13 and other findings - under coverage, RH sub-cluster was active during the pandemic and floods.

Currently national preparedness and response plans do not include MISP but efforts on advocacy to include MISP and pre-positioning of supplies are ongoing. Some capacity building of managers has been done in MISP as part of the CP and during the floods, but it needs strengthening.

</td><td>

Primary Data - FGDs
Semi-structured key informant interviews (on-line or in person)

- UNFPA staff
- MOH
- Municipality level heath staff
- Community networks
- GBV focal persons
- Other UN agencies related to humanitarian work
- UNFPA Humanitarian focal point, POs
- MOH (MCH and humanitarian)
- WHO, UNICEF
- IPs who were involved in humanitarian
- Municipal health officers
- Doctors and midwives of flood affected districts
- Protection mobile teams
- Health service providers, women, adolescents, survivors of GBV

</td></tr>
<tr><td>

Assumptions 37: UNFPA supported in building capacity and resiliency of the humanitarian partners and beneficiaries

</td><td colspan="2">

Indicators:

i. Capacity building of managers of municipalities, health service providers and local partners in implementation of MISP
ii. -Evidence of implementation of MISP during the floods
iii. - Evidence of linking humanitarian response to recovery and development phases including use of SBCC materials
iv. -Evidence that specific approaches (e.g. peer led approaches, counselling) institutionalized within large national programs for women and girls
v. - Capacity building community leaders, youth groups, women's groups in emergency preparedness.
vi. -Establishment of support systems

</td></tr>
<tr><td colspan="2">

Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*

</td><td>

Sources of information *[List the source(s) of evidence for each of the data collected]*

</td></tr>
</table>

UNFPA used the established CSO network /IPs to help work in the affected areas. They were identified by FOKUPERS during assessment in the field that they need healing and a new environment. The aims of the reflection and group counselling was to engage women and girls on how to manage their feelings and their problems during a difficult moment. UNFPA used the existing system of CSO network to reach out to those in furthest areas. A two-day Reflection and Counselling group for women and girls affected by flooding conducted on 17-18 December 2021 at FOKUPERS for 30 participants (17 women and 13 girls) from 6 evacuation centres (Hera, Lahane, Eskola 4 Setembro-Balide, Masilidun, Manleuana and INFORDEPE). These target groups are women, girls and vulnerable groups who were considered as victim of flooding. Strengthening the CSOs and providing them with the necessities was one-way UNPA helped assist the affected populations. (Role of PD) For this MSSI and other relevant line ministries took the lead. The indicators are more or less the same as for Assumption 37 and responses also will be similar. Under the SRHR Assumptions, same information available. Challenges: ● Pandemic Covid 19 which result in frequent home confinement delays some of the planned activities specially in the affected districts ● Majority of health staff exposed to Covid-19, hence activities in districts could not be carried out ● Limited numbers of people allowed to participate in the meeting or training ● Most government funds are dedicated to response to Covid-19 rather than regular activities; consequently, funds from agencies allocated for regular programs. Time slot is very limited when the government declares back to normal work, competing priorities, making it difficult to prioritize which activities must be implemented first	**Secondary Data - Desk review/document analysis** ● UNFPA Annual reports, M&E ● Reports of response to floods and COVID-19 ● Humanitarian project monitoring reports ● National COVID 19 response plans ● National humanitarian response and preparedness plans ● IP reports ● Reports of cluster meetings ● Evidence of continuing use of behaviour communication materials in development activities **Primary Data** ● UNFPA staff
Assumptions 38: UNFPA COVID-19 response and recovery efforts contributed to strengthening national capacities and systems in the fields of SRHR, and GBV prevention and protection and data	**Indicators:** i. Capacity building of managers of municipalities, health service providers and local partners in implementation of MISP ii. Evidence of implementation of MISP during the floods iii. Evidence of linking humanitarian response to recovery and development phases including use of SBCC materials iv. Capacity building community leaders, youth groups, women's groups in emergency preparedness. v. Establishment of support systems vi. Establishing formal linkages to (community and government/municipality services) during or preparing for emergency.
Data collected *[must be strictly linked to the assumptions and corresponding to the above-indicated indicators]*	**Sources of information** *[List the source(s) of evidence for each of the data collected]*

Capacity building in MISP of health service providers, managers at municipal level and selected NGOs working with UNFPA has been done. Most of the elements were implemented- missing elements are related to HIV/STI prevention and ASRH services (see Finding 13). A good example of linking humanitarian response to recovery is the use of general ANC and PNC guidelines developed during COVID (excluding the specific section on COVID) to build capacity of health service providers. Similarly, some of the health education materials developed during COVID are being used. There is no evidence of capacity building of community leaders, women's groups in emergency preparedness as currently there are no preparedness plans at municipality level (See Finding 13). TL declared a state of emergency when the pandemic hit in April 2020 and until Dec 2021. While the community spread was successfully averted until Mar 2021, with 138 people reportedly having died from COVID 19. While the there is doubt about the credibility of data, no fatalities reported from covid 19 since Aug 2022 (BTI Transformation Index). https://bti-project.org/en/reports/country-dashboard/TLS	**Secondary Data - Desk review/document analysis** ● UNFPA Annual reports, M&E ● Reports of response to floods and COVID-19 ● Humanitarian project monitoring reports ● National COVID 19 response plans ● National humanitarian response and preparedness plans ● IP reports ● Reports of cluster meetings ● Evidence of continuing use of behaviour communication materials in development activities **Primary Data-** UNFPA Humanitarian focal point, POs

The Annex tables and charts on SRHR

Please Note: (These additional charts and graphs are under the SRHR Matrix under the Effectiveness. Reference is made to the tables and charts in the discussion above under SRHR Effectiveness section)

SRHR Effectiveness – Includes additional tables and 14 Charts (Annex 1-A, B and C)

Annex 1-A.

CP Outcome and Output indicators

UNSDCF OUTCOME INVOLVING UNFPA: Outcome 4: By 2025, the people of Timor-Leste increasingly demand and have access to gender-responsive equitable, high quality, resilient and inclusive Primary Health Care and strengthened social protection, including in times of emergencies.			
UNSDCF outcome indicator	Baseline 2021	Current	Target 2025
Proportion of married women aged 15–49 years who currently use modern contraceptive methods.	24.1% (TLDHS 2016)	55.1% (estimated) (HMIS 2023 (Source: UNFPA CO MEL report 2023)	40%
Proportion of births attended by skilled health personnel (SDG indicator 3.1.2/SP indicator) (geographical disaggregation)	56.7% (TLDHS 2016)	64.9% (2023) (Source: UNFPA CO MEL report 2023) 68.5% (Census 2022) SBA increase in Dili 85% (2016) to 93.3% (Census) and in Ermera, the increase was from 20% (2016) to 41% (Census)	>70%
Maternal deaths per 100,000 live births	195 per 100,000 live births (2016 DHS) UN estimate -204 (2022)	NA Census 2022 reported 413 per 100,000 live births	135 per 100,000 live births
Proportion of population 15-49 years with comprehensive knowledge of HIV (gender disaggregated)	Men 16%; Women 10% (TL DHS 2016)	NA	Men 25%; Women 25%
UNSDCF OUTCOME INVOLVING UNFPA: Outcome 3: By 2025, all people of Timor-Leste, regardless of gender identity, abilities, geographic location and particular vulnerabilities, have increased access to quality formal and innovative learning pathways (from early childhood through lifelong learning) and acquire foundational, transferable, digital and job-specific skills.			
Adolescent birth rate Per 1000 women in that age group	42 (TL DHS 2016)	20.8 (reported) or 33.8 (own children method- source Thematic report on Fertility and Nuptiality, Census 2022)	35
Percentage of women 15–24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission •	7.7%	NA	25%
Percentage of men 15–24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major	14.6%	NA	25%

misconceptions about HIV transmission .			
Output 1.1. The capacity of the national health system to provide high-quality, rights-based integrated sexual and reproductive health and HIV services, including availability and increased demand for family planning, response to GBV, in line with essential service package, stigma-free HIV services and referrals is strengthened, including in humanitarian settings.			
Number of community health centres providing good quality comprehensive reproductive health services including HIV and family planning in municipalities.	0	22 (61% achievement) (Source: UNFPA CO Mel report 2023)	36 (CPAP)
Percentage of health facilities with no stock out of modern contraceptives in the previous year	38%	72% no stock out in the last 3 months (2022 Facility audit) 54% no stockout for 3 methods of contraception (all facilities are expected to provide) and 60% for 5 methods of contraception (CHCs and Hospitals provide) (Source: UNFPA. Report on assessment for reproductive health commodities and services in Timor Leste 2023).	100%
Number of community health centres with capacity to provide essential services and referrals to survivors of gender-based violence.	0	6 (46% achievement) (Source: UNFPA CO Mel report 2023)	13 (CPAP)
Output 1.2. The capacity of skilled birth attendants to provide high-quality maternal health services, including antenatal care, EmONC, postpartum care, and elimination of mother-to-child transmission of HIV and syphilis, as well as to carry out maternal death reviews, is strengthened, especially in areas most in need.			
Number of health facilities providing 24/7 basic EmONC services as per national standards.	0	5 (In addition, one in Passabe about to be completed) (Source: UNFPA CO Mel report 2023)	32
Number of municipalities with functioning maternal and perinatal death surveillance response mechanisms.	5	13 (100%)(Source: UNFPA CO Mel report 2023)	13
Midwifery schools that have the capacity to deliver the updated national curriculum, skill	0	3 (100%)(Source: UNFPA CO Mel report 2023)	3

lab and clinical training site that meet ICM standards and are accredited by the government.			
Output 1.3. Awareness on prevention, transmission and treatment of HIV and other sexually transmitted infections, and uptake of HIV testing, especially among key populations, young people and pregnant women is increased, contributing to reduced stigma.			
Number of UNFPA supported organizations (CSOs or other national institutions) actively working towards increasing comprehensive knowledge of HIV.	1	3 (100%)(Source: UNFPA CO Mel report 2023)	3
Number of people who have been tested for HIV in the past 12 months and received the results of the last test.	0	34084 (34.8%) (Source: the total numbers are for 21-23, from reports submitted to MOH)	100,000
Percentage of people 15-49 years with discriminatory attitudes towards People Living with HIV, disaggregated by gender.	Men 54.9% Women 76.4 % Source not known TL DHS 2016 reported that 68%-85% of women and 50%-62% of men had discriminatory attitudes	No data is available	Men- 36.6% Women-50.9%

SRHR Annex 1-B – Facilities visited

	Baucau HOREX Regional referral hospital CEmONC	Viqueque villa CHC (Viqueque) BEmONC	Gleno (Ermera) BEmONC	Liquica (Liquica) BEmONC	Laga CHC (Baucau)	Ossu CHC (Viqueque)	Railaco CHC (Ermera)	Vera Cruz CHC (Dili) (*purpose was to see the safe space) Not a UNFPA assisted BEmONC centre*
Infrastructure and sufficiency of facilities Maternity ward Labour room Operation theatre Equipment functional Clinical protocols displayed	Yes Ventouse and MVA syringe not functional Clinical protocols- Yes	No theatre as a BeMONC Clinical protocols- Yes	No theatre as a BeMONC Clinical protocols- Yes	No theatre as a BeMONC Clinical protocols-?	No theatre as CHC Clinical protocols- No	No theatre as CHC No No NNR kit Only one delivery set No radiant warmer	No theatre as CHC Clinical protocols- Yes	No theatre as a BeMONC Clinical protocols- ?
Safe space for survivors of GBV	Yes (not functional as yet)	Yes	Yes (not functional as yet)	Yes	No	Yes (not as per SOP)	No	Yes
Staffing Trained staff BEmONC GBV FP	Yes in BEmONC and GBV Not in FP	Yes in all	Yes(in all 3	Yes in all 3	Yes in BEmONC (not functional as not a BemONC centre)	Yes in GBV	No	Trained in all
Ease of access	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Opening hours	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7	9-1 pm Emergency 24/7
Services provided ANC Screening for HIV, Syphilis, Hep B PNC Delivery EmONC	All except: NO screening for HIV, Syphilis and Hep B for all pregnant 0 only done if suspected Is an ART centre	ANC centre in another building NO screening for HIV, Syphilis and Hep B due to shortage of	All except NO screening for HIV, Syphilis and Hep B due to shortage of reagents	Men allowed in labour room Shortage of Mag Sulf and oxytocin sometimes Mother and baby kept for 24 hrs after	No BEmONC No screening for HIV, Syphilis, Hep B	No BEmONC No screening for HIV, Syphilis, Hep B	No BEmONC not sure about screening for HIV, syphilis, Hep B during ANC	All- not sure about screening for HIV, syphilis, Hep B during ANC

Mother and baby kept for 24 hrs after delivery	with VCT facility and hence surprising about the testing for the 3 antigens ANC only provided on selected days CEMONC centre Men allowed in labour room Mother and baby kept for 24 hrs after delivery	reagents Men allowed in labour room Mother and baby kept for 24 hrs after delivery	Men allowed in labour room Mother and baby kept for 24 hrs after delivery	delivery				
FP services	Implants and IUCDs by MSI Post partum FP advised	All methods provided Post partum FP advised	Trained in implant and IUCD insertion No lignocaine and so no implant FP commodities stored properly and maintains records Post partum FP advised	All methods provided Post partum FP advised	Implants not provided Post partum FP advised	Implants and IUCDs not provided Post partum FP advised	No implant or IUCD provided Post partum FP advised	Not observed
ASRH services	No ASRH services but provide FP services if requested	No ASRH services but provides contraceptives if requested	No ASRH services but provides contraceptives if requested and also provides community education	No ASRH services but provides contraceptives if requested	No ASRH services	No ASRH services	No ASRH services	No ASRH services
Cervical cancer and HPV vaccination Only in HNGV and referral hospitals, pap smear facility NO HPV vaccination	Cervical cancer screening in the facility specially meant for pap smear NO HPV vaccination	No cervical cancer screening and HPV vaccination	NO cervical cancer screening and HPV vaccination	NO cervical cancer screening and HPV vaccination	NO cervical cancer screening and HPV vaccination	NO cervical cancer screening and HPV vaccination	NO cervical cancer screening and HPV vaccination	NO cervical cancer screening and HPV vaccination
HIV/STI services	ART centre VCT services available	NO, refers to VCT centres in municipality health department	No, refers to VCT centre in municipality health department	No, refers to VCT centre in municipality health department	No, refers to VCT centre in municipality health	No, refers to VCT centre in municipality health	No, refers to VCT centre in municipality health	No, refers to VCT centre in municipality health

					department	department	department	department
Integrated services	No	No	No	No	No	No	No	No
Lab facilities	No reagents for HB, urine and limited supply of HIV, Syphilis and Hep B	No reagents for HB, urine and HIV, Syphilis and Hep B	No reagents for HB, urine and HIV, Syphilis and Hep B	No reagents for HB, urine	No reagents for HB, urine and HIV, Syphilis, Hep B	No reagents for HB, urine HIV, Syphilis, Hep B	No reagents for HB, urine HIV, Syphilis, Hep B	-
IEC materials	In FP clinics	In FP clinics	In FP clinics	In FP clinics	In OPD	No	No	-
Observations in facilities								
Privacy and confidentiality	Yes	Yes	Yes	Yes	Not observed	Not observed	Not observed	-
Interaction between staff and patients	Clients satisfied	Clients satisfied Both pregnant and just delivered	Clients satisfied Both pregnant and just delivered	Clients satisfied Both pregnant and just delivered	Inpatient satisfied	Not observed	Not observed	-
ANC and education	Yes except urine, Hb, screening for three antigens	Yes except urine, Hb, screening for three antigens	Yes except urine, Hb, screening for three antigens	Yes except urine, Hb	Yes except urine, Hb, screening for three antigens	Yes except urine, Hb, screening for three antigens	Yes except urine, Hb, screening for three antigens	-
Intrapartum care	Yes	Yes	Yes	Yes	Yes	Not checked	Not checked	-
Infection prevention labour room	Yes	Yes	Yes	Yes	Yes	Not sure	Yes	-
Emergency tray	Yes	Yes	Yes	Yes	?	No	No	-
Sterilisation of equipment and storage	Yes	Yes	Yes	Yes	Yes	No	Yes	-
Signal functions of BEmONC	Yes	Yes	Yes	Yes	No except Neonatal Resuscitation	No	No except Neonatal Resuscitation	-
Referrals	As CEmONC complications mostly managed	All except those needing Caesareans, anaemia,	All except those needing Caesareans, anaemia,	All except those needing Caesareans, anaemia,	All referred	All referred	All referred	-
Health education	Not observed was informed that Birth preparedness and complication management is supposed to be included	Not observed Was informed that Birth preparedness and complication management is supposed to be included	Not observed Was informed that Birth preparedness and complication management is supposed to be included	Not observed Was informed that Birth preparedness and complication management is supposed to be included	Not observed Was informed that Birth preparedness and complication management is supposed to be included	?	?	-
HMIS (inclusion of	Yes	Yes	Yes	Yes	Yes	Yes	Not observed	-

GBV and supplies initiated at national level) ANC PNC Delivery PNC Complications					Complications are referred	Complications are referred		
Referrals and feedback	Not checked							
GBV case management	Yes	Yes	Yes	Yes	?	Yes	?	?
Disability friendly facilities	No	No	No	No	No	No	No	No

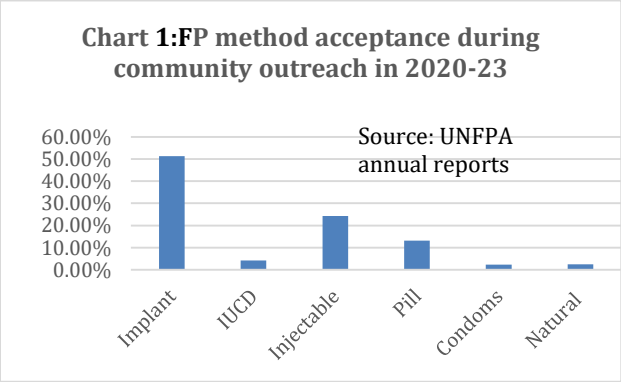
HPS visited

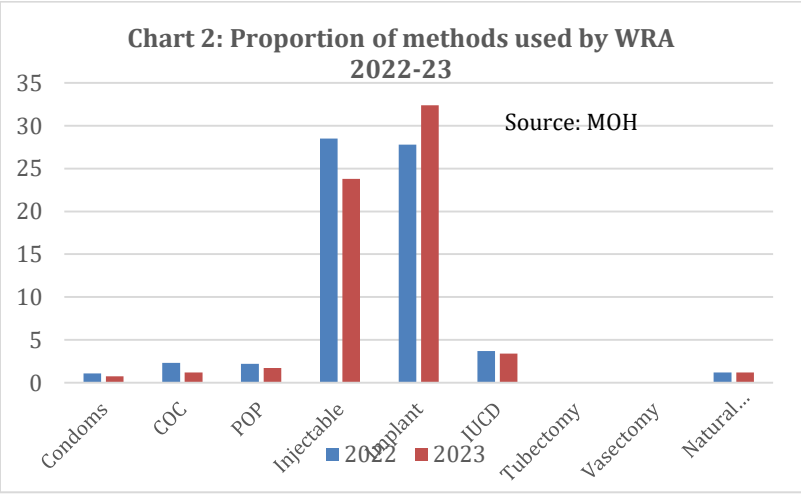
	Boleha (Baucau)	Lohiumu (Viqueque)	Lodudo (Ermera)
Access	Difficult as the roads are not good	Easy	Difficult especially when the river is flooded
Infrastructure	Adequate	Adequate	Needs improvement
Labour room	Yes	Yes	Yes
Ice-lined refridgerator for vaccines	Yes	Yes	Yes
Neonatal resuscitation kit	Yes	No	No
Cold chain for oxytocin	No	No	No
ANC	Yes	Yes	Yes (selected days
Delivery			
GBV services	No	No	No but information on helpline available
FP	Yes, condoms, pills and injectable	Yes, condoms, pills and injectable	Yes, condoms, pills and injectable

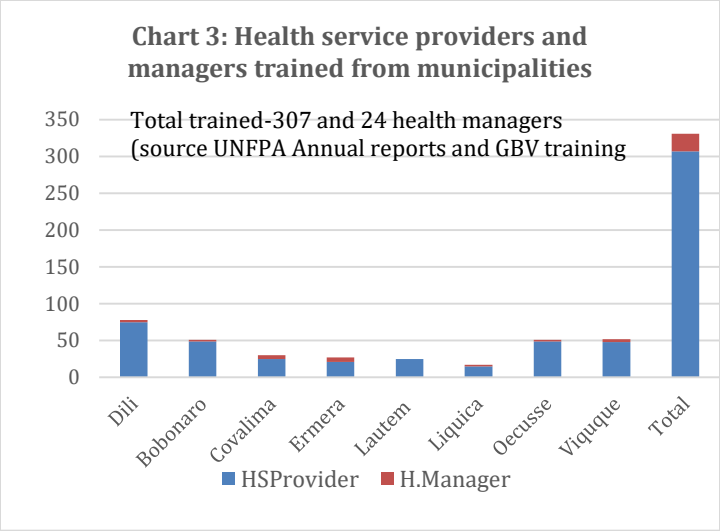
Baucau regional INFPM

Clean, temperature maintained, supplies organised, cold chain maintained and no stock out of contraceptives or maternal health drugs
Uses e-LMIS and also assists CHC staff
Condoms kept outside the main warehouse with the food supplies of WFP and is a concern.

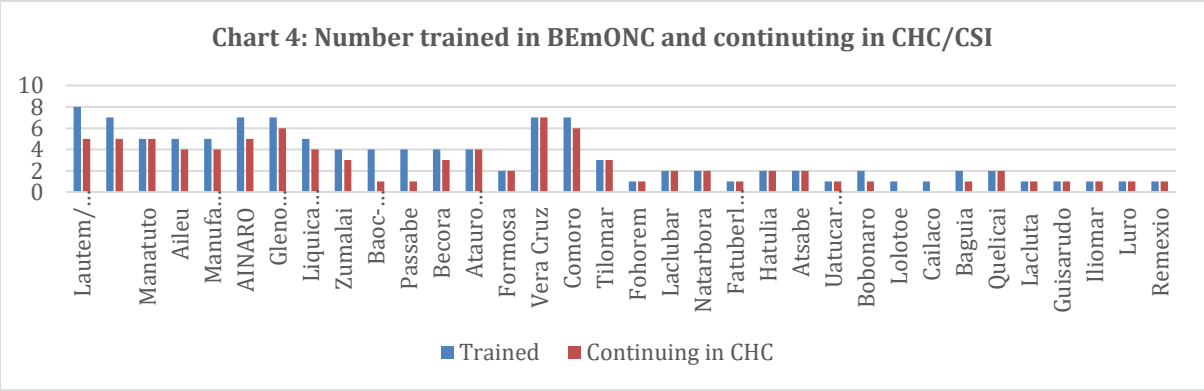
SRHR ANNEX 1-C







Analysis of BEmONC reports (SOURCE BEmONC reports received from UNFPA CO)



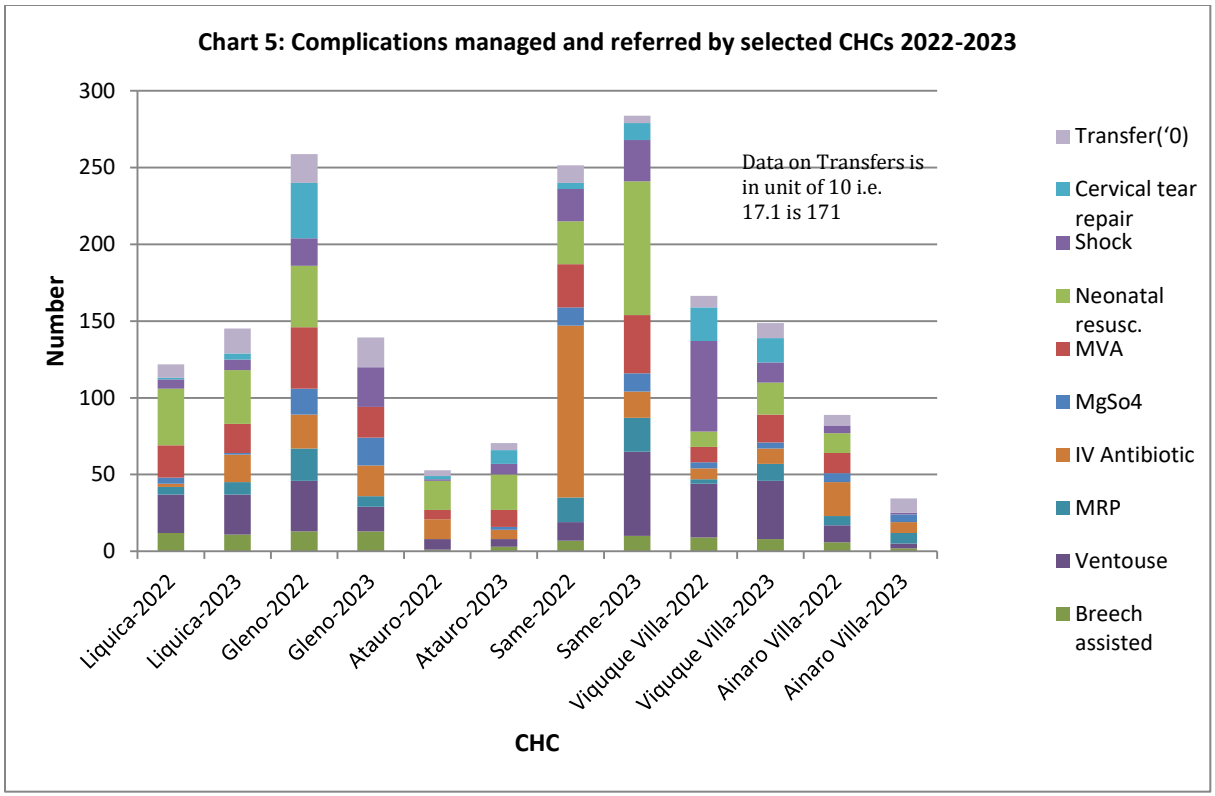


Chart 5: Complications managed and referred by selected CHCs 2022-2023
Number
300
250
200
150
100
50
0
Data on Transfers is in unit of 10 i.e. 17.1 is 171
Liquica-2022
Liquica-2023
Gleno-2022
Gleno-2023
Atauro-2022
Atauro-2023
Same-2022
Same-2023
Viquque Villa-2022
Viquque Villa-2023
Ainaro Villa-2022
Ainaro Villa-2023
CHC
Transfer('0)
Cervical tear repair
Shock
Neonatal resusc.
MVA
MgSo4
IV Antibiotic
MRP
Ventouse
Breech assisted

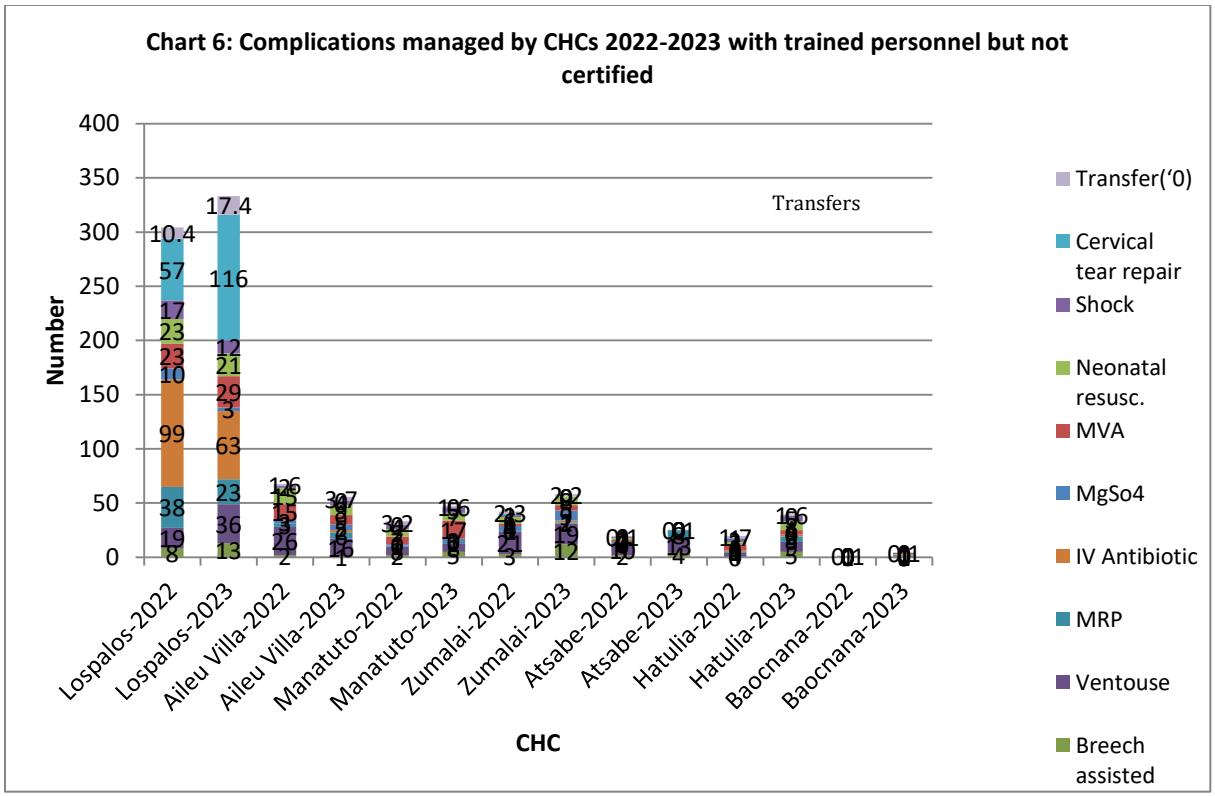


Chart 6: Complications managed by CHCs 2022-2023 with trained personnel but not certified
Number
CHC
Transfers
Transfer('0)
Cervical tear repair
Shock
Neonatal resusc.
MVA
MgSo4
IV Antibiotic
MRP
Ventouse
Breech assisted
Lospalos-2022
Lospalos-2023
Aileu Villa-2022
Aileu Villa-2023
Manatuto-2022
Manatuto-2023
Zumalai-2022
Zumalai-2023
Atsabe-2022
Atsabe-2023
Hatulia-2022
Hatulia-2023
Baocnana-2022
Baocnana-2023

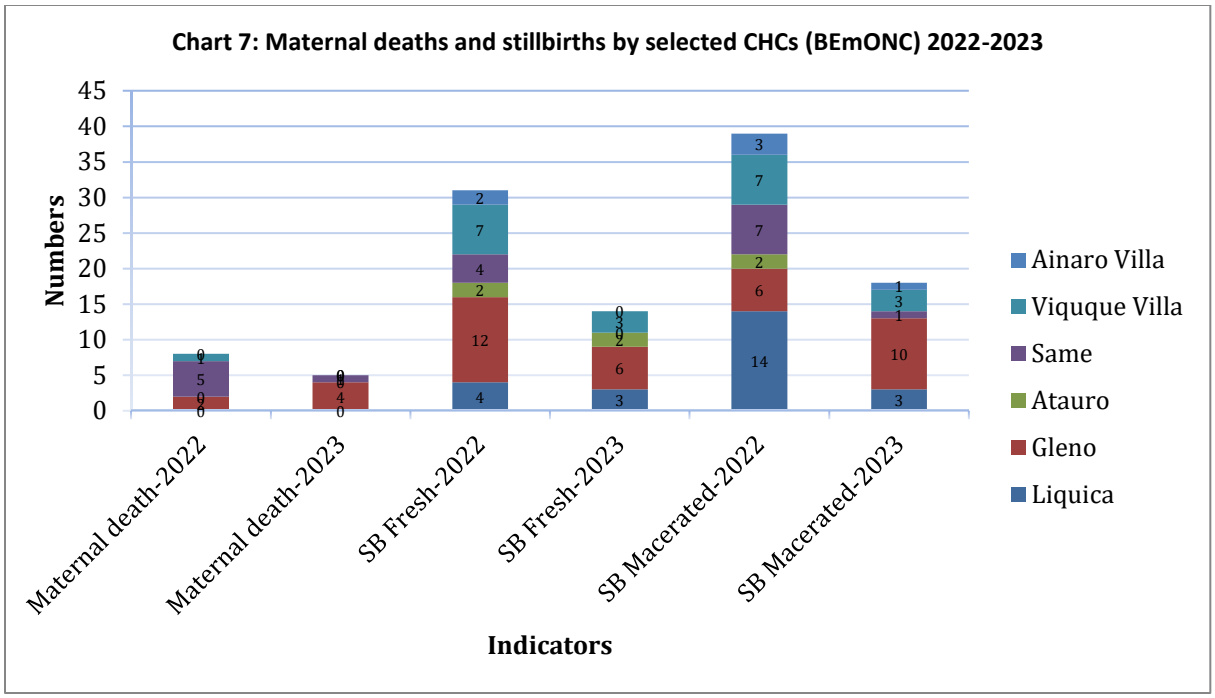


Chart 7: Maternal deaths and stillbirths by selected CHCs (BEmONC) 2022-2023
Numbers
45
40
35
30
25
20
15
10
5
0
Maternal death-2022
Maternal death-2023
SB Fresh-2022
SB Fresh-2023
SB Macerated-2022
SB Macerated-2023
Indicators
Ainaro Villa
Viuque Villa
Same
Atauro
Gleno
Liquica

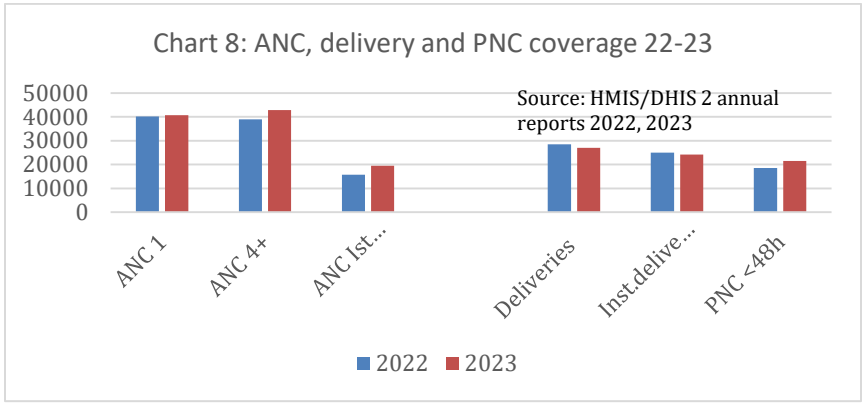
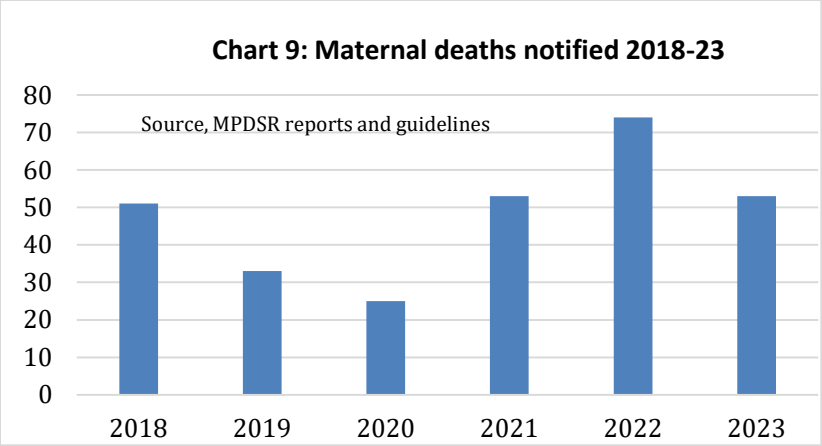


Chart 8: ANC, delivery and PNC coverage 22-23
Source: HMIS/DHIS 2 annual reports 2022, 2023
50000
40000
30000
20000
10000
0
ANC 1
ANC 4+
ANC Ist...
Deliveries
Inst.delive...
PNC <48h
2022
2023



HIV/AIDS interventions (SOURCE MOH AIDS CONTROL PROGRAMME)

Chart 10: No. of key populations reached with BSP and HIV test 21-23

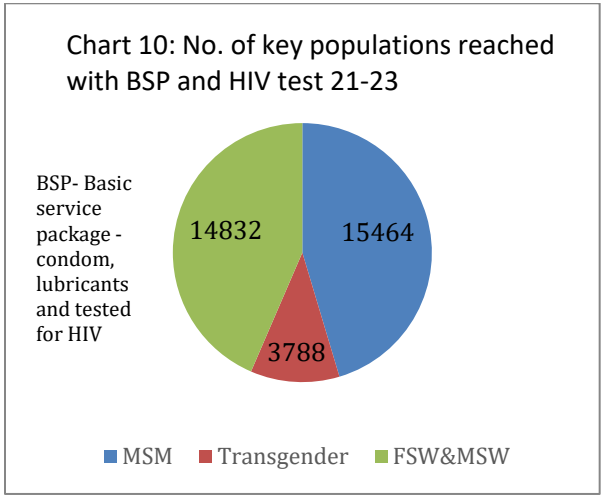


Chart 11: Indicators showing achievement in KP Programme MSM and TG

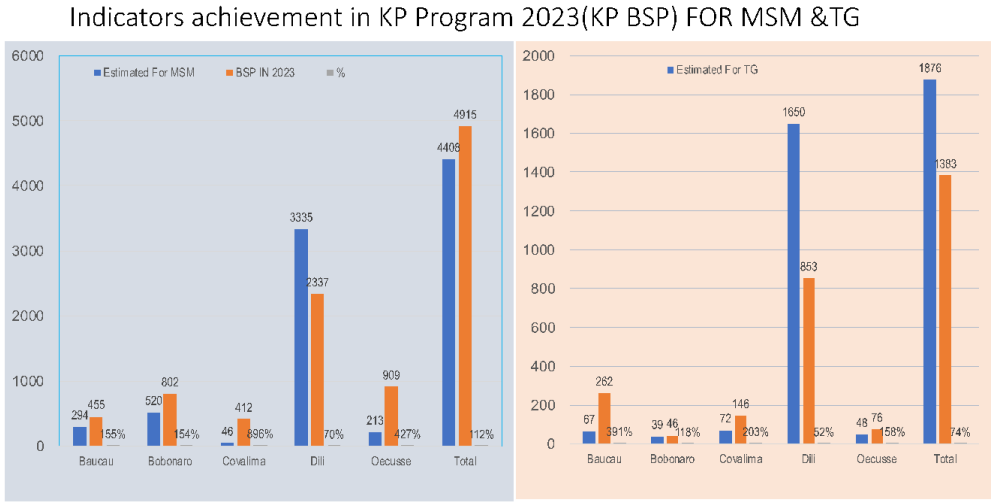


Chart 12: Indicators showing achievement in KP programme FSW and MSW

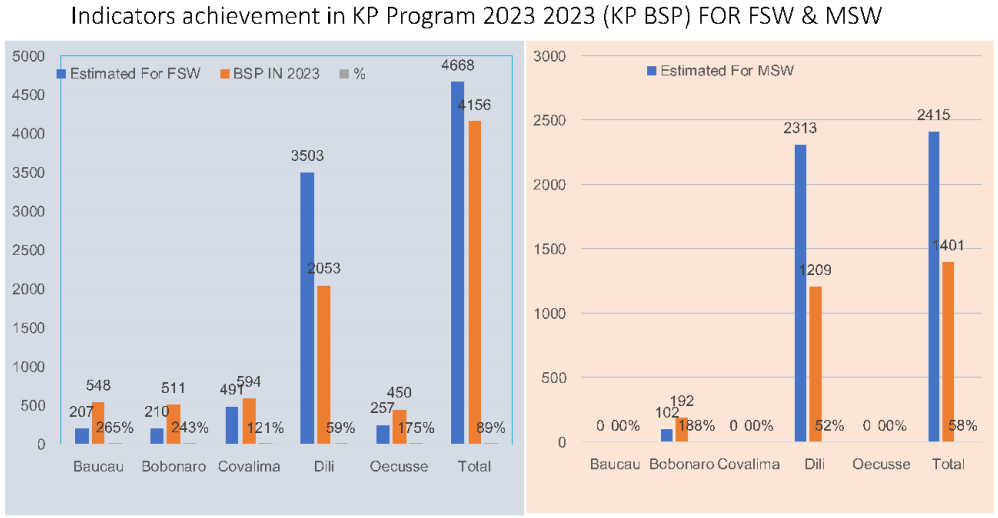


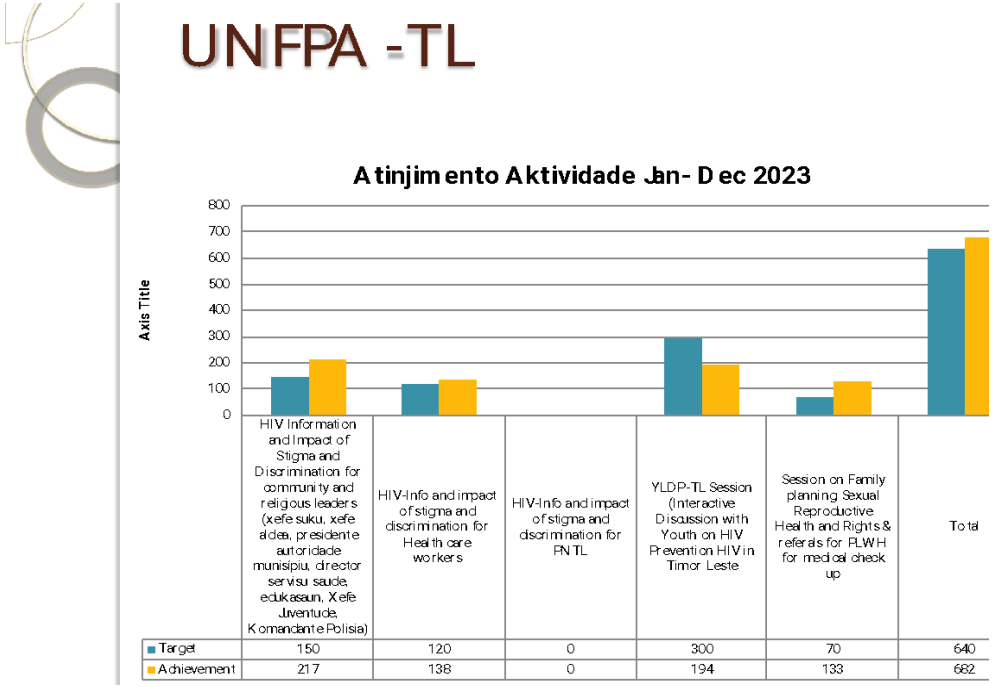
Chart 13: Indicators showing achievement in KP programme in priority municipalities

Indicators achievement in KP Program 2023 (KP BSP)

Munisipio	BSP				Test HIV				Positivo			
	MSM	TG	FSW	MSW	MSM	TG	FSW	MSW	MSM	TG	FSW	MSW
Dili	2337	853	2053	1209	2337	853	2053	1209	16	12	6	2
Baucau	455	262	548	0	455	262	548	0	1	0	0	0
Bobonaro	802	46	511	192	802	46	511	192	0	1	0	0
Covalima	412	146	594	0	412	146	594	0	1	1	0	0
Oecusse	909	76	450	0	909	76	450	0	2	1	3	0
Total	**4915**	**1383**	**4156**	**1401**	**4915**	**1383**	**4156**	**1401**	**20**	**15**	**9**	**2**

Munisipio	Test Syphilis				Positivo Syphilis			
	MSM	TG	FSW	MSW	MSM	TG	FSW	MSW
Dili	1564	594	1367	809	22	13	18	16
Baucau	455	262	548	0	1	1	1	0
Bobonaro	802	46	511	192	11	2	2	0
Covalima	307	129	466	0	0	0	0	0
Oecusse	909	76	399	0	4	0	3	0
Total	**4037**	**1107**	**3291**	**1001**	**38**	**16**	**24**	**16**

Chart 14: Categories educated for reducing stigma and discrimination towards PLWHA



Source: Estrela +

ANNEX 2: List of Documents Consulted

List of Documents Consulted
CP4 documents
Country Programme Document 2021-25
Country Programme Action plans CPAP 2021-25
UNFPA CO Annual Reports 2021,22, 23
UNFPA Timor Leste. Organization Structure as of March 2024
UNFPA Timor Leste. Theory of change SRHR, Gender, Adolescents and Youth and Population and Development
Evaluation of the 3rd Country Programme 2015 – 2019/2020 in Timor-Leste, 2020
Final Timor Leste Commitment on ICPD 25
MEL report 2023, June 2024
Project monitoring reports 2021, 22
SMT dashboard 2024
Financial follow up 2024
Work plans 2021, 22, 23
Activity reports (thematic area-wise)
Donor reports
Implementing Partner Reports
UNFPA Timor-Leste "Healthy Relationship Manual". 2023
UNFPA Country Programme Evaluation Report (CPE, 2023)
UNFPA Timor Annual Reports, 2021, 2022, 2023
UNFPA Final Cumulative Spotlight Report, 2024
T4E Endline Survey Report, 2024 (Sung, S. (2024). Together for Equality (T4E) "Preventing and Responding to Gender-Based Violence in Timor-Leste 2020-2024": Endline Survey Result Report (Final Version)
Disability and Development Survey (2021). Findings on exclusion from mainstream programs in Timor-Leste.
Humanitarian Related
Ensuring continuity of essential SRH and GBV response services for nationwide flood response during the COVID-19 pandemic, 2021
Situation report, needs assessment of floods in municipalities in southern and eastern coasts of Timor Leste 11 municipalities (Covalima, Ainaro, Manufahi, Lautem, Manatuto, Ermera, Baucau, Viqueque, Bobonaro, Liquica and Dili).
UNFPA emergency fund October 2023- March 2024
EF326 Narrative Report Humanitarian Fund 2021 (Jan 2022)
EF476Narrative final Repot-Humanitarian
UNFPA SRHR
CO presentation on SRHR activities in CP 4
Investment Case for Family Planning, Maternal, Newborn and Child Health in Timor-Leste
EMONC trainers' manual
ANC and PNC training manuals
Essential service package SOP
Guiding document for UNFPA SBCC strategy
MISP guidelines
Final Report On Facility Assessment For Reproductive Health And Family Planning Commodities And Service In Timor-Leste 2018
Report of assessment for reproductive health commodities and services in Timor Leste 2022

UNFPA HMIS SRMNCAH Assessment
Draft Operational Guideline for Integrated SRHR in Primary Health Care 2024
Guiding document UNFPA SBCC Strategy
UNFPA APRO reviews
Takeaways from deep dive analysis
Thematic reviews on SRHR, Family Planning, Gender and Human Rights, Adolescents and Youth, Financing, Population Data, Humanitarian
WHO Timor-Leste. Draft National RMNCAH Strategy 2024-2030.
Joint programmes
Together for equality: Preventing and responding to Gender Based Violence (KOICA, UN Women, UNFPA, IOM, UNDP
Spotlight initiative to eliminate violence against women and girls- Country Programme Document Updated October 2022 Partnership between EU, RCO and ILO, UNDP, UNICEF, UN Women
Strengthening National Capacities of Health Sector in Papua New Guinea and Timor-Leste to Deliver Survivor-Centred Response to Gender Based Violence Survivors (2020- 2022) Zonta International Foundation and UNFPA Asia and the Pacific Regional Office (APRO)
Mapping of Quantitative and Qualitative Data on Violence Against Women and Girls Report Summary (Spotlight Initiative)
Administrative Data Mapping on Violence Against Women and Girls in Timor-Leste 2022
UN Timor Leste
CCA 2019
CCA updated 2023
UNSDCF 2021-25
UNCT. Report for the Universal Periodic Review (UPR) of Timor-Leste 40th Session of the UPR Working Group 2022
UN Results Report 2021
UN Results Report 2022
UN Socio-economic impact assessment of COVID-19 second round 2021
UNFPA Mapping and Analysis of positioning the ICPD agenda and UNFPA mandate in the Common Country Analysis (CCA) and in the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2020
CEDAW report (UN Women)
UNDAF evaluation report 2019
UNCT Timor Leste: Report for the Universal Periodic Review (UPR) of Timor-Leste- 40th Session of the UPR Working Group 2022
UNCT Meeting Minutes (selected sessions)
UNFPA Global documents
UNFPA Strategic Plan 2022-25
UNFPA Strategic Plan 2022-25: Implementation toolkit
UNFPA strategic plan, 2022-2025 :Annex 2 “Change stories” to accelerate the achievement of the three transformative results
UNFPA Strategic Plan 2022-25: Annex 3 Business model
Annex 6: Integrated results and resources framework, Strategic plan, 2022-2025
UNFPA Evaluation and other documents
UNFPA Evaluation Handbook 2024
UNFPA Evaluation tool kit 2024
UNFPA Guidance on Evaluation Quality Assurance and Assessment 2024
UNFPA EQA Grid 2024

UNFPA Evaluation policy 2024
UNFPA Leveraging the Power of Youth in Evaluations 2024
Government
National Strategic Development Plan 2011-30
National Health Strategic Plan 2020-30
Essential Services Package for Primary Health Care 2022
Policy Brief Reaching the un-reached through INTEGRATED HEALTH PROGRAM (IHP), 2023
Programme of the Ninth Constitutional Government
National Family Planning Policy 2022
National Reproductive Health Commodity Security Strategy, Timor-Leste (2019 – 2023), 2018.
Memorandum of Understanding between Sames IP and UNFPA for Third Party Procurement Services by the UNFPA at the Request and on Behalf of Sames IP for Reproductive Health, Population and Related Supplies, 2022
Memorandum of Understanding between the UNFPA and the MOH of Timor Leste, 2022 (Framework of Cooperation)
Draft RMNCAH Strategy 2024-2030
Emergency Obstetric and Newborn Care Improvement Plan 2016-19
Timor-Leste National Strategic Development Plan 2011-2030
National Action Plan Against Gender-Based Violence 2022 - 2032
National Action Plan on Gender Based Violence 2017-2021
Health Sector Response to GBV/IPV: National Guideline for Health Care Providers to address Gender-Based Violence Including Intimate Partner Violence, 2018
National Health Workforce Plan of Democratic Republic Of Timor-Leste 2005-2015, 2005
National Strategic Plan for Human Resources For Health (NSPHRH) 2020 – 2024, 2020
Timor Leste National Youth Policy 2016
National Action Plan for Youth 2023
Timor-Leste's National Adaptation Plan - Addressing climate risks and building climate resilience 2020
Report on the Implementation of the Sustainable Development Goals - From Ashes to Reconciliation, Reconstruction and Sustainable Development. Voluntary National Review of Timor-Leste 2019
People-Centred Sustainable Development: Leaving No One Behind. The Second Voluntary National Review of SDG Implementation Progress, 2023 (Timor-Leste VNR-2)
Timor-Leste's roadmap for the Implementation of The 2030 Agenda and the SDGs Timor
Report of the Timor-Leste National Consultation to prepare the 7th Asia Pacific Population Conference
National Strategic Plan for HIV, STIs and Viral Hepatitis 2022–2026
HIV/AIDS External Mid-term Review, 3-14 June 2019
HIV Sentinel Surveillance Plus 2018-19
National Guidelines on implementation of MPDSR 2022
MPDSR presentation 23
MPDSR Brief 2024
Advanced New Born Action Plan Draft 2023
Family Planning Training Package – Participants' manual 2017
National curriculum for healthcare providers responding to gender-based violence in Timor-Leste – Facilitators' and Participants' Guide 2023
Data on training in GBV 2024
Boys and girls cycle training manual
Healthy Relationships: Education for Young People. A Guide to Facilitators

Research Bulletin – Timor-Leste's Youth Population: A Resource for the Future (National Transfer Accounts)
Timor Leste 2021 HMIS Report
Timor Leste 2022 HMIS Report
Timor Leste Population and Housing Census 2022- Main Report
Timor Leste Population and Housing Census 2022- Fertility and Nuptiality Report
Timor Leste Population and Housing Census 20220 – Mortality Report
Timor Leste Demographic Health Survey 2010
Timor Leste Demographic Health Survey 2016
NACP. HIV/AIDS Estimates 2024
NACP. Indicators of Achievements of Key Populations Programme 2024
NACP, WHO, et al. Report of Hotspot Mapping and Size Estimation of Key Populations in Timor-Leste April 2023
Reports by NGOs, CSOs, Donors
Estrela. HIV stigma index report 2017
INCSIDA: Strategic Plan of National AIDS Institute 2023-27
World bank and ADB. Climate risk country profile- Timor Leste
World Bank. Timor-Leste Economic Report. Honoring the Past, Securing the Future, December 2022
Government of Japan. Reducing maternal and perinatal morbidity and mortality through strengthening the emergency obstetric and newborn care services in Timor Leste (2024-2027).
WHO. Health expenditure profile
World Bank. Human capital country brief
Other
https://www.unv.org/Success-stories/ensuring-those-affected-floods-timor-leste-have-access-dignified-and-safe-solutions https://timor-leste.unfpa.org/en/topics/humanitarian-emergencies-0
https://www.mj.gov.tl/files/CEDAW20StateReportPressRelease_5.pdf
HAMNASA. (2023). Communities Ending Gender-Based Violence Activity: Quarterly Report Sept-Dec 2023. Dili, Timor-Leste: UNFPA.
Zonta International. (2023). Her Health and Dignity, Our Priority: 2022-2024 Project Description - Timor-Leste and Papua New Guinea.
Airoldi, G., & Rejinders, M. (2022). Mission Report of APRO GBV Specialist - Q4 (13-17 November 2022). UNFPA APRO, Timor-Leste.

Annex 3: List of Persons Met (names are not included*)

(stakeholder analysis brief note added at the end of the table)

UNFPA Timor-Leste 4th Country Programme Evaluation Data Collection Phase Persons Met (1 July 2024 to 26 July 2024)					
#	**Position**	**M/F**		**Area of work**	**Institution/Organization**
1	Country Representative a.i	M		Management	UNFPA Timor-Leste
2	Asst. Country Rep. Head of Programmes	F		Management	UNFPA Timor-Leste
3	M&E Analyst	M		Management/Adolescent and Youth	UNFPA Timor-Leste
4	M&E Specialist	M		Management	UNFPA Timor-Leste
5	International Operations Manager (IOM)	F		Management	UNFPA Timor-Leste
6	HR & Admin Associate/Officer in Charge of Operations	M		Management	UNFPA Timor-Leste
7	Program Analyst	F		Sexual and Reproductive Health	UNFPA Timor-Leste
8	Consultant OBGYN	F		Sexual and Reproductive Health	UNFPA Timor-Leste
9	Programme Analyst	M		Gender	UNFPA Timor-Leste
10	Gender Consultant	F		Gender	UNFPA Timor-Leste
11	Gender Consultant	F		Gender	UNFPA Timor-Leste
12	Program Associate	F		Gender and PD	UNFPA Timor-Leste
13	Programme Analyst	M		Population Dynamics	UNFPA Timor-Leste
14	Programme Analyst	F		Sexual and Rreproductive Health	UNFPA Timor-Leste
15	mSupply Consultant	F		Sexual and Reproductive Health	UNFPA Timor-Leste
16	Former Programme Specialist for HIV/AIDS	M		Sexual and Reproductive Health	UNFPA Timor-Leste
17	Former AY CSE Out of School Consultant	F		Adolescent and Youth	UNFPA Timor-Leste
1	Resident Coordinator	F			UNRCO Timor-Leste
2	DMO/M&E	M			UNRCO Timor-Leste
3	Representative	M			WHO Timor-Leste
4	Team Lead ba RMNCAH	M			WHO Timor-Leste
5	National Technical Officer for RMNCAH	M			WHO Timor-Leste

6	Team Lead, Communicable Diseases	M			WHO Timor Leste
7	Programme ManagerTogether for Equality (KOICA)	F			UN Women Timor-Leste
8	UNICEF TL Dep Rep	F			UNICEF Timor-Leste
9	UNICEF Health Manager	M			UNICEF Timor-Leste
10	MCH Officer	F			UNICEF Timor-Leste
11	Head of UN Women	F			UN Women Timor-Leste
12	UNDP, Dep. Resident Rep	F			UNDP Timor-Leste
Government of Timor-Leste					
1	Director General	M		Dili	Ministry of Youth Sports Art and Culture
2	Director General	M		Dili	Secretary of State for Equality
3	National Director for Gender Equality Policy	F		Dili	Secretary of State of Equality
4	Chief of Department for Public Relations and International Partners	M		Dili	Secretary of State of Equality
5	President	M		Dili	National Institute of Statistics (INETL)
6	Municipal Chiefs	3 M		Bobonaro, Ermera, Covalima	National Institute of Statistics (INETL)
7	Director-General for Social Protection	M		Dili	Ministry of Social Solidarity and Inclusion
8	National Director of Maternal and Child Health	F		Dili	Ministry of Health
9	Head of MCHD	F		Dili	Ministry of Health
10	MCH Officer (Safe Motherhood)	F		Dili	Ministry of Health
11	Newborn Care Officer	F		Dili	Ministry of Health
12	GBV Officer	F		Dili	Ministry of Health
13	Chief, HMIS	M		Dili	Ministry of Health
14	HMIS Officer (Baucau, Ermera and Manatuto)	F		Dili	Ministry of Health
15	HMIS Officer (Viqueque, Manufahi and Covalima)	M		Dili	Ministry of Health
16	GGCQ National Institute of Pharmacy Drug Products	M		Dili	Ministry of Health

	(INFPM)				
17	DC National Institute of Pharmacy Drug Products (INFPM)	M		Dili	Ministry of Health
18	DAC National Institute of Pharmacy Drug Products (INFPM)	M		Dili	Ministry of Health
19	National Institute of Pharmacy Drug Products (INFPM)	F		Dili	Ministry of Health
20	Warehouse officer for Family Planning and EPI National Institute of Pharmacy Drug Products (INFPM)	F		Dili	Ministry of Health
21	National Institute of Pharmacy Drug Products (INFPM)	F		Dili	Ministry of Health
22	MPDSR	M		Dili	HNGV
23	MPDSR	M		Dili	HNGV
24	Facility Audit	M		Dili	HNGV
25	Manager National HIV/AIDS Programme	M		Dili	Ministry of Health
26	DG for Employment	M		Dili	Secretary of State for Vocational Training and Employment (SEFOPE)
27	National Director of Employment	F		Dili	The Secretary of State for Vocational Training and Employment (SEFOPE)
28	Senior Staff of Labour Market Information Center	F		Dili	The Secretary of State for Vocational Training and Employment (SEFOPE)
29	Chief of Inpatient Health Center of Vera Cruz	F		Dili	Ministry of Health
30	Director of Municipal Health Services of Baucau	M		Baucau	Ministry of Health
31	Coordinator of MCH Baucau	F		Baucau	Ministry of Health
32	Executive Director of HoREX	M		Baucau	Ministry of Health
33	Head of Maternity Unit HoREX	F		Baucau	Ministry of Health
34	Midwife in Maternity Unit	F		Baucau	Ministry of Health

	HoREX				
35	Midwife in Maternity Unit HoREX	F		Baucau	Ministry of Health
36	Midwife in Maternity Unit HoREX	F		Baucau	Ministry of Health
37	Midwife in Maternity Unit HoREX	F		Baucau	Ministry of Health
38	Midwife in Maternity Unit HoREX	F		Baucau	Ministry of Health
39	Specialist OBGYN in Maternity Unit HoREX	M		Baucau	Ministry of Health
40	Chief of CHC Laga	F		Baucau	Ministry of Health
41	Midwife in CHC Laga	F		Baucau	Ministry of Health
42	Midwife in CHC Laga	F		Baucau	Ministry of Health
43	Midwife in HP Bolehá, Laga	F		Baucau	Ministry of Health
44	Doctor in HP Bolehá, Laga	F		Baucau	Ministry of Health
45	BemONC/Maternity Coordinator	F		Viqueque	Ministry of Health
46	FP Coordinator in BemONC	F		Viqueque	Ministry of Health
47	General doctor	F			
48	Midwife in BemONC	F		Viqueque	Ministry of Health
49	Midwife in BemONC	F		Viqueque	Ministry of Health
50	Midwife in BemONC	F		Viqueque	Ministry of Health
51	Midwife ? CSM Clinic of Viqueque Vila	F		Viqueque	Ministry of Health
52	Chief of CHC Ossú	M		Viqueque	Ministry of Health
53	Midwife in CHC Ossú	F		Viqueque	Ministry of Health
54	Midwife in CHC Ossú	F		Viqueque	Ministry of Health
55	Midwife in CHC Ossú	F		Viqueque	Ministry of Health
56	Pharmacist in CHC Ossú	F		Viqueque	Ministry of Health
57	Midwife in HP Loihunu, Ossú	F		Viqueque	Ministry of Health
GBV – Spotlight					
1	Chief of SSL CHC Uatulari	M		Viqueque	Ministry of Health
2	SSH CHC Uatulari	M		Viqueque	Ministry of Health
3	General Practitioner (Doctor) CHC Uatulari	F		Viqueque	Ministry of Health
4	Midwife CHC Uatulari	F		Viqueque	Ministry of Health
5	GBV Medical Forensic	M		Viqueque	Ministry of Health

	Examination (Doctor) CHC Viqueque				
6	Nurse CHC Viqueque	F		Viqueque	Ministry of Health
7	Doctor CHC Viqueque	F		Viqueque	Ministry of Health
8	Nurse CHC Viqueque	F		Viqueque	Ministry of Health
9	Midwife CHC Viqueque	F		Viqueque	Ministry of Health
10	GBV Forensic Examination	F		Viqueque	Ministry of Health
11	SMH Unit Municipal Health Service	F		Viqueque	Ministry of Health
12	Chief Department of Municipal Health Service	M		Viqueque	Ministry of Health
13	Nurse CSI Viqueque	M		Viqueque	Ministry of Health
14	Forensic Medical Examination Municipal Health Service	M		Viqueque	Ministry of Health
15	Chief of CSM Viqueque	M		Viqueque	Ministry of Health
16	Midwife CSM Viqueque	F		Viqueque	Ministry of Health
17	Doctor and Coordinator of GBV in CHC Ossú	F		Viqueque	Ministry of Health
18	Doctor CHC Ossú	M		Viqueque	Ministry of Health
19	Director of Municipal Health Services of Ermera	M		Ermera	Ministry of Health
20	Coordinator of Maternal and Child Health of Ermera	F		Ermera	Ministry of Health
21	Chief of Health Programme	M		Ermera	Ministry of Health
22	Coordinator fo BemONC Gleno	F		Ermera	Ministry of Health
23	Doctor in BemONC Gleno	M		Ermera	Ministry of Health
24	Midwife in BemONC Gleno	F		Ermera	Ministry of Health
25	Nurse in HP Lodudu, Ermera	M		Ermera	Ministry of Health
26	Midwife in Maternity Railaco	F		Ermera	Ministry of Health
27	Midwife in Maternity Railaco	F		Ermera	Ministry of Health
28	Midwife in Maternity Railaco	F		Ermera	Ministry of Health
GBV - Spotlight					
29	Midwife – GBV CSI Gleno	F		Ermera	Ministry of Health
30	Medical Doctor	M		Ermera	Ministry of Health

	CSI Gleno				
31	CFF – GBV SSHM Ermera	F		Ermera	Ministry of Health
32	Nurse CSI Gleno	F		Ermera	Ministry of Health
33	Medical Doctor CSI Gleno	M		Ermera	Ministry of Health
34	Medical Doctor CSI Gleno	M		Ermera	Ministry of Health
35	Midwife CSI Gleno	F		Ermera	Ministry of Health
36	Nurse CSI Gleno	M		Ermera	Ministry of Health
37	Medical Doctor CSI Gleno	F		Ermera	Ministry of Health
38	Pharmacist CSI Gleno	M		Ermera	Ministry of Health
39	Midwife CSI Gleno	F		Ermera	Ministry of Health
40	Chief of VPU Vulnerable Person Unit PNTL	F		Ermera	Ministry of Health
41	Legal Assistant ALFELA	F		Ermera	Ministry of Health
42	Member of VPU Vulnerable Person Unit PNTL	F		Ermera	Ministry of Health
43	Regional Secretary of Health	M		RAEOA	Ministry of Health
44	Chief of Health Center Passabe	F		RAEOA	Ministry of Health
45	Chief of CHC Liquiça	F		Liquiça	Ministry of Health
46	Coordinator of Maternity/BemONC Liquiça	F		Liquiça	Ministry of Health
47	DPHO SMI of Liquiça	F		Liquiça	Ministry of Health
Implementing Partners (CSOs)					
1	Country Director	F		Dili	Maries Stopes International Timor-Leste
2	Pharmacy Officer	F		Dili	Maries Stopes International Timor-Leste
3	Public Sector Support	M		Dili	Maries Stopes

	Manager				International Timor-Leste
4	Evidence to Action Manager	M		Dili	Maries Stopes International Timor-Leste
5	Executive Director	F		Dili	Estrela+
6		F		Dili	Estrela+
7	Executive Director	M		Dili	HAMNASA
8	Program Performance Manager	M		Dili	HAMNASA
9	Midwife Facilitator	F		Dili	HAMNASA
10	Country Director	M		Dili	Global Fund
11	Executive Director	F		Dili	FOKUPERS
12	Advocacy Coordinator	F		Dili	FOKUPERS
13	DMEL	F		Dili	FOKUPERS
14	Field Officer Advocacy	F		Dili	FOKUPERS
15	Director	M		Dili	Belun
16	Project Manager	M		Dili	Belun
17	Finance Manager	F		Dili	Belun
18	Dean of Faculty of Medicine and Science UNTL Head of Asosiasaun Parteira (APTL)	F		Dili	UNTL/APTL
19	Head of Midwifery Department	F		Dili	The Cristal Superior Institute (ISC)
20	Vice Dean	M		Dili	The Institute of Health Science (ICS)
21	Vice Rector of Academic	M		Dili	The Institute of Health Science (ICS)
22	Head of Midwifery Department	F		Dili	The Institute of Health Science (ICS)
23	Executive Director	M		Dili	PRADET
24	Chief Executive Officer	F		Dili	ALOLA Foundation
25	Advocacy Program Manager	F		Dili	ALOLA Foundation
26	Executive Director	M		Dili	INSCIDA
27	Executive Director Ermera Youth Center	M		Ermera	Ermera Youth Center
28	Programme Manager Ermera Youth Center	F		Ermera	Ermera Youth Center
29	Capacity Building Ermera Youth Center	M		Ermera	Ermera Youth Center
30	English Training Ermera Youth Center	F		Ermera	Ermera Youth Center

31	Staff Youth Center	M		Ermera	Ermera Youth Center
32	Executive Director Covalima Youth Center	M		Covalima	Covalima Youth Center
33	Executive Director Viqueque Youth Center	M		Viqueque	Viqueque Youth Center
34	CSE Facilitator	F		Dili	Volunteer
35	CSE Facilitator	F		Dili	Volunteer
36	CSE Facilitator	F		Dili	Volunteer
37	CSE Facilitator	M		Dili	Volunteer
38	CSE Facilitator	M		Dili	Volunteer
39	School Teachers (in charge of CSE)	M		Ermera and Covalima	Secondary Schools
40	Director Disabilities association	F		Dili	RHTO, NGO
Donors					
1	Director for Health & Nutrition	F		Dili	Partnership for Human Development
2		F		Dili	La Trobe University
3	Head of Cooperation	M		Dili	European Union
4	Programme Officer – Social Affair	M		Dili	European Union
5	Program Manager	F		Dili	KOICA
6	Program Coordinator	M		Dili	KOICA

*Note: Names of those the team met are not included as per the UNFPA evaluation policy guidelines. (Community Beneficiaries not include in the list are : women's groups (one group), three student groups (N= 12) and GBV survivor (1), mothers who were interviewd (over 15) at the clinics. Some of the duty bearers participated in FGDs under SI are also not included in this list)

CO provided the stakeholder map comprised of all those who are (and who were) involved in the CP4 development, design, implementation, funding, advising, monitoring, consulting and implementing the programme and those who are directly or indirectly affected by CP4 implementation. Stakeholder map contained names, contact numbers and email addresses. Hence it is not attached here. CO also identified the beneficiaries through CO staff as well as CSOs.

ET after examining the CP4 interventions for the evaluation identified the stakeholders who are closely responsible as well those who had and could make an impact on the programme. Those who were directly implementing the programme and the direct beneficiaries were selected in consultation with each of the CO programme staff. ET also independently selected the stakeholders and suggested for the interviews. Beneficiary interviews could not be pre-planned, thus as field visits took place, beneficiarieds were contacted for interviews and discussions.

Duty bearers comprised government representatives at both the national and local levels, including maternal and infant health and sexual and reproductive health (SRH) municipal authorities and administrators, as well as relevant directorates and staff under the Ministry of Health. Additionally, post-administrative health staff, including doctors, midwives, and nurses were interviewed from the National Hospital, regional hospitals in Baucau, municipal health centers, and health posts in Dili, Baucau, Liquiça, and Viqueque. These healthcare professionals had received training in Basic Emergency Obstetric and Newborn Care (BEmONC) and Health GBV Response. Pharmacists, mSupply coordinators, and representatives of the Regional Medical and Pharmacy Institute in Baucau were also included in the evaluation.

Furthermore, representatives from the Vulnerable Persons Unit (VPU) at the administrative level and community leaders were engaged. Including the Directorate General of MSSI and SEI that oversees the coordination of GBV Management Case and GBV Plan Implementation, respectively. Including also was the Directorate General of Youth under the Ministry of Youth, Sports, and Culture which oversees the planning, revision, and implementation of CSE. Civil society organizations (CSOs) and nonprofit organizations implementing gender-based violence (GBV) awareness programs in targeted municipalities and communities, through initiatives such as SPOTLIGHT, T4E, and ZONTA were also interviewed. This included organizations involved in implementing Comprehensive Sexuality Education (CSE) programming, as well as those providing services and awareness programs for people living with HIV.

Another important NGO that used to collaborate with UNFPA in providing Psychosocial support for GBV survivors and forensic GBV training to healthcare professionals, was also involved in the stakeholder interviews.

An International partner delivering maternal and SRH services, particularly for youth and adolescents, were consulted to gather insights on improving Adolescent Sexual and Reproductive Health and Rights (ASRHR), which was identified as a gap in this Country Programme Evaluation (CPE). Primary donors were also engaged to understand their observations on the implementation and coordination of their donor-funded programs.

For the **CSE component**, teachers and youth advocates who participated in CSE training conducted by CSOs were included through informal group duscussions. Considering the time fator for FGDs- ET could not conduct proper FDG with the beneficiaries. to elicit information. Two FGDs were held with students who participated in CSE programme in school and two with mothers and with health staff who provide services and responsible for the safe space. Photos are included in the Annex on Additional Information.

Rights holders included community members who participated in discussions on GBV conducted by the Social Impact (SI) consultant in Ossú and Viqueque, as well as several beneficiaries (women, and pregnant mothers) who were approached by evaluators during their observations as they were waiting to receivie care in the health centers and hospitals. However, the CPE acknowledges the limited direct engagement with rights holders during the evaluation, relying instead on insights gathered through CSOs. However, the interactins with students, community memebers (safe space and clinic users) and suco level memebers provided additional information to support the inforatin collected through CSOs.

Interview Procedure was explained and the consent forms were signed by the interviewees. Where it was not appropriate (mothers who could not read and understand, ET explained the form verbally to receive their consent. When students were intervewd (those under 18 yrs) teachers'permission was sought before the interview. All interviewed followed ethicalstandarads and guidelines.

CPE ANNEX 4: Data Collection Tools

Tools for data collection

This annex includes five sections:

Section A: General guidance
Section B: Points for semi-structured interviews, grouped according to stakeholders
Section C: Facility visit
Section D: General outline for semi-structured interviews (guide for all team)
Section E: Points for focus group discussion
Section F: Consent Form

SECTION A: GENERAL

INTRODUCTORY REMARKS: TALKING POINTS (guidelines only)

- Explanation of the UNFPA 4th Country Programme (2021-25)
- The purpose of the country programme evaluation (accountability to results, take stock of actual performance and achievements, hindering and facilitating factors that and lessons learnt to design the next UNFPA country programme)
- CPE team: Four person team with three thematic area experts in sexual and reproductive health and population and development and a team leader (international) and national consultant on Youth and Adolescents, and a young emerging evaluator (YEE)
- Confirming the role played by the interviewee in the country programme implementation
- Inform that the interview will cover both experiences and views on UNFPA's country programme and partnerships and suggestions for future UNFPA programme
- Inform and assure the confidentiality of the discussion in line with UN Evaluation Group norms and standards (Example: no identifiers - name or title of the interviewee will not be mentioned in any quotes, won't quote directly, will not share notes with UNFPA, encourage to speak off the record, the report will only highlight common responses (aggregated) among interviewees). If phots are taken the consent will be sought if used in the report. The consent form will be signed or if it is too formal, we will read it out and obtain the verbal consent. If the interviewee is under 18 years of age, parents' or teachers' or any other guardians' permission will be sought. Mention the right to refuse to answer any time of the interview.
- Mention specific issues you want to learn from the person being interviewed or groups with whom discussions are taking place (refer to individual checklists).
- Thank the interviewee for the time and input. Remember to ask for if any recommendations for CP5!

GENERAL GUIDANCE and SEQUENCE FOR ALL INTERVIEWS

1. Begin the interview
   - Ask about experiences with UNFPA as partner or collaborator (responses to be sorted out after the interview in appropriate sections of the evaluation matrix).
   - Probe further to find out what worked well and what has not.
   - For long-term partners such as government or implementing partners, probe about continuity or lack of continuity in initiatives (sustainability)
     If continuity is mentioned, ease of doing business
2. Any significant achievements or contributions of UNFPA-supported programmes that you would like to share (effectiveness)

- Probe factors that contributed to the achievements (Lessons learned)

3. Ask specific questions as relevant from the specific checklist (SECTION B)
4. At the end of the interview:
    - What suggestions do you have for UNFPA to improve the effectiveness of the current programme (CP 4) and for future programme (CP 5)
    - Are there emerging issues or opportunities for significant development contributions UNFPA should be addressing?

SECTION B: POINTS OF DISCUSSION FOR SEMI-STRUCTURED INTERVIEWS

Provide assurance about the confidentiality of the interview

Points for discussion by evaluation questions	UNFPA PO	Government	Municipality	IPs	INGOs Donors	UN partners	Academia	Beneficiary
Special instructions	*Focus on strategic and policy issues to identify UNFPA's niche*							
Relevance of the UNFPA CP 4 in terms of : 1. Alignment of CP outputs and interventions with SP 2022-25 outcomes and SRHR outputs including adolescent and youth and humanitarian action outputs with focus on relevant accelerators (find out which) 2. Alignment of the outputs and interventions with UNSDCF priorities (mention which ones) 3. Alignment with national development and health strategies, essential services package and other policies in youth, GBV and contribution to national development goals 4. Needs of women and girls, survivors of GBV, adolescents and youth, vulnerable	All	(3) (4)	(3) (4)	(4)	(3)	(1) (2) (3)		

populations including PwD considered in the planning and intervention of CP interventions. Provide if any examples. 5.Rationale for selection of target groups 6.Needs of government agencies at national and municipality level (disparities) and NGO/CSO groups have been considered while planning, implementing and monitoring the CP 7.Balance between policy and programme 8.Adaptation made to contextual changes especially during COVID-19 and major floods		(5) (6) (8)	(5) (6)	(5) (6) (8)				
Coherence 1. UNFPA's SRH contribution to achieving the UNSDCF outcomes 2. Efficiency of Monitoring systems in place for tracking UNSDCF outcome indicators related to SRH and ease of tracking UNFPA's contribution 3. Comparative advantage of UNFPA versus other development partners in providing support to the Government in UNFPA focus areas, advancing SRHR	All				(3)	(1) (3)		

4. UNFPA's additional value through partnership with CSOs. Academia, etc. in promoting 5. UNFPA's role in supporting joint UN plans for humanitarian programming especially during the COVID 19 pandemic while ensuring SRH issues are covered adequately					(4)	(4) (5)		
Effectiveness – **SRH** Results achieved through outputs and its contribution to outcomes Discuss overall effectiveness: 1. Progress of RRF indicators and means of assessment 2. Contribution to outcome indicators 3. Effectiveness of the strategies and activities planned to achieve the outputs 4. Any missing intervention/ population groups?	All to POs Only main points with SMT	(4)						
<u>OUTPUT 1.1 : Integrated SRH services</u> 1.Availability of rights-based FP services at all levels of the health system - Access to FP services in <u>underserved areas</u> – discuss selection, strategies employed, methods promoted and referral		All Additional	All		INGO (1)	(1)		FP:FGD with women, LGBTIQ, PWD

- Availability of FP services for vulnerable (adolescents, youth, LGBTIQ and PwD) (policy, training, communication) - Integration of FP in services for postpartum women, HIV and GBV - Capacity building in rights-based FP – coverage (what proportion of providers and which municipalities), *follow up for adherence to guidelines* - Reproductive Health Commodity Security (RHCS) system is operational with improved availability and minimum stock-outs of commodities (for FP, MH, HIV and GBV)- LMIS operational, skills in forecasting supplies		focus on youth, LGBTIQ, PwD Addl.focus (integration) INSPTL INFPM	Addl.focus (integration) Addl.in Facilities		Donor (RHCS)			
2.Services for survivors of GBV including referrals are available at all levels of the health facilities especially health posts and community health centres (Coverage), in-service training, inclusion in pre-service curriculum		Addl.focus on GBV services SEI INSPTL	Addl.focus on GBV services		Partners supporting prevention and management GBV		UNTL (curriculum) La trobe training GBV	Women in safe spaces or survivors
3.Integrated services – *components and its delivery*, inclusion in curriculum of doctors and midwives		Focus on defining integration	Focus on understanding integration					
4.Evidence of capacity for provision of integrated SRH services including services for								

survivors of GBV in humanitarian situations through implementation of Minimum Essential Services Package (MISP) 5.Impression on quality of services delivered		Focus on MISP Contribution of UNFPA to quality	Focus on MISP UNFPA's contribution to quality		(5)			
<u>OUTPUT 1.2: Capacity of skilled birth attendants</u> 1.Quality of MH services: - Updated protocols for ANC, PNC based on WHO recommendations and adherence to the same - Availability of guidelines - Integration of PMTCT, screening for GBV and FP in the protocols and guidelines - Standards for certification of BEmONC facility - CHCs and PHCs that provide BEmONC as per standards for BEmONC facilities in <u>underserved areas (criteria for selection of municipalities, inputs provided, referral for CEmONC)</u> - Access to BEmONC within 2 hours and to CEmONC within half an hour current coverage of BEmONC and CEmONC - Capacity building initiatives 2.Quality of MPDSR - Impression on quality of	All (only main points with SMT)	All (except standards of midwifery edu) INSPTL (Capacity building)	All except midwifery schools Focus on underserved		Japan,Portugal, DFAT (BEmONC facility)	WHO, UNICEF (protocols) UNICEF (BEmONC)		Women attending facilities

MPDSR at national and referral hospital levels) by municipal and referral hospital committees - Evidence of initiation of MPDN application initiated - SSTC with Indonesia on MPDSR on use of MPDSN (electronic version of MPDSR) 3.Information on health seeking behavior of mothers during pregnancy and childbirth and ? SBCC developed 4.Evidence of maternal health services provided during the COVID pandemic and floods 5.Information on current availability of midwives 6.Midwifery schools capacity building - Standards of practice and education as per ICM standards of midwifery practice and education developed - Plans for regulation and law related to midwifery developed - Capacity of midwifery association built as per ICM recommendations - Curriculum and training modules developed as per ICM standards		INFPM (supplies and equipment to schools)		Humantiarian (Belum) Midwifery association		WHO (MPDSR) WHO (5)	Un Tasmania (health seeking) Midwifery schools UNTL Burnett Mahidol (midwifery capacity) Univesade Cambrae	FDG with midwifery schools and Associations

- Three midwifery schools ((UNTL, ICS and Escola Superior Cristal) accredited based on ICM standards - SSTC collaboration for midwifery education under TICA Mahidol University developed 7.UNFPA contribution to expanding access to SBAs, EmONC and reducing MMR						(7)		
<u>OUTPUT 1.3: HIV and STI awareness and services</u> 1.Current strategies for reaching key populations in selected districts with information and preventive services and availability of data disaggregated by type - Data on key populations reached with testing, treatment and care - Data on numbers provided with PrEP - Availability of services during COVID 19 pandemic and floods 2.Capacity building of PNTL - Impressions about the partnership, awareness created about FP, HIV, GBV - Percentage of police force	Only main points with SMT	All INFPM (supplies)	Selected Municipalities	KP (1,3,4) PNTL (2)		WHO		Key Populations PNTL

covered, services provided in clinics managed by PNTL 3.Impressions about strengthening the information about HIV prevention and screening among pregnant women and young people - Data on coverage of pregnant and young people 4.UNFPA's contribution towards reducing stigma and discrimination 5.Policy support - Strategic plan for INCSIDA, national strategy for reducing stigma and discrimination towards PLWHIV and comment on its implementation -Evidence creation about stigma and discrimination towards PLWHIV -Advocacy strategies implemented towards gate keepers about reducing stigma and discrimination towards PLWHIV (disaggregated by groups) 6.Specific actions under the three outputs for coverage of adolescents and young people for FP and HIV prevention and treatment- Policy level and service level, integration with CSE, youth centre activities 7.Assessment of contribution to implementation of integrated		? MOYSAC		Estrela (4, 5)				FDGs with community and religious leaders Adolescents and youth Pregnant women Key populations

PHC								
<u>Points applicable to all three outputs</u> 1.The extent to which the inputs to policy and programme were guided by /mainstreamed by international normative frameworks to advance GEEW and reproductive rights especially for adolescent girls and marginalized 2.The extent to which the inputs were guided by accelerators of UNFPA SP 2022-25 3.Promotion of rights-based approaches, integrated services, gender equality and empowerment of women with partners and their sub-contractors 4.The extent to which the programme implementation has covered vulnerable and persons with disability (also asked under specific outputs) 5.Enabling and constraining factors for reaching results 6.Continued provision of services to key populations during COVID-19 pandemic and floods (some points are also discussed under specific outputs) - Activities undertaken to ensure minimal disruption of FP and maternal health	All to SMT also							

services including EmONC, access to GBV services and HIV and STI prevention during COVID in underserved areas (services, supplies, capacity building), access of key populations to services, supplies such as maternity kits, hygiene kits, etc.to meet immediate needs of women and adolescent girls and pregnant women 7.Application of mode of engagement as an Orange country - key results achieved in capacity development, advocacy and policy dialogue, knowledge management, partnership and coordination including SSTC and interagency coordination during humanitarian; Please provide examples 8.Unintended results, both positives and negatives	Focus SMT							
Efficiency 1.Financial: - Adequacy of financial resources allocated to match the inputs and efficiency in use of financial resources - Timeliness of release of funds - Efficient use of resources	All	All except support from APRO, coordination between thematic areas, UN Joint programme)	(1)	All	All (except inter-thematic coordination and support from APRO)			

- Availability of financial management and procurement procedures and their efficiency 2.Technical: - Adequacy of staff- in terms of numbers to meet the programme requirements and technical capability including consultants, comments on gaps in the original staffing and now - Technical support from APRO, programmatic support from APRO 3.Coordination and complementarity among various thematic areas and Inter-thematic consultations while developing programmes and also during assessments 4.Appreciation of UNFPA support by implementing partners and donors (provide examples) 5. UN joint programme - Adequacy of support under UN joint programme- human resources, technical collaboration, finances - Cost effectiveness of UN Joint programmes and opportunities for enhancing processes, results, transaction costs compared to results			(2)			(4) (5)		

- Efficient use of financial resources - Participation in joint resource mobilisation during the pandemic and humanitarian crisis 6. Efficiency of monitoring framework 7. Effectiveness of the resource mobilization strategy and provide list of resources raised 8. Examples of UNFPA's capability to trigger additional resources based on the investments made under the CP from the government, other partners and donors 9. Impressions on Partnerships - Timeliness of support to partners - Effectiveness of the partnership strategy: rationale for partnerships, criteria for selection of partners - Effectiveness of partners in implementing interventions - Capacity building of partners - UNFPA's role as a partner and flexibility 10. SSTC efficiency in capacity building, any gaps, areas for improvement 11. Flexibility to adapt resources – financial and human resources and partnerships during the			(6) (9) (11)					

pandemic and floods (some points overlap with effectiveness) - Efficiency in reallocating CP resources, raising resources - Innovations introduced in delivering services and capacity building								
Sustainability 1.Impressions on sustainability - Sustainability of capacity developed of implementing partners to manage the project and implement interventions and raise resources - Capacities of beneficiaries developed to demand services particularly women, adolescents, key populations, PwD - Changing attitudes of community and religious leaders to advocate for FP, prevention fo GBV, on stigma and discrimination towards PLWHIV 2.Sustainability of interventions with government counterparts at national and municipal level - Ownership of the interventions (i)provide examples of policies, strategies, changed at national and municipal level	All	All	All esp. 2	All	All			

(FP, HIV, GBV)(ii) financial allocations to continue some of the interventions - Continuation of support by MOH to LMIS, contribution to procurement of contraceptives - Continuing midwifery training as per ICM standards with increased support from Government and private agencies managing the schools - Expansion of policies to include services for adolescents especially FP - National preparedness and response plans include MISP								
Coverage Some of the points may overlap with effectiveness and efficiency 1.Coverage of population groups facing life threatening conditions particularly hard to reach, vulnerable, PwD <u>During COVID 19 pandemic</u> - Support to MOH and other partners to continue SRH services, including for survivors of GBV, and vulnerable groups - Continuation of supply systems - Awareness creation on availability of services and its utilization, prevention of GBV and services	All	All	Selected municipalities	All				

- Prevention of HIV and care and support among vulnerable groups especially key populations Reactivation of the SRH sub-cluster under health cluster -Capacity development of health service providers to provide services while adhering to strict infection prevention measures <u>During the floods</u> - Provision of SRH, GBV and HIV services by local municipalities affected by floods based on the principles of MISP (Numbers provided services by type) - Provision of supplies for pregnant women, women and adolescent girls-numbers provided by type of supplies - Numbers provided psychosocial support - SBCC materials distributed (type), topics covered and communication methods								FGDs with key populations FGDs with displaced women, adolescents

Connectedness **1.** UNFPA's leadership in sub-clusters- provide examples **2.** Whether MISP has been included as part of national emergency preparedness and response plans for pandemic response as well as humanitarian crisis **3.** Awareness about MISP among Municipal health officers and health service providers and local NGOs and feedback on its use 4. Preparedness plans at municipality include MISP 5. Lessons learned/materials developed during COVID and floods being used in regular programme implementation	All	All						
Lessons learned • Lessons learned and experiences that can be applied for future support and can be shared with other countries	√	√	√	√	√	√	√	√
Recommendations for future support • Suggestions for areas of focus in the next CP • Suggestions for mode of engagement and adaptations needed to achieve results	√	√	√	√	√	√	√	√

SECTION C: FACILITY VISIT

Observation During On-Site Visits

Please note there may be changes after discussions with CO and stakeholders at the national level.

Evaluator …….. Date of visit ……
Name/Type of Site

Location- Municipality

Population covered
Infrastructure – maternity ward, labour room, operation theatre, mention if any safe space for survivors of GBV
Staffing
External environment (brief description) [*insert text here]*
Ease of access (location, transport access, etc) [*insert text here]*
Opening hours (and appropriateness for given clientele) [*insert text here]*
Sufficiency of facilities: size, rooms, overcrowding, equipment (space for privacy as well as service provision, whether all equipment functioning, condition of the rooms etc) [*insert text here]*
Range of services that can be accessed and are fully operational (i.e. supplement to documented services); indicate anything that is not operational [*insert text here]* **SRHR services included** - Preconception care -FP (type of services provided) - Maternal care (type of services provided)- ANC, delivery (including immediate care of mother and newborn), PNC -EmONC services- basic /comprehensive - Screening for HIV, Syphilis, Viral hepatitis in pregnant -Prevention of mother to child transmission - STI/HIV prevention, diagnosis and treatments - Services for survivors of GBV -Voluntary counselling and testing - Adolescent and youth health -HPV vaccination - Cervical cancer screening

- Breast cancer screening
- SRHR and adolescent and young people's issues
- Referral arrangements

Home visit

Lab facilities

- Hb estimation
- Blood grouping
- Urine routine and culture
- Biochemistry- Blood glucose, blood urea
- Obstetric ultrasound
- Others – specify relevant to SRH

Availability of IEC/BCC materials, leaflets and posters etc (e.g. variety, numbers, documents to take away etc, language, attractiveness, relevance, range, catering to which client groups)
[*insert text here]*

Guarantee of privacy for consultation/counselling/physical examination (note adequate doors/walls to prevent any overlooking or overhearing); any lapses in privacy observed
[*insert text here]*

Queueing for services, streamlined flow of integrated service provision or multiple queueing required for different services/staff to client ratio
[*insert text here]*

Youth and gender-friendliness (e.g. youth and gender-related materials, youth corner/youth-related activities, appropriate opening hours, staff trained to be youth and gender friendly, privacy and confidentiality for young people)
[*insert text here]*

Interactions between staff and clients (friendly, relaxed, rushed?)[1]
[*insert text here]*

Observation of maternal health service provision
ANC – as per standards
Intrapartum care- as per standards
Labour room, operation theatre- Infection prevention including waste disposal, Emergency tray, Tray for PPH, neonatal resuscitation
availability of pre-packed delivery sets, sets for various procedures and number of sets
Post-natal care to mother and newborn- as per standards
EmoNC- signal functions provided (adequacy of equipment, supplies, skills of providers)
Referral as per guidelines
Health education

FP services
FP- Counselling and services as per standards and level of care
Integrated FP – PNC, HIV/STI, GBV
PLWHIV, disabled

[1] Only to be addressed in appropriate circumstances without infringement of privacy or service

Adolescents – referral
Services for survivors of GBV Provision of services as per standards Observe interaction of staff
Care HIV and STI Counselling Treatment as per protocols Observe interaction of staff
Type of integrated SRH services provided
Disability inclusion: wheelchair accessible, availability of braille materials, staff who know sign language, other criteria [*insert text here]*
Other observations/comments [*insert text here]*

Source: MODIFIED. UNFPA CPE toolkit 13

Effectiveness/ Results

- Awareness about UNFPA supported initiatives
- Capacity building initiatives –topics of capacity building, type of staff trained
- New activities/ services initiated as a result of training
- Improvement in FP services (access to all methods as relevant to the facility, quality)
- Improvement in maternal care – especially increase in quality and number of ANC visits, deliveries by skilled birth attendants, postnatal care
- Increased access of adolescents and young people to SRHR services
- Access of GBV survivors to services
- Service delivery during COVID
  - -Mode of delivery of services during COVID (Changes in service delivery)
  - -Capacity building
  - - Availability of supplies including PPE
  - -Use of digital platforms
- Services provided during floods- awareness about MISP

Review of HMIS and facility level reports

- FP
- ANC, delivery, EmoNC, referral, PNC
- ASRH
- GBV
- Integrated services
- Flow of information to district and feedback

Section D: Additional Data collection tools: Outline and as a guide for Semi-structured interviews (for all four outcome areas as a guide) & Coordination and Humanitarian Response) as relevant, select the questions and modify and add to suit the interviewee and the situation.

Criteria/Evaluation Questions (at what level/interviewee)	**Key Stakeholders/data collection mode (fill in the stakeholder ID)**
A: RELEVANCE	
National partners/policy level 1) How and what priority needs of the most vulnerable population[2] including marginalized groups (adolescents, youth, pregnant women, disability, ethnic group) have been addressed in the national programs? (consistent with CP4CP4 period of Jan 2021 -Jun 2024) 2) How has CP4 aligned with the National sectoral priorities, policies and programmes[3], UNFPA SP, and SDG principles[4]? 3) What actions have been taken to implement commitment made at the ICPD and Programme of Action of ICPD in Timor Leste? What are the key priority areas that are relevant for the context of Timor Leste? 4) How human rights and gender issues have been considered/ reflected in the design and implementation of the country programme? **UNFPA CO** 1) What and how priority needs of the most vulnerable population including marginalized groups had been addressed at the planning phase of the CP4? Who are the MOST marginalized groups as defined by CO? 2) At what extent UNFPA CO has contributed to the development of national policies and programs (identify Timor Leste national plans that are relevant) SOPs including National health facility standards, the National Youth Development Plan and Policy, NAP Gender etc) 3) What was CO's role? How has CP4 aligned with existing national priorities/programs? 4) How have CP4 and its strategies priorities been aligned with the UNSDCF Framework? How does UNFPA contribute to achieving the UNSDCF results? how does partnership work? 5) How has CP4 been aligned with the priorities set by ICPD Plan of Action and national policy frameworks related to UNFPA mandate areas? 6) How the design and implementation stages of the country programme have considered human rights and gender issues? 7) What are the lessons learnt? What are the successes and challenges that should be reflected/addressed in the CP5? 8) How the UNFPA SP and SDG core principles, transformative goals, and ICPD had been addressed at the planning phase of the CP4? 9) To what extent the SSC/SSTC under CP4 has enhanced international development	**Key Informant Interview (KII):** **U**NFPA staff **IPs:** **KII:** **U**NFPA staff **IPs:**

[2] Vulnerable groups include: the poor, women, pregnant women, children, people living with HIV, survivors of GBV, LGBTQI and people with disabilities

[3] National Policies (on relevant areas) on Health, National Policy on Youth, GBV, National RH plan, National Programme on Youth Development, National policy on population development etc

[4] (LNOB and reaching the furthest behind), transformative goals, and business model

cooperation? 10) What are the lessons learnt? What are the successes and challenges that should be reflected/addressed in the CP5? **UNFPA CO** **Implementing partners** 11) How have CP4 been aligned with the national strategies/policies in relation to international development cooperation? **National partners/policy level** 12) How the SSC/SSTC under CP4 corresponds to SDG core principles, transformative goals, and ICPD? 13) How the SSC/SSTC under CP4 is in line with the national strategies/policies in relation to international development cooperation? **Implementing partners** 1) How has CP4 projects/programmes been integrated with national policies and programmes? 2) How CP4 projects considered human rights and gender issues? 3) How CP4 projects considered the needs of the most vulnerable population including marginalized groups 4) What are the lessons learnt? What are the successes and challenges that should be reflected/addressed in the CP5?	
B: EFFECTIVENESS:	
National partners/policy level 1) What and how have CP4 projects/programmes contributed to establish the national mechanism to promote youth participations and youth organizations including marginalized group ? What was the degree of achievement? 2) How have the strategic media and private partners actively engage in right based advocacy and youth empowerment 3) How human rights and gender issues have been considered/ reflected in the implementation and reporting results? 4) What were the main supporting and hindering factors? 5) How sustained the results are and what actions were taken at the Ministerial/national and sub national level? (youth representatives, curriculum, model)? Governance? 6) What are the lessons learnt? 7) How COVID-19 pandemic affected the continuity of the CP4/other donor funded projects/programmes? **UNFPA CO** 8) Have intended programme outputs been achieved? How they have been monitored? How has CO ensured quality of the programming? 9) What contributed to the achievement of the planned outcomes and what was the degree of achievement of the outcomes? 10) What were UNFPA's policy and advocacy roles in reaching the planned outcomes?	**KII:** **Observation** **Beneficiaries:** FGD youth representatives

11) How COVID-19 pandemic affected continuity of the CP4/projects and programmes? **IPs** 12) What were the key changes made in the youth development and AYSRHS as a result of CP4/UNFPA projects/programmes? How has it been monitored? Was the change/support systematic? 13) What were the main supporting and hindering factors? 14) How has COVID-19 pandemic affected continuity of the CP4 interventions/projects/programmes? **Beneficiaries** **(for youth (in-school students and out-of-school community) In TL, secondary school has some students who are above 20 yrs.** 15) Have you been to (or used) any adolescent and youth friendly clinic or a place where comprehensive sexual and reproductive health services are offered? Are you aware of any such programme or initiative? 16) Are contraceptive available in these places? (If yes), Was their confidentiality been protected? Are they respected while receiving services? 17) How human rights and gender issues have been considered/ reflected in the service delivery? Are girls and boys treated the same way? 18) What suggestions do you have to improve the services? 19) How have you been the youth representatives in the national/ subnational committee? 20) What suggestions do you have to improve the mechanism to promote youth participations?	
C. EFFICIENCY	
National/policy level 1) Does CP4 have sufficient resources to implement its planned interventions? Do you think there is value for money for its intervention vis-à-vis the results achieved? 2) How do you evaluate UNFPA CO's staffing portfolio and their appropriate skills to implement/support implementation of the planned interventions? 3) How has UNFPA CO demonstrated accountability to achieve its outcome? What are the evidences? **UNFPA CO** 1) Does CP have sufficient resources to implement activities? 2) How has UNFPA CO demonstrated accountability to achieve its outcome? What are the evidences? 3) Human resources: has UNFPA CO adequately staffed who possess required skills to implement activities? 4) What are the evidence of CP4' s accountability to achieve its outcome? **IPs** 1) Does CP4/UNFPA CO have sufficient resources to implement planned activities? How important these activities are to the implementation of the national program/policy? 2) 3) How has UNFPA CO demonstrated accountability to achieve its outcome? What are the evidences? Can you provide examples?	- **KII:** select relevant informants from the list provided

D: SUSTAINABILITY	
National/policy 1) How effective is the partnership that has forged as a result of CP4? What are the areas of collaboration as far as UNFPA mandate areas are considered? How about advocacy and policy level interventions? 2) How has UNFPA supported IPs to strengthen their ownership, capacity and sustainability of CP4 and its projects? 3) Was there structure (TWG?) that ensured sustainability of the CP4 results? **UNFPA CO** 4) How effective is the partnership that has forged as a result of CP6? What are the areas of collaboration as far as UNFPA mandate areas are considered? How about advocacy and policy level interventions? 5) How has UNFPA supported IPs to strengthen their ownership, capacity and sustainability of CP4 and its projects? 6) Was there structure (TWG?) that ensured sustainability of the CP4 results? **IPs** 1) How has sustainability of the UNFPA supported projects maintained as far as planning, budget allocation and human resources are concerned? 2) What were the achievements? 3) What were the supporting and hindering factors as far as sustainability is concerned? 4) What are the suggestions for the CP5 (priority areas)?	**KII:**
E**. Coordination with development partners and Added value**	
National/policy 1) What is the UNFPA's added value in the country context? Please provide some examples. (Evidences) **Donor** **1)** What is UNFPA's added value in the country context? (Evidence) 2) What were UNFPA's main responsibilities/roles? How UNFPA increased its value? 3) What is UNFPA's added value in the country context? **IPs** 1) What is UNFPA's added value in the country context? (Evidence)	**KII:**
E**. Coordination with development partners and Added value (specific to Outcome 4 Population Dynamics/Output 3)**	
National/policy 1) What is the UNFPA's added value in the country context? Please provide some examples. (Evidences) **IPs** 2) What is UNFPA's added value in the country context? (Evidence) **Beneficiaries** 3) What is UNFPA's added value in the country context? (Evidence)	**KII:** **U**NFPA staff **IPs:** **Beneficiaries:**
Criteria: Coordination & Added Value	**Key Stakeholders/data collection mode**
1. Could you please tell me about current UNCT coordinating mechanism? 2. How is UNFPA contributing to the coordination mechanism? (probe: UNFPA's	UNFPA Head of Office,

contribution to UNDAF (not the details, your perceptions and observations if any), technical contribution, division of tasks and coordination 3. Can you provide examples of evidence that UNFPA has actively contributed to the coordination mechanism of UNCT (probe: leadership, initiatives taken, etc)?	RC and relevant UNCT members (key members UNICEF, UNDP, UNWomen, WHO)
4. What is your view about UNFPA's participation in UNCT working groups and joint initiatives? Any examples of such collaborations? Is there a clear division of tasks amongst the UN agencies at the national level and sub-national levels?	UNFPA Head of Office, RC and relevant UNCT members
5. In your understanding what is the UNFPA's comparative advantage? 6. Do you think the Agency uses it optimally? (probe). Any examples? What do you think about UNFPA on establishing, maintaining and leveraging partnerships with UN agencies and other development partners (if you are aware) to utilize UNFPA's comparative strengths? (probe) 7. On partnerships, do you have any partnership (technical cooperation) with UNFPA? (Probe - In the areas of A&Y, SRHR, GBV, PD, SSC etc) 8. Are human rights and gender issues considered/ reflected in these partnerships? Probe for examples: design stage, budgetary allocations, implementation) **9.** What is your opinion about the role played by UNFPA in this partnership? Any suggestions to improve (if any need)?	UNFPA Head of Office, RC and relevant UNCT members Donors Partners (Public and Private) CSOs, UNFPA CO relevant staff
10. About emerging issues: What is your opnion/understanding or observation about UNFPA's preparedness in and response to emerging issues in the country (eg. COVID19), joint initiatives and leadership role (if any you are aware)?	RC and other relevant UNCT members UNFPA CO relevant staff
11. What is **the key Added Value** that UNFPA brings to the table compared to other development partners (outside the corporate mandate)?[Probe]	RC and other relevant UNCT members Development Partners
12. What is the benefit UNFPA CO receive from coordinating with other United Nations agencies and partners in the country to ensure complementarity?	UNFPA CO relevant staff, UNCT members in joint programme, RGs and TWGs
13. Any other issues you would like to mention, related to what I mentioned before?	RC and other relevant UNCT members Development Partners
14. In relation to what we discussed, what recommendations would you like to offer UNFPA for CP5 (and/or for the remaining period of CP4)?	RC and other relevant UNCT members Development

	Partners *(if needed KII – hold remotely using digital connecting facilities)*
Coverage and Connectedness	
1. Who were affected most in the (humanitarian emergencies during CP4 – ask about floods in 2021, 2023 and COVID 19)? 2. What percentage (roughly) was UNFPA able to cover? What populations? Do you have the list of groups that UNFPA covered – Are they the neediest groups? (ask for data) 3. How many from hard-to-reach and "furthest-behind"? 4. What kind of systems that UNFPA established? Who did UNFPA coordinate with when responding to humanitarian needs? 5. What were the long-term plans (apart from the response) to reduce the effects from such emergencies in the future? 6. Establishments with line miniseries, municipal bodies, community groups, CSOs etc,?.	UNFPA CO staff CSOs UNCT

SECTION E

Guidelines for focus group discussions

The interview guide identifies focus group discussions as a tool under selected questions under the effectiveness and sustainability.

The following is a general guideline for conducting focus group discussions.

1. *Selection of participants*

- Similarity of participants (with regard to the issue and level of beneficiary)
- Size- 8-12 participants (may be even less if digital interview)
- Absence of hierarchical relations to enable each member to express their views without fear or repercussions
- Permission of parents for adolescents below 18 years (see Annex 1 – consent form)
- Moderator- facilitated by a skilled moderator

2. *Develop focus group discussion guide*

- Develop the objective
- Questions should cover knowledge about a service, client rights, access to new services, the experience during the visit to a provider/facility

3. *Sequencing*

- Building rapport with the group
- Informing the group about the context and purpose of the discussions
- Opening question to gauge general understanding of a particular issue
- In-depth questions ensuring that all are given a chance to express, summarize opinions. Probe if the question is not understood. (interviewer should not express their views)
- Wrap up by asking the participants to reflect on the discussions and present a summary of the discussions

Suggested topics for focus group discussions

Please note that the list below includes a few topics. The team will develop a detailed checklist to help the facilitators of focus group discussions

<u>Women and adolescent girls</u>

- Access to FP (including barriers, availability of methods, possible side effects, action to be taken, attitudes of providers)
- Access to maternal health (ANC care (explanations provided, examinations including screening for depression, danger signs); care during delivery- respectful providers, explanations provided and advice on discharge especially on FP and danger signs)
- GBV- attitude of providers, counselling, emergency contraception, PrEP, treatment
- Support of community to survivors of GBV
- Cervical cancer- awareness about services – screening and treatment and awareness about HPV vaccines (adolescent girls)
- Ease of access to facilities and providers during COVID, special precautions
- Access to services during floods

<u>Vulnerable groups including PWD</u>

<u>Key populations</u>

- Inclusiveness in UNFPA programmes (design of interventions, in implementation)
- UNFPA initiatives to prevention, care and treatment of HIV and STI and its effectiveness, issues and problems

- Special actions taken by UNFPA to support the SRHR needs
- Support provided in cases of violence
- Recommendations for the next CP

PwD

- Inclusiveness in UNFPA programmes (design of interventions, in implementation)
- Special actions taken by UNFPA to support the SRHR needs
- Special actions taken by UNFPA to overcome barriers due to disability
- Recommendations for the next CP

Tools used in collecting data by other CPE (Online survey by UN Women), Interview questions by SI and CF evaluations are not included here)

Section F:

Participation Assent Form UNFPA [insert country] CPE

Note to the M&E Officer: *Please make sure the evaluation team fills in the text below and/or develop text as required.*

This form should be used to obtain consent from rights-holders aged less than 18, to take part in a focus group discussion or interview. **Written consent is required** from their respective parents/guardians. Note that even if the child's guardian has signed a consent form, the child is free to refuse to sign an assent form and not to participate in the group. In this case, no one is allowed to put pressure on the child to participate.

Focus Group Interview Number …… Moderator/evaluator …….
Date[dd/mm/yy] ……. Site Location ……
Interpreter [delete if not needed] **…….**

Purpose

You have been invited to participate in [a focus group/an interview] organised by UNFPA as part of the evaluation of the UNFPA [name of country] [cycle of assistance: number] Country Programme [programme period: year-year]. The purpose of this exercise is to help UNFPA understand better the effects of its support to [insert nature of the programme that forms the subject of the focus group interview]. The aim is to hear your views regarding the issues that are relevant to you, how the [programme] supported by UNFPA have helped you; and what you think is working well or not working well. We would also like to hear suggestions you may have for how UNFPA might improve its support in the future.

Procedure

The evaluator will ask the questions and make notes of responses. The [focus group discussion/interview] may be audio recorded for reference when compiling the final notes. However, all responses will remain confidential, and no names will be included in the final report. You can choose whether or not to answer any particular question, and you are free to leave early if you wish to.

There are no right or wrong answers, and you are free to give your personal viewpoints, whether or not you agree with what someone else has said.

Confidentiality

Information about you that will be collected from the exercise will be put away and only the evaluator will be able to access it. Any information about you will have a number on it instead of your name. Your responses will also remain confidential.

I understand the purpose of the [focus group discussion/interview] and hereby agree to participate on the understanding that my contributions are confidential.

Name ……
Signed …… **Date** ……..

Age…….. **Sex** ……

Source: UNFPA CPE toolkit 12 B

In addition, UNFPA country office informed in advance about the CPE and the team's interview date and purpose. UNFPA CO prepared the consent forms to be used in interviews (for the team use).

Annex. 5 (Additional Information)

Annex 5 includes additional information to the main report. Due to the report page limit some important information could not be included in the report. Please refer to this additional information for further details.

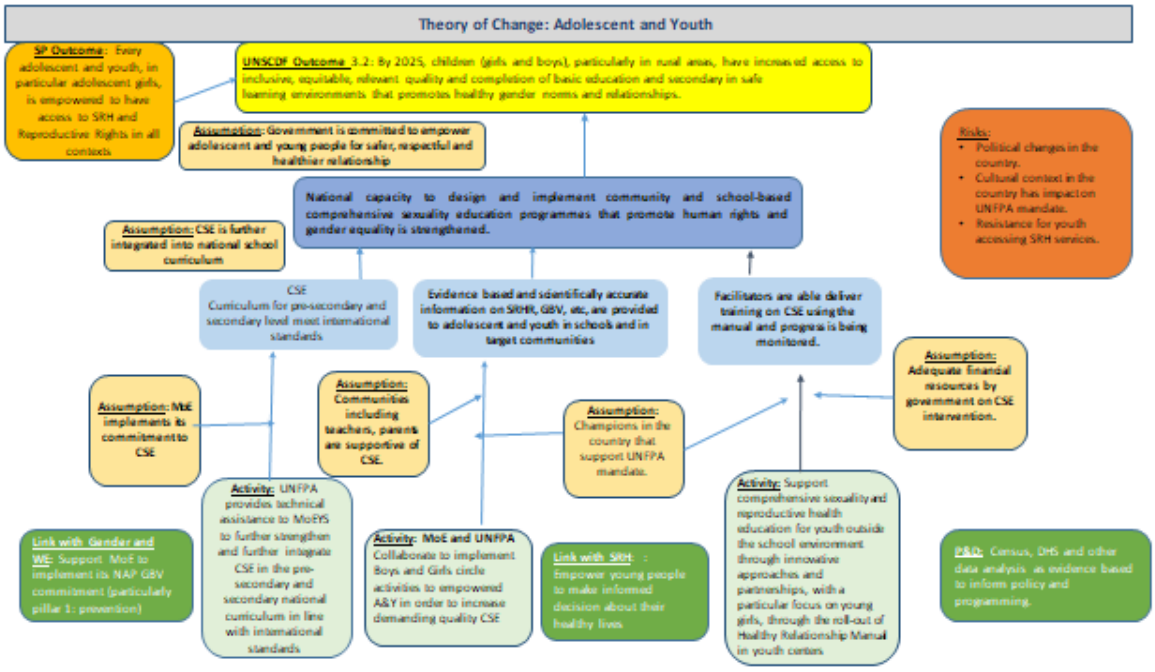
Table 1. Selection of Sample Sites for data collection

Municipality	Post Administrative	Programme Intervention	Criteria (Justification for Selection)
Baucau	Quelicai Baguia Horex Baucau	SRHR (13), AY (3), GEWE (1) and PD (2)	• Baucau, the second-largest city in Timor-Leste, has a significant adolescent and youth population with 2 AY interventions • High coverage of integrated SRHR interventions (13) in the Eastern Region, including GEWE, AY, and PD. • Focused SRHR interventions in remote areas of Quelicai and Baguia. • New referral hospital in Baucau City, the only one in the Eastern Region. • An old hospital repurposed as a COVID-19 isolation and treatment facility has been modernised, with some renovated rooms now used for maternal care High prevalence of GBV and HIV (53 cases).
Covalima	Suai Zumalai Tilomar Fatumea Maucatar	SRHR (14), GEWE (4), AY (3), and PD (1)	• Highest coverage of integrated SRHR interventions (14) in the Western Region, including significant interventions for GEWE (3), AY (3), and PD. • Referral hospital located in Suai, West Region. • Vulnerable to cross-border diseases, with a high number of HIV cases (95). • Focus on HIV and STI prevention at the post-administrative level. • While Bobonaro and Covalima are geographically close, UNFPA's programming in Covalima emphasizes HIV/STI interventions alongside integrated sexual and reproductive health and family planning activities.

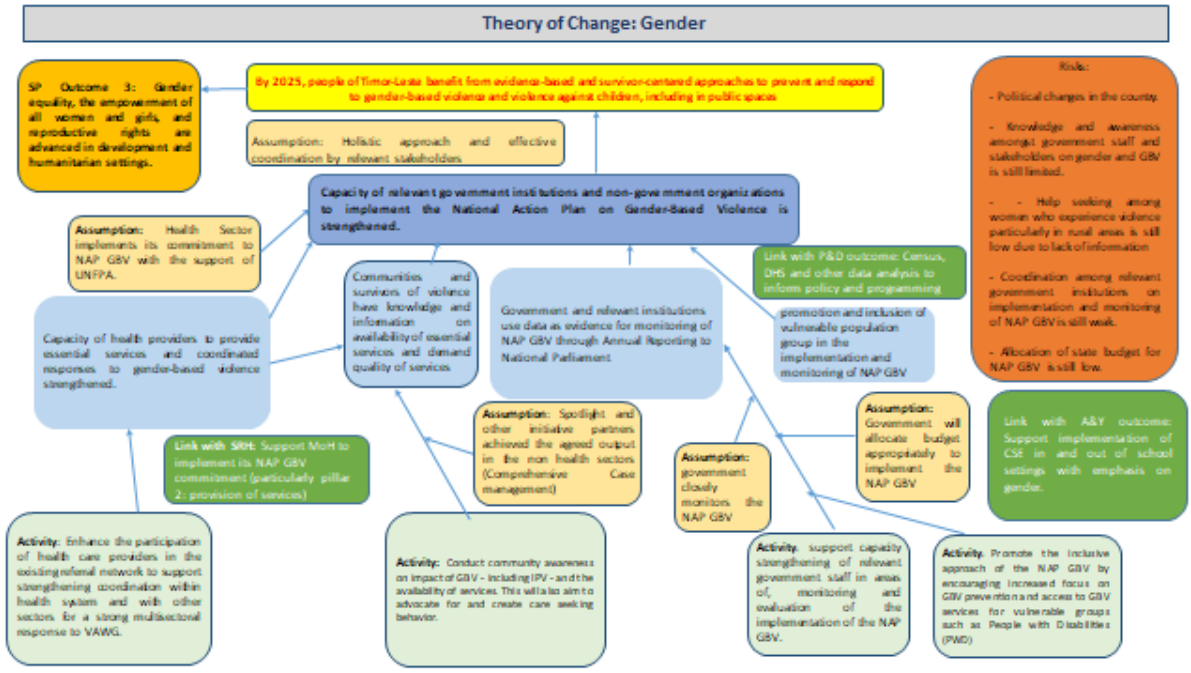
Dili		SRHR (20), GEWE (2), AY (3), and PD (2)	• Capital city with the highest number of interventions in the Integrated SRHR programme • Most populated city in Timor-Leste experiencing rural-to-urban migration, particularly among adolescents and youth • Centralisation of most services, including health care requiring specialists, in Dili • All health agencies and organisations, directly or indirectly under the Ministry of Health, are based in Dili, including Rede Ba Saude-Timor-Leste (REBAS-TL), a civil society health umbrella established in 2022 • Most affected from floods (April 2021) and COVID-19 pandemic, resulted in an increased displacement of people • National General Hospital of Guido Valadares serves the highest number of patients and health cases
Liquiça		SRHR (6), GEWE (7), AY (1), and PD (1)	• Closest municipality to Dili • Highest intervention for gender-based violence (GBV), funded by Zonta International, alongside integrated SRHR interventions, including BEmNOC strengthening and safe spaces
Ermera	Hatulia B Railaco Hatulia Atsabe	SRHR (11), GEWE (8), AY (3), and PD (1)	• Highest coverage of integrated SRHR interventions (11) in the Central Region, apart from Dili, with significant interventions for GEWE (8), AY (3), and PD (1) in the Western Region • One of the most impoverished municipalities in Timor-Leste, despite being the only municipality that produces coffee, the second most exported product after petroleum • Severely affected by floods (April 2021) in addition to the COVID-19 pandemic • High rate of adolescent pregnancy (822 cases) • Notable number of HIV cases (35)
Viqueque	Caraubau Matahoi	SRHR (7), GEWE (8), AY (3), and PD (1)	• Significant coverage of interventions, particularly in GEWE (GBV response), SRHR, AY, and PD in the Eastern Region, aside from Baucau • Focus on GBV at the post-administrative and suco levels through the Spotlight Initiative (The UN joint project) • Least accessible area, with a high maternal mortality ratio and limited access to sexual and reproductive health services • Lack of awareness, limited availability of contraceptives, and underutilised family planning services, often due to cultural barriers.

Four schematic diagrams (AY, P, Gender and SRHR): Theory of Change (since they are not legible enough, PPT presentation is attached).

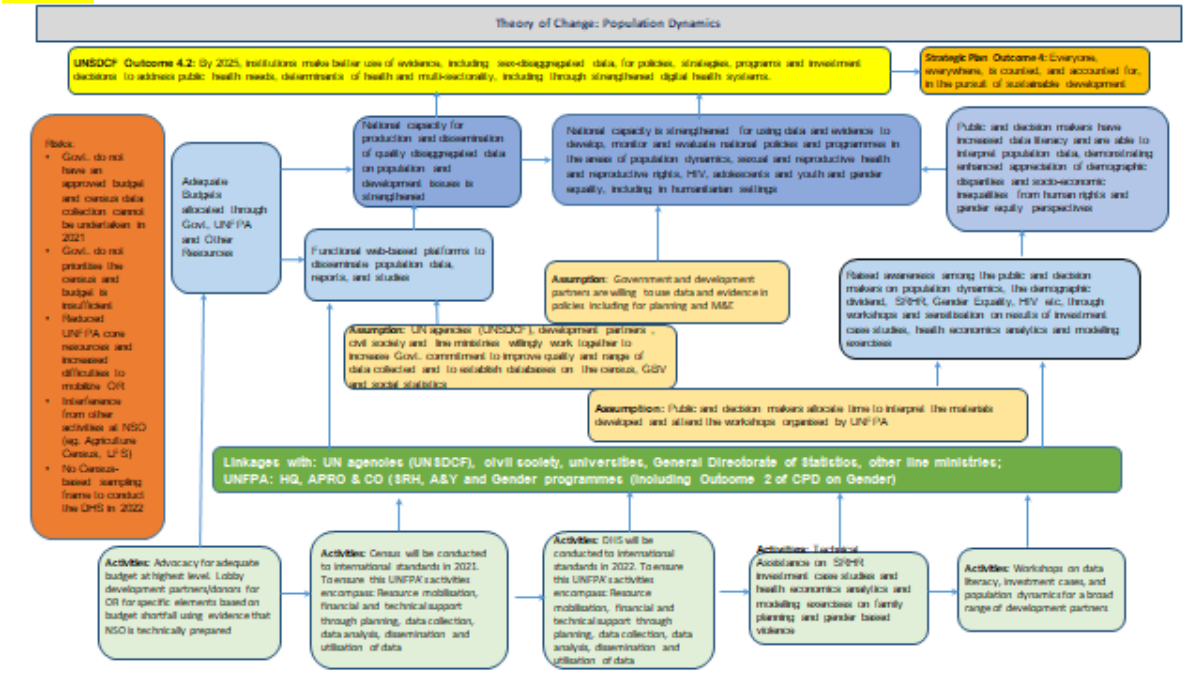
TOC-AY



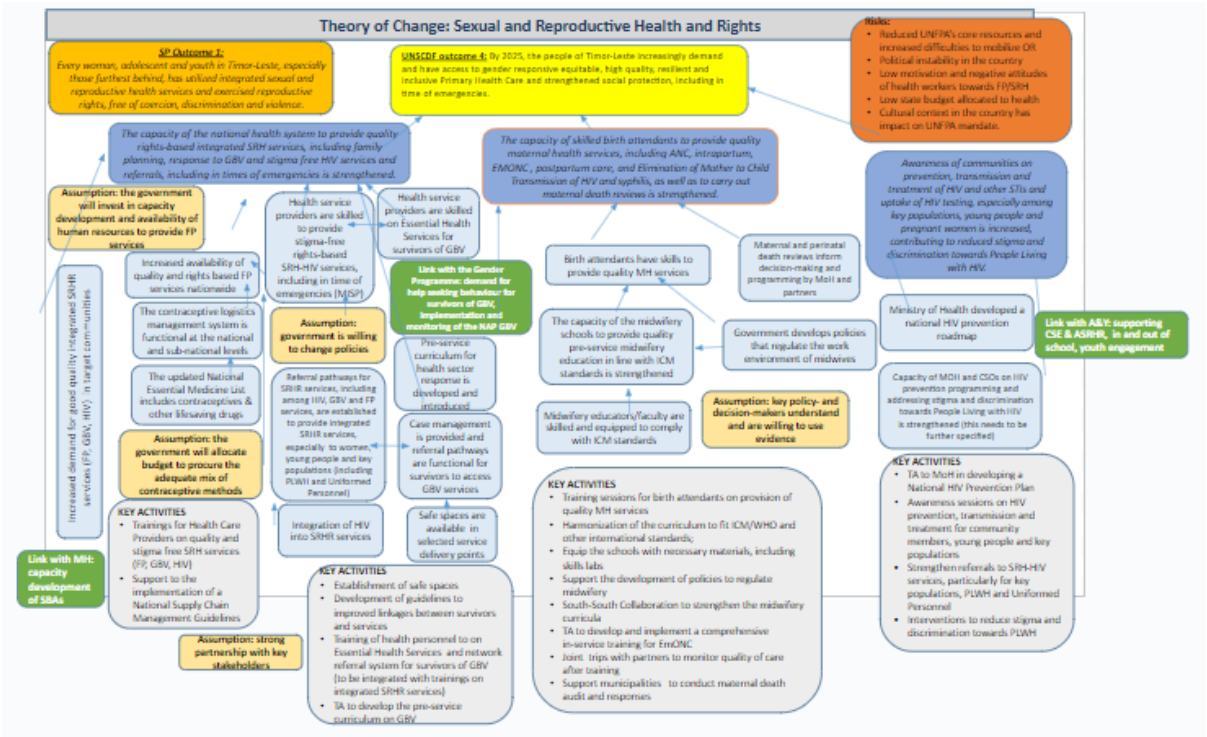
TOC-GEWE



TOC-PD



TOC-SRHR



Discussion notes on the above TOCs

Topic	Minutes	Follow-up
Preliminary findings	• The CO has not performed the realignment of TOC with the SP 2022-2025 • Since the future review of the SP will not be significantly different from its old version, the Timor-Leste TOC for the new cycle may need to undergo this alignment workshop • Though the CO obviously engaged in activities aligned with the SP, the CP4 TOC do not display any linkages with the three transformative results, but more importantly with the 6 SP outputs and the 6 accelerators • The TOCs mentioned risks but there is no risk mitigation matrix	• CO to organize a workshop on TOC – plus alignment with UNFPA Strategic Plan • Missing linkages have to be recorded • Next TOC should refer as much as possible to the SP outputs and the accelerators • Risk mitigation matrix should be added to the TOC
SRH	• The Supply Chain Management is missing in the TOC • The Community awareness for SRHR is missing in the TOC • The Adolescent SRH is missing in the TOC • Although those activities are implemented, they are not explicitly included in the TOC • Need for more focus on policy alongside service provision	• Those missing activities can be added in the TOC but should be condensed
Adolescents & Youth	• Good ownership of the government of the CSE programme should that the expected results of strengthening the capacity is a success	• The NAP Youth must have more focus on the health part • More focus on advocacy work for legal age of marriage • More focus on engagement of male • Quid school health services as entry point to reach A&Y
GEWE	• No exit strategy • (Missing linkages in the TOC will be shared later on by Gender team)	•
PD	• Why are the investment cases (on SRH) placed under PD and not under SRH?	•

General Comment: Integrate the six accelerators and focus on results pathways to achieve the three transformative results
Six ACCELERATORS OF SP Human rights and gender transformative approaches, Innovation and digitalization, SSTC, data evidence, LNOB, Resilience, adaptation and complementarity among development and humanitarian efforts

SRHR has three outputs – they are shown in detail in the schematic diagram below

Theory of Change – Sexual and Reproductive Health and Rights

SP Outcomes: 1). By 2025, the reduction in the unmet need for FP has accelerated. 2).By 2025, the reduction in preventable maternal deaths has accelerated. 3). By 2025, the reduction in GBV and harmful practices has accelerated.

SP Outcomes 2022-25

Output 1.1. The capacity of the national health system to provide high-quality, rights-based integrated sexual and reproductive health and HIV services, including availability and increased demand for FP, response to GBV, in line with essential service package, stigma-free HIV services and referrals is strengthened, including in humanitarian settings.

Output 1.2. The capacity of skilled birth attendants to provide high-quality maternal health (MH) services, including antenatal care, EmONC, postpartum care, and elimination of mother-to-child transmission of HIV and syphilis, as well as to carry out maternal death reviews, is strengthened, especially in areas most in need.

Output 1.3. Awareness on prevention, transmission and treatment of HIV and other sexually transmitted infections, and uptake of HIV testing, especially among key populations, young people and pregnant women is increased, contributing to reduced stigma and discrimination towards people living with HIV.

CP Outputs

Link with Gender

- Support for Health system strengthening
  - to improve access to quality rights-based FP services, integrated with MH, HIV and GBV services
  - to improve availability of FP and other reproductive health supplies (RHCS)
  - to respond to GBV with essential services including referrals and safe spaces
  - to provide MISP during humanitarian

- Support for health system strengthening
  - to provide quality MH services integrating screening for HIV, syphilis and viral hepatitis and violence and FP during PP period.
  - to provide timely and quality EmONC services and referrals
  - MPDSR reviews at municipality and national level
- Institutional capacity strengthened
  - for quality midwifery education to meet ICM standards with TA through SSTC
  - regulations of midwifery practices
  - supported by strengthened midwifery association

- Support for policy and systems for improving access of key populations and vulnerable groups to comprehensive package of information on SRH, STIs, testing, preventive services and treatment of key and vulnerable populations
- Development of evidence-based policy for reducing stigma and discrimination towards PLWHIV

- Support for health system strengthen. for adolescent responsive health services, preconception pkg and cervical cancer prevention

Linkage with Adol. and Youth programme

Strategies

Support for health system strengthening to provide integrated SRHR services (FP, MH, HIV, GBV) at CHC level (one stop centre), focus underserved, young people vulnerable including PWD

Six ACCELERATORS OF SP : Human rights and gender transformative approaches, Innovation and digitalization, SSTC, data evidence, LNOB, Resilience, adaptation and complementarity among development and humanitarian efforts

Accelerators

Assumptions: Strong partnership with civil society, NGOs, INGOs and Donors and UN partners; Continued support from UNFPA thematic funds, donors and others to expand the availability of EmONC services, RH supplies; Increased funding from the Government for RH commodities especially FP supplies.
Risks: Political instability, pandemics and humanitarian crisis, reduced funding, increased resistance to provide FP services to adolescents

Assumptions and Risks

TOC discussion with CO staff

(Continued) Additional Information Annex 5

(SRHR)

a. Table CP Outcome and Output Indicators
b. Other graphs

a. CP Outcome and Output indicators and comments on output indicators

UNSDCF OUTCOME INVOLVING UNFPA: Outcome 4: By 2025, the people of Timor-Leste increasingly demand and have access to gender-responsive equitable, high quality, resilient and inclusive Primary Health Care and strengthened social protection, including in times of emergencies.			
UNSDCF outcome indicator	Baseline 2021	Current	Target 2025
Proportion of married women aged 15–49 years who currently use modern contraceptive methods.	24.1% (TLDHS 2016)	55.1% (estimated) (HMIS 2023 (Source: UNFPA CO MEL report 2023)	40%
Proportion of births attended by skilled health personnel (SDG indicator 3.1.2/SP indicator) (geographical disaggregation)	56.7% (TLDHS 2016)	64.9% (2023) (Source: UNFPA CO MEL report 2023) 68.5% (Census 2022) SBA increase in Dili 85% (2016) to 93.3% (Census) and in Ermera, the increase was from 20% (2016) to 41% (Census)	>70%
Maternal deaths per 100,000 live births	195 per 100,000 live births (2016 DHS) UN estimate -204 (2022)	NA Census 2022 reported 413 per 100,000 live births	135 per 100,000 live births
Proportion of population 15-49 years with comprehensive knowledge of HIV (gender disaggregated)	Men 16%; Women 10% (TL DHS 2016)	NA	Men 25%; Women 25%
UNSDCF OUTCOME INVOLVING UNFPA: Outcome 3: By 2025, all people of Timor-Leste, regardless of gender identity, abilities, geographic location and particular vulnerabilities, have increased access to quality formal and innovative learning pathways (from early childhood through lifelong learning) and acquire foundational, transferable, digital and job-specific skills.			
Adolescent birth rate Per 1000 women in that age group	42 (TL DHS 2016)	20.8 (reported) or 33.8 (own children method- source Thematic report on Fertility and Nuptiality, Census 2022)	35
Percentage of women 15–24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission •	7.7%	NA	25%

Percentage of men 15–24 years old who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.	14.6%	NA	25%
Output 1.1. The capacity of the national health system to provide high-quality, rights-based integrated sexual and reproductive health and HIV services, including availability and increased demand for family planning, response to GBV, in line with essential service package, stigma-free HIV services and referrals is strengthened, including in humanitarian settings.			
Number of community health centres providing good quality comprehensive reproductive health services including HIV and family planning in municipalities.	0	22 (61% achievement) (Source: UNFPA CO Mel report 2023)	36 (CPAP)
Percentage of health facilities with no stock out of modern contraceptives in the previous year	38%	72% no stock out in the last 3 months (2022 Facility audit) 54% no stockout for 3 methods of contraception (all facilities are expected to provide) and 60% for 5 methods of contraception (CHCs and Hospitals provide) (Source: UNFPA. Report on assessment for reproductive health commodities and services in Timor Leste 2023).	100%
Number of community health centres with capacity to provide essential services and referrals to survivors of gender-based violence.	0	6 (46% achievement) (Source: UNFPA CO Mel report 2023)	13 (CPAP)
Output 1.2. The capacity of skilled birth attendants to provide high-quality maternal health services, including antenatal care, EmONC, postpartum care, and elimination of mother-to-child transmission of HIV and syphilis, as well as to carry out maternal death reviews, is strengthened, especially in areas most in need.			
Number of health facilities providing 24/7 basic EmONC services as per national standards.	0	5 (In addition, one in Passabe about to be completed) (Source: UNFPA CO Mel report 2023)	32
Number of municipalities with functioning maternal and perinatal death surveillance response mechanisms.	5	13 (100%)(Source: UNFPA CO Mel report 2023)	13
Midwifery schools that have the capacity to deliver the updated national curriculum, skill lab and clinical training site that meet	0	3 (100%)(Source: UNFPA CO Mel report 2023)	3

ICM standards and are accredited by the government.			
Output 1.3. Awareness on prevention, transmission and treatment of HIV and other sexually transmitted infections, and uptake of HIV testing, especially among key populations, young people and pregnant women is increased, contributing to reduced stigma.			
Number of UNFPA supported organizations (CSOs or other national institutions) actively working towards increasing comprehensive knowledge of HIV.	1	3 (100%)(Source: UNFPA CO MeI report 2023)	3
Number of people who have been tested for HIV in the past 12 months and received the results of the last test.	0	34084 (34.8%) (Source: the total numbers are for 21-23, from reports submitted to MOH)	100,000
Percentage of people 15-49 years with discriminatory attitudes towards People Living with HIV, disaggregated by gender.	Men 54.9% Women 76.4 % Source not known TL DHS 2016 reported that 68%-85% of women and 50%-62% of men had discriminatory attitudes	No data is available	Men- 36.6% Women-50.9%

Comments on output indicators

Indicators related to Output 1.1 on building capacity of national health system on high quality, rights-based and integrated SRH and HIV have progressed, despite some of the initial set back due to the COVID-19 pandemic. 61% of Community health Centres (CHC) is reported to be providing good quality comprehensive SRH services including HIV and family planning compared to zero in the baseline; however, there are concerns about integration as discussed under Finding 7. The second indicator related to percentage of health facilities with no stock out in the previous year showed that that 72% of facilities surveyed in the 2022 assessment of RH commodities had no stockout of 'any contraceptive' in the 3 months prior to the survey[1] which is a progress compared to the baseline figure of 38% (the indicator refers to previous one year for which the data is not available). It should be also noted that for three modern methods of contraception (which is expected to be available at all levels of health facilities), the level of 'no stockout' was 54% (shows improvement). However, during visits to municipalities stockouts of selected contraceptives and other RH supplies have been reported (details give under Finding 7). The progress of the third indicator related to the number of CHCs providing services to survivors of GBV is good (46%). It is likely that the progress will be 100 % by the end of the CP. The CHCs are CSI Viquque (Viqueque), Gleno (Ermera), CSI Liquica (Liquica), Vera Cruz (Dili), Atabe (Bobonaro) and Oecusse.

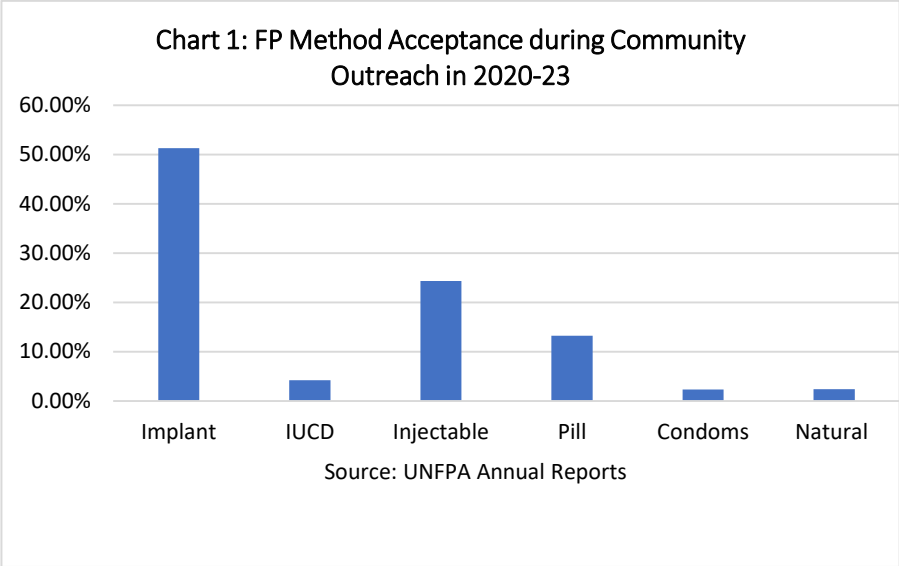
Indicators related to the Output 1.2 on *strengthening the capacity of the skilled birth attendants to provide maternal health including EmONC services and maternal deaths reviews* have made progress despite the setback due to COVID in the early days of the CP. The inputs for strengthening BEmONC services had started in the previous CP. The number of functional, certified BEmONC facilities has increased but the numbers are few as the refurbishment of facilities takes time and the certification process is thorough. The progress with regard to the indicator on functional MPDSR committees – all 14 municipalities have a MPDSR committee- but their quality of functioning is not known. The third indicator related to capacity of midwifery schools has been achieved- One government and two

[1] UNFPA. Report on assessment for reproductive health commodities and services in Timor Leste 2023.

private midwifery schools have been strengthened. However, there are few concerns described in the main report.

Indicators related to Output 1.3 on HIV/STI prevention among key populations, young people and pregnant women and reducing stigma and discrimination show progress. The indicator related to the number of UNFPA supported CSOs or others working towards increasing comprehensive knowledge of HIV. Three organizations- A*ssociação Komunidade Progresu* (KP+), Estrela+ and National AIDS Institute (INSCIDA) were supported under the CP to build their capacities on prevention, testing and referrals for treatment as well as to reduce stigma. However, there are few gaps in the implementation of the activities. The indicator related to number of people who have been tested for HIV in the previous 12 months and received the test results, has progressed well among key populations in five priority municipalities for HIV prevention – approximately 34.8% of the target has been met. The third indicator is related to percentage of people with discriminatory attitudes towards PLWHA, disaggregated by gender. The source of the baseline data is not known; however, the data from Demographic Health Survey of 2016 reported that 68%-85% of women and 50%-62% of men had discriminatory attitude towards PLWHA. The current status is not known as the Demographic Health Survey is due only in 2025.

Additional Charts on SRHR



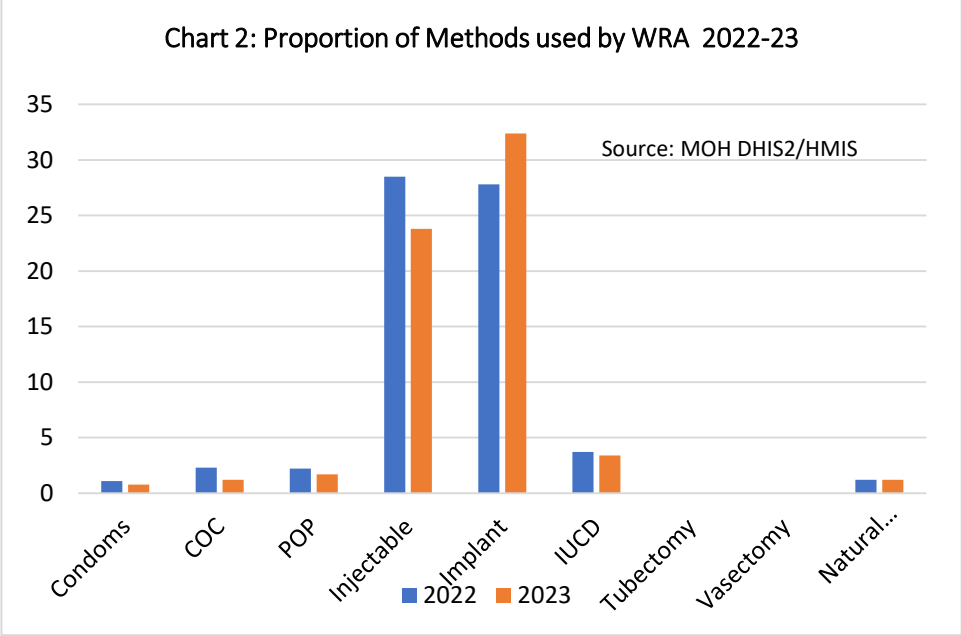


Chart 2: Proportion of Methods used by WRA 2022-23
35
30
25
20
15
10
5
0
Source: MOH DHIS2/HMIS
Condoms
COC
POP
Injectable
Implant
IUCD
Tubectomy
Vasectomy
Natural...
2022
2023

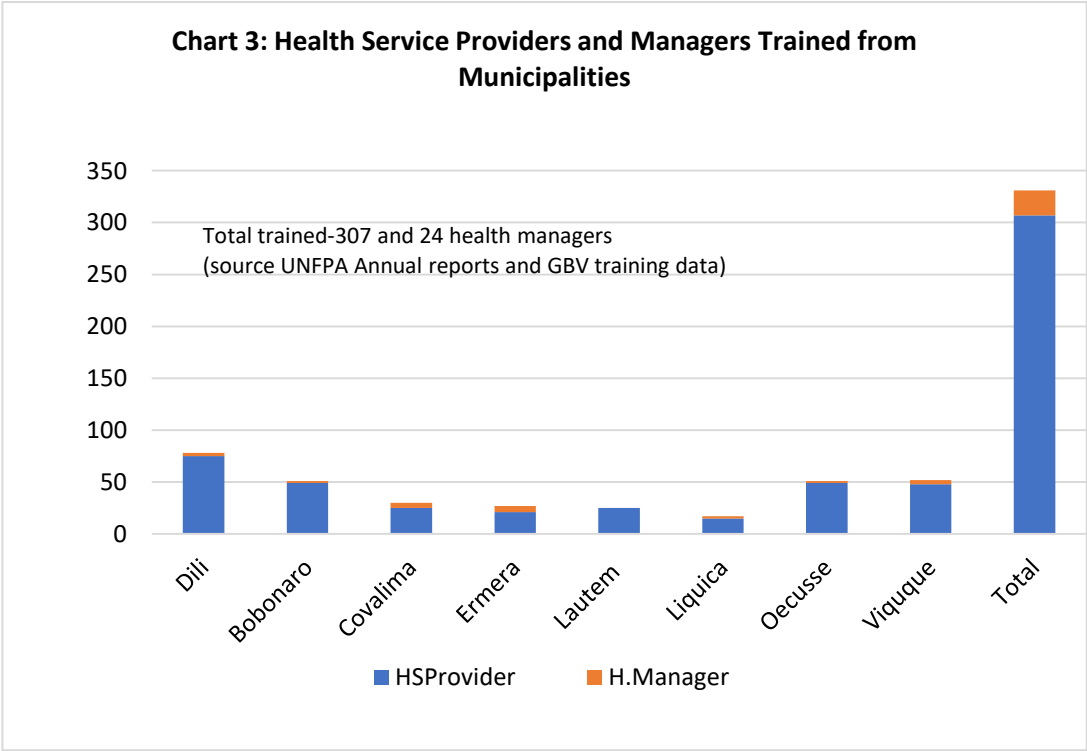


Chart 3: Health Service Providers and Managers Trained from Municipalities
350
300
250
200
150
100
50
0
Total trained-307 and 24 health managers
(source UNFPA Annual reports and GBV training data)
Dili
Bobonaro
Covalima
Ermera
Lautem
Liquica
Oecusse
Viquque
Total
HSProvider
H.Manager

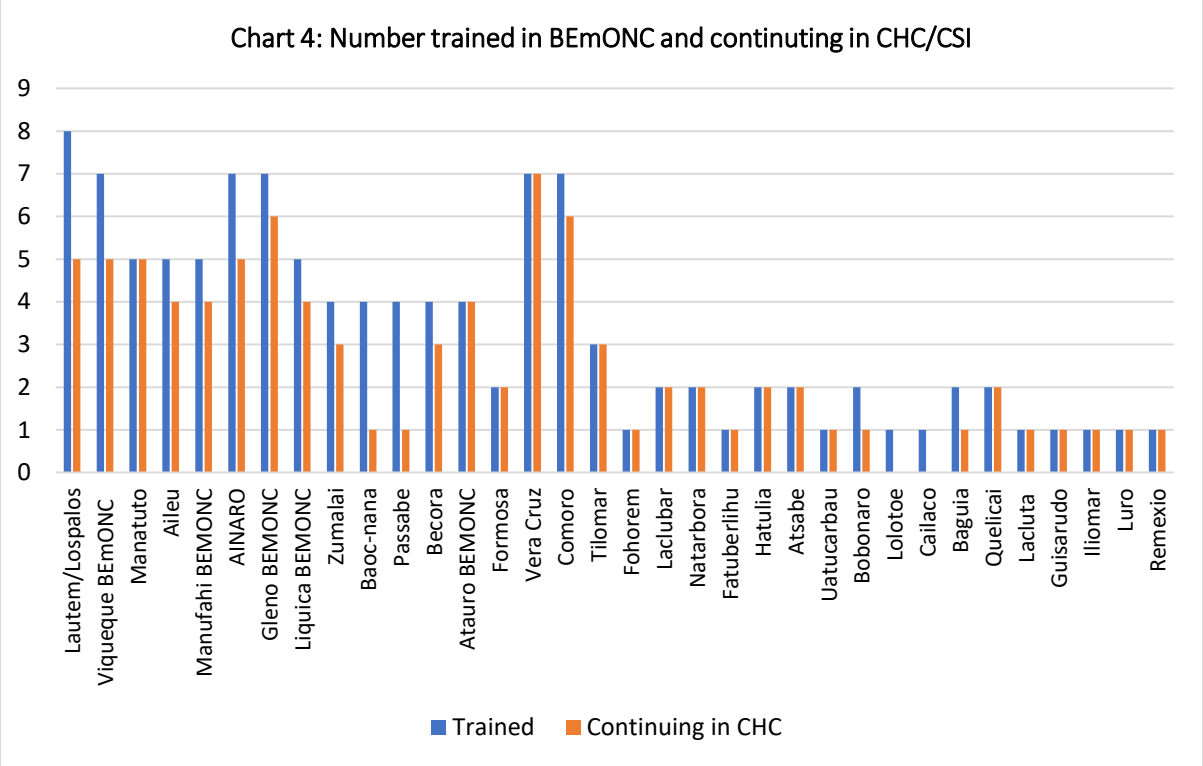


Chart 4: Number trained in BEmONC and continuting in CHC/CSI
9
8
7
6
5
4
3
2
1
0
Lautem/Lospalos
Viqueque BEmONC
Manatuto
Aileu
Manufahi BEMONC
AINARO
Gleno BEMONC
Liquica BEMONC
Zumalai
Baoc-nana
Passabe
Becora
Atauro BEMONC
Formosa
Vera Cruz
Comoro
Tilomar
Fohorem
Laclubar
Natarbora
Fatuberlihu
Hatulia
Atsabe
Uatucarbau
Bobonaro
Lolotoe
Cailaco
Baguia
Quelicai
Lacluta
Guisarudo
Iliomar
Luro
Remexio
Trained
Continuing in CHC

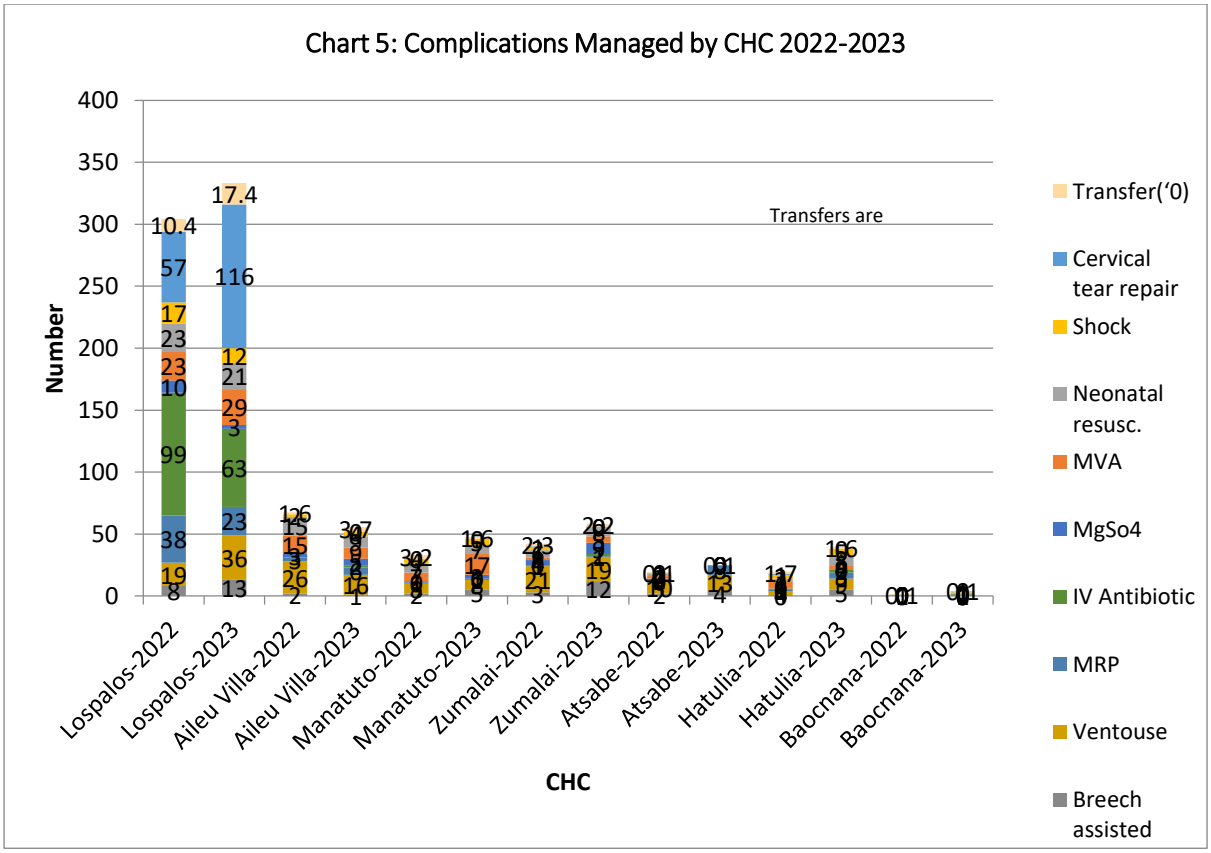


Chart 5: Complications Managed by CHC 2022-2023
Number
400
350
300
250
200
150
100
50
0
Transfers are
Lospalos-2022
Lospalos-2023
Aileu Villa-2022
Aileu Villa-2023
Manatuto-2022
Manatuto-2023
Zumalai-2022
Zumalai-2023
Atsabe-2022
Atsabe-2023
Hatulia-2022
Hatulia-2023
Baocnana-2022
Baocnana-2023
CHC
Transfer('0)
Cervical tear repair
Shock
Neonatal resusc.
MVA
MgSo4
IV Antibiotic
MRP
Ventouse
Breech assisted

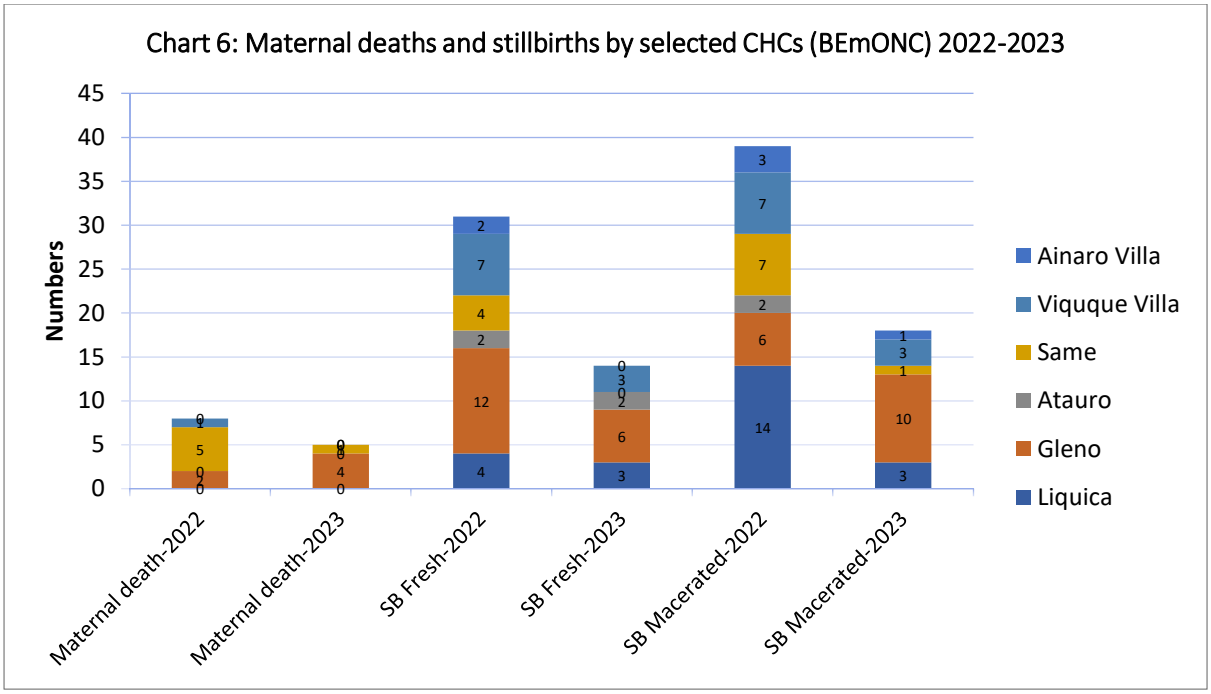


Chart 6: Maternal deaths and stillbirths by selected CHCs (BEmONC) 2022-2023
Numbers
45
40
35
30
25
20
15
10
5
0
Maternal death-2022
Maternal death-2023
SB Fresh-2022
SB Fresh-2023
SB Macerated-2022
SB Macerated-2023
Ainaro Villa
Viuque Villa
Same
Atauro
Gleno
Liquica

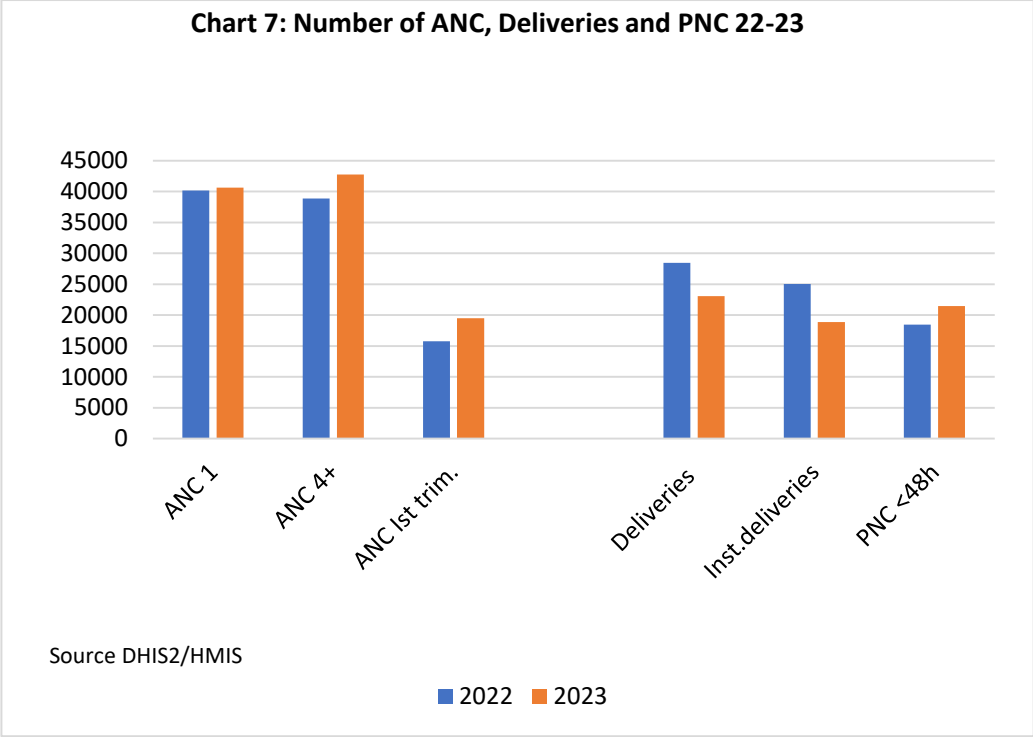
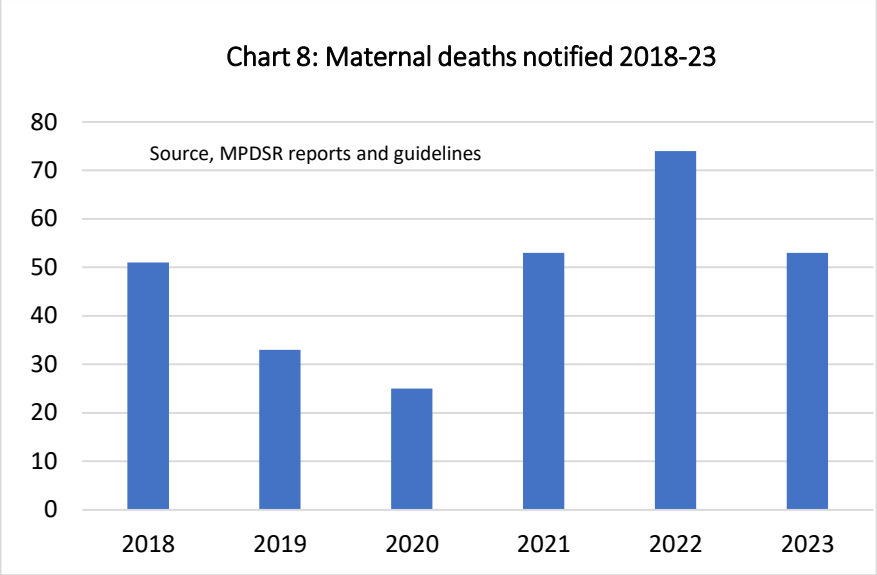


Chart 7: Number of ANC, Deliveries and PNC 22-23
45000
40000
35000
30000
25000
20000
15000
10000
5000
0
ANC 1
ANC 4+
ANC Ist trim.
Deliveries
Inst.deliveries
PNC <48h
Source DHIS2/HMIS
2022
2023



Pamphlet on SRHR produced during COVID-19

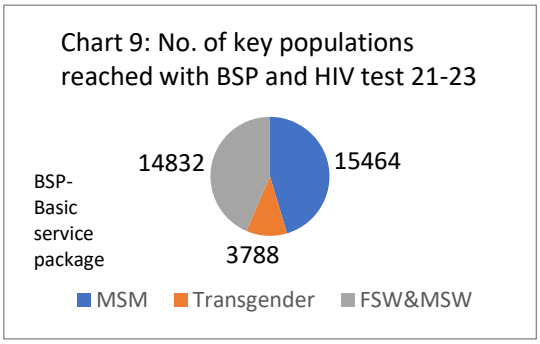
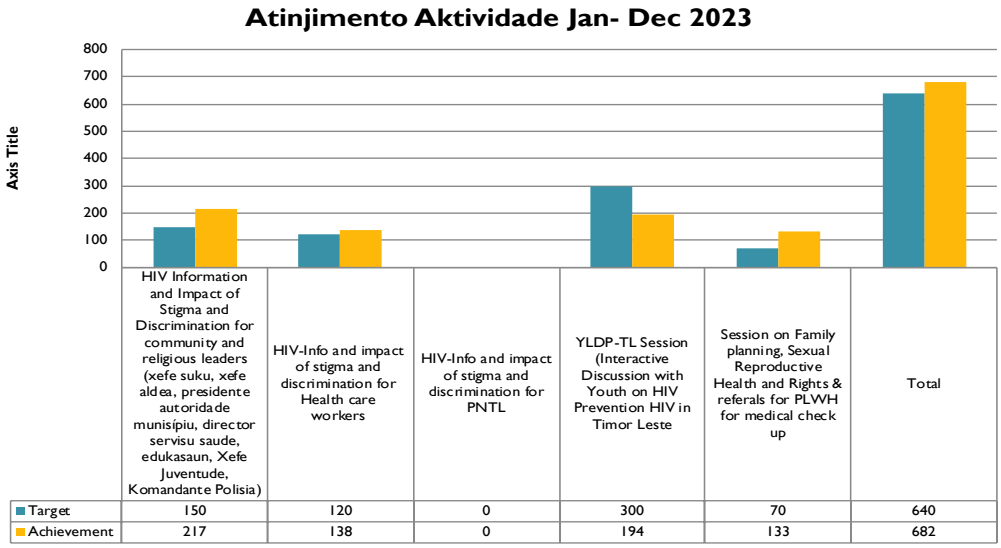


Chart 9: No. of key populations reached with BSP and HIV test 21-23
BSP-Basic service package
14832
15464
3788
MSM
Transgender
FSW&MSW

UNFPA -TL


Atinjimento Aktividade Jan- Dec 2023
Axis Title
800
700
600
500
400
300
200
100
0
HIV Information and Impact of Stigma and Discrimination for community and religious leaders (xefe suku, xefe aldea, presidente autoridade munisípiu, director servisu saude, edukasaun, Xefe Juventude, Komandante Polisia)
HIV-Info and impact of stigma and discrimination for Health care workers
HIV-Info and impact of stigma and discrimination for PNTL
YLDP-TL Session (Interactive Discussion with Youth on HIV Prevention HIV in Timor Leste
Session on Family planning, Sexual Reproductive Health and Rights & referals for PLWH for medical check up
Total
Target 150 120 0 300 70 640
Achievement 217 138 0 194 133 682

Additional Information on AY

Table 3. Implementation of Comprehensive Sexuality Education (CSE) in Schools by Year

Years of Initiations	2021	2022	2023	2024
Number of. Schools implementing CSE	N/A	16	47	N/A

Source. Sixteen schools implemented CSE through Spotlight Initiative. Spotlight Narrative Report published Aug 2022.
Forty-Seven schools implemented CSE in 2023 according to A&Y Programme, Briefing by CO

Table 4. Service Provision to Adolescents and Youth

"Service Provision and Beneficiaries Among Adolescents and Youth"					
Service Provision		**2021**	**2022**	**2023**	**Total Beneficiaries**
Comprehensive Sexuality Education	In School	N/A	103	3.862	3.965
	Out of School	40	559	1355	1.954
HIV/AIDS prevention, testing and treatment		11.077	11.382	52.956	75.415
Total		11.117	12.044	58.173	81.334

Source: UNFPA 2021, 2022, 2023 annual report-Timor-Leste.

Table 5: Output Indicator Achievements (Adolescents and Youth)

Output. The national capacity to design and implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality is strengthened.				
Indicators (as per RRF)	**Baseline 2021**	**Status 2023**	Status 2024	**Target 2025**
1. Timor-Leste drafts new and/or strengthens Comprehensive Sexuality Education programmes in line with international standards	No	National CSE guidelines or policies (Healthy Relationship Curriculum and Boys and Girls Circle) officially approved and disseminated to selected primary and secondary schools in selected municipalities.	No New Policy Development.	Expected target (in 2025) YES
2. Number of youth organizations and centres in selected municipalities conducting CSE training programmes that adhere to national and global standards.	0	**14** Youth Organizations (Youth Center) Conducting CSE training for out of School adolescents and youth	Status – overachieved. Youth-Focused Activities and Initiatives continued without a designated PO for AY (M&E officer supported MoYSAC in 2024) See details below	Target: 13 (Ataúroas a new municipality was approved on May 31, 2021) after the CPD targets were set)

3. School Based Intervention: Indicator 3. Number of schools implementing boys and girls circle interventions that promotes gender-equitable norms and behaviours and exercise of rights, including reproductive rights).	3 (2019)	School Based CSE intervention has reached 3,862 in school in 47 Secondary schools in seven municipalities	2024. the target is overachieved	Target: 20 schools (in 6 municipalities)

Under number 2 indicator, several achievements in 2024 are as follows:

- **Continuation of Training of Trainers (ToT) for Healthy Relationships:**
  Ongoing capacity-building efforts targeted facilitators from all youth centers to equip them with the skills and knowledge required to effectively deliver Healthy Relationships programs.
- **Roll-out of Healthy Relationships Programs for Out-of-School Youth:**
  Facilitators trained through ToT sessions expanded the program's outreach by implementing Healthy Relationships sessions for out-of-school youth across various communities.
- **Support for International Youth Day Celebrations:**
  Financial and technical assistance was provided for a **Panel Discussion on Digitalization**, fostering dialogue on the role of technology in youth empowerment and development.
- **Support for National Youth Day Celebrations:**
  Collaborated with the Ministry of Youth, Sport, Art, and Culture (MoYSAC) by offering financial and technical support for the successful celebration of National Youth Day.
- **Finalization and Translation of the National Action Plan (NAP) on Youth:**
  The National Action Plan on Youth was finalized and translated into English, ensuring accessibility to a broader audience.
- **Printing of NAP in English and Tetum:**
  Both English and Tetum versions of the National Action Plan on Youth were printed, promoting inclusive dissemination of the policy document

Discussion with School Students

FGD with a group of students on CSE

Student explaining what she learnt in CSE

Table 6: CP Outcome and Output Indicators: Gender Equality and Women's Empowerment

UNSDCF OUTCOME INVOLVING UNFPA: Outcome 5: By 2025, the most excluded people of Timor-Leste are empowered to claim their rights, including freedom from violence, through accessible, accountable and gender responsive governance systems, institutions and services at national and subnational levels.			
UNSDCF outcome indicator	**Baseline 2021**	**Current (2024 Q3)**	**Target 2025**
Percentage of people who think it is justifiable for a man to subject his wife/intimate partner to violence, by age and sex	Baseline: Men: 53%; Women: 74% (2016) In 2016, 81% of women and 79% of men justified wife-beating under certain circumstances,*	NA	Target: Men: 35%; Women: 55%
Proportion of women, including those facing intersecting and multiple forms of discrimination, who report experiencing physical or sexual violence who seek help, by sector[2]	Baseline: 19.5% (2016)	NA	Target: 35%
Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by age and place of occurrence (SDG 5.2.1)[3]	Baseline: 36.8% (2016)[4]	NA	Target: 20%
UNFPA Country Programme Output: Output 3.1. The capacity of relevant government institutions and non-government organizations to implement the National Action Plan on Gender-based Violence is strengthened.			
Number of annual monitoring exercises conducted by the government on the implementation of the national action plan on gender-based violence[5]	Baseline: 1 (2019)	3/3 annual monitoring exercise done	Target: 3
Number of women and girls who have access to SRH and education programmes that integrate VAWG response into their strategies[6]	Baseline: 0	So far has reached 4,634/1500 beneficiaries	Target: 1500

*"The lack of reliable data poses significant challenges for planning at both central and local levels. It also hinders the monitoring and adaptation of national development frameworks and programs, including the SDGs and other regional and global initiatives.

[2] Never used by Gender programme of UNFPA or tackled by DHS. But may be used as a proxy indicator (noted in the CPD Results Dashboard)

[3] SDG 5.2 Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

[4] DHS mentions 35% in 2016, the Nabilan survey mentions 47% in 2015 (noted in the CPD Results Dashboard)

[5] It is difficult to understand how this will measure the output

[6] ibid

Table 7: Additional Indicators on GBV [7]

Sub-output indicators	Total 2021	Total 2022	Total 2023	Total 2024	Target 2025
Number of health facilities with Safe Space to provide LIVES and other components of essential health service package as required ensuring confidentiality and privacy in response to GBV	0	1	3	NA Is it 7 4 safe spaces established in Dili, Covalima, Baucau and Lautem municipalities.	Are there 2025 targets for these or no plans since major GBV prevention projects will be over by end 2024). Comments: CO will capitalize on Japan-funded project to establish an integrated services within the BEmONC centers which will include a safe space for GBV survivors. We are doing this with a BEmONC center to be launched soon in Oecussi under DFAT-funded project.
Number of in-service trainings conducted	0	3	4	7 rollout training conducted.	
Number of health providers trained in in-service training package response to GBV	0	30	86	175 trained healthcare providers including health managers.	
Number of GBV referral coordination meeting conducted	0	0	1	4 coordination meetings were conducted.	
Number of coordination meeting in response to GBV	0	5	0	4	
Number of members of GBV referral network sensitized in HS response to GBV	226	323	0	85	
Number of health service providers sensitized in HS response to GBV	0	246	227	425	

[7] UNFPA Country Office Timor-Leste. "Context Analysis - CDP Results Dashboard 26.06.2024." Excel, 2024

Number of campaigns on prevention of early pregnancy and SRH	0	4	37	11	
Number of people sensitized on GBV, Domestic Law Against DV, CEDAW, Gender equality, women's empowerment, women's participation to socioeconomic activities	2203	2224	4509	1,135	
Number of healthcare providers trained to provide forensic medical exam	NA	NA	NA	15	
% of knowledge increase on GBV	NA	NA	NA	NA	
% of knowledge increase on conflict transformation	NA	NA	NA	NA	
Total Beneficiaries for Gender Program[8]	2429	2823	4822	1,846	

Notes:

The Together for Equality (T4E) program also significantly expanded GBV service coverage in Timor-Leste, establishing three Safe Spaces in Dili, Baucau, and Covalima, and increasing the number of referral network providers from 4 to 14, including 10 institutions offering specialized GBV services and facilities tailored for vulnerable populations like PWDs and LGBTQ individuals.[9]

Facilities in a safe space

Safe Space

[8] Both Beneficiaries of right-holders and duty-bearers

[9] Sung, S. (2024). Together for Equality (T4E) "Preventing and Responding to Gender-Based Violence in Timor-Leste 2020-2024": Endline Survey Result Report (Final Version)

FGD with a safe space health staff

Combined field visits with SI

SI brainstorming activity for health staff

Group work by health staff

Population Dynamics

Table 8: Number of Thematic Reports Published using Census Data[10]

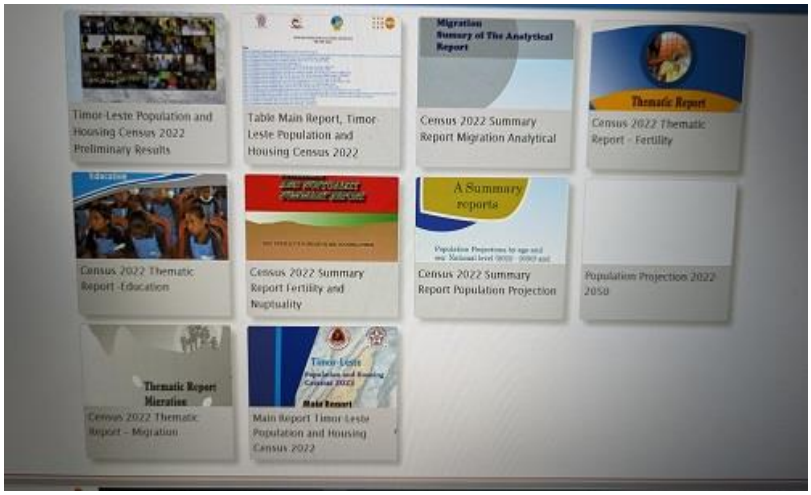
No	Census Thematic Reports	Status	
1	Demographic evaluation of census to include reported age displacement, age heaping due to digit preference, the ratio of males to females by areas of residence, and administrative divisions.	**Completed**	UNFPA/ INETL
2	Fertility Levels – adolescent fertility rates, general fertility rates for women, age at first marriage, age-specific marriage rates, marriage patterns	**Completed**	UNFPA/INETL
3	Mortality levels – Infant Mortality and under-five Mortality rates, Maternal Mortality Rates, life expectancy by sex	**Completed**	UNFPA/INETL
4	International and Internal Migration such as migration between municipalities, international migration rates presented for a one-year and 5-year duration since migration.	**Completed**	UNFPA/INETL
5	Population projections at national and sub-national levels for the next 50 years by different age groups and sex	**Completed**	UNFPA/INETL
6	Education status such as school attendance rates, school completion rates, field of study and literacy rates by Socio-economic Groups and by Areas of Residence.	**Completed**	UNICEF/INETL
7	Analysis of the Disabilities and Differences according to Age, Sex, Education, Social Groups, and Area of Residence	**Completed**	UNFPA
8	Household and Housing characteristics and Access to Health Services.	**No Funding**	UNFPA
9	Gender thematic analysis	**In Progress**	UNWOMEN
10	Children and Youth Analysis	**Completed**	UNFPA
11	Demographic Dividend Analysis	**Completed**	UNFPA
12	Labor force and economically active population to show the population that is employed, unemployed, and the sectors of employment.	**Completed**	ILO

Source: UNFPA country office

[10] PD outputs in terms of completion of the census and related publications achieved. DHS is delayed (hence the related reports based on DHS data could not be completed) due to the interruptions experienced with the Covid 19 pandemic. Rest of the planned outputs is achieved as of July 2024.

Publication Fo Fila Fali

Official Launch of Fo Fila Fali



Publications INETL and UNFPA

Effort to include disability in GBV data collection

ANNEX 6: UNFPA Timor-Leste CPD 2021-2025 - STAKEHOLDER MAP
(Provided by UNFPA Country Office)

Donor	Implementing agency					Other partners				Rights holders	Other
	Gov	Local NGO	Int. NGO	Academia	Other	Gov	Other UN	Academia	Other		
Strategic Plan 2022-2025 Outcomes											
SP Outcome 1 *By 2025, the reduction in the unmet need for family planning has accelerated*			**SP Outcome 2** *By 2025, the reduction of preventable maternal deaths has accelerated*					**SP Outcome 3** *By 2025, the reduction in gender-based violence and harmful practices has accelerated*			
Output 1.1: The capacity of the national health system to provide high-quality, rights-based integrated sexual and reproductive health and HIV services, including availability and increased demand for family planning, response to GBV, in line with essential service package, stigma-free HIV services and referrals is strengthened, including in humanitarian settings.											
- Partnership for Human Development (PHD, Department of Foreign Affairs and Trade of the Australian Government) - European Union (Spotlight Initiative)	- Ministry of Health - Instituto Nacional de Saude Publica de Timor-Leste (INSPTL, ex-INS) -National Institute of Pharmacy and Medical Products (INFPM, ex-SAMES)	- Belun	- Brandkind Ltd			- Civil Protection Authority -SNAEM - Ministry of Higher Education and Science	WHO, UNICEF (Health Cluster)			- Health care providers - Health professionals -Local authority -Local community (mother support groups, community members, religious)	
Output 1.2:											

The capacity of skilled birth attendants to provide high-quality maternal health services, including antenatal care, EmONC, postpartum care, and elimination of mother-to-child transmission of HIV and syphilis, as well as to carry out maternal death reviews, is strengthened, especially in areas most in need.											
- Partnership for Human Development (PHD, Department of Foreign Affairs and Trade of the Australian Government) - Government of Japan - Government of Portugal - Neighbouring Countries Economic Development Cooperation Agency (NEDA) - Indonesia Agency for International Development (Indonesian AID)	**- Ministry of Health - Instituto Nacional de Saude Publica de Timor-Leste (INSPTL, ex-INS) - Timor-Leste National Police (PNTL)**			**- University of Tasmania**				**- Burnet Institute - Midwifery Association of Timor-Leste (APTL)**		**- Health care providers - Health personnel - Pregnant women -BEmONC -Midwifery schools**	
Output 1.3: Awareness on prevention, transmission and treatment of HIV and other sexually transmitted infections, and uptake of HIV testing, especially among key populations, young people and pregnant women is increased, contributing to reduced stigma and discrimination towards people living with HIV											
- Global Fund	**- Ministry of Health - National AIDS Institute (INCSIDA)**	**- Organizaçao Estrela+ - Associaçao**								**- Uniformed personnel - People living**	

		Communidade Progresso (KP)								HIV - Member of key populations - Adolescents and youth - Pregnant women and newborn - Health care providers - Health personnel	
Output 2.1: **The national capacity to design and implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality is strengthened.**											
	- Ministry of Youth Sports Art and Culture (MOYSAC, ex-Secretary State for Youth and Sport)	-Fokupers				-Ministry of Education - Ministry of Higher Education and Science				- Students from public and private schools - Members of youth training centers - Young people - Comprehensive sexuality education facilitators and trainees	
Output 3.1: **The capacity of relevant government institutions and non-government organizations to implement the National Action Plan on Gender-Based Violence is**											

strengthened.											
- Korea International Cooperation Agency (KOICA) - Zonta International - European Union (Spotlight Initiative)	**-Secretary of State for Equality (SEI) - Ministry of Social Solidarity and Inclusion**	**- Alola Foundation - BELUN - Hamutuk Nasaun Saudavel (HAMNASA) -Psychosocial Recovery and Development in East Timor (PRADET)**		**- La Trobe University**			**- IOM, UNICEF, UN WOMEN (GBV Sub-cluster)**			**- Health care providers - Health personnel - Members of youth organizations - Local authority - Community members**	
Output 4.1: National capacity for production and dissemination of quality disaggregated data on population and development issues that allows for mapping of demographic disparities and socio-economic inequalities and for using this data and evidence to monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings is strengthened.											
	- Instituto Nacional de Estatistica Timor-Leste , I.P. (INETL, ex-GDS)									**- Government - Development partners**	

Table 2

Note: *Contact persons' names and email addresses are deleted to maintain privacy. In most cases more than one person parson participated in the interviews. All were face-face interviews with a few exceptions that are mentioned below.							
Acronym	**Name of the entity/organization**	**Role/responsibilities**	**Starting date of the collaboration with the CO**	**Contact person(s)**			**Included in the CPE interviews (contact person mentioned or a representative and/or other relevant staff)**
				Name* (DELETED)	**Title/Function**	**E-mail* (DELETED)**	
MOH	**Ministry of Health (Maternal and Child Health Department)**	**-Responsible for maternal and Child health -Responsible for GBV**	Before 2021		**General Director for Primary Health Care**		**yes**
MOH	**Ministry of Health (HIV Department)**	**-Responsible for HIV programme**	Before 2021		**Manager of the HIV, STI and Viral Hepatitis Program**		**Yes**
MOH	**Ministry of Health (HMIS Department)**	**-Responsible for Health Management Information System**	Before 2021				**YES**

INSPTL	**Instituto Nacional de Saude Publica de Timor-Leste**		Before 2021		President National Director for Training		YES
INCSIDA	**National AIDS Institute**		Before 2021		Executive President		YES
INFPM (ex-SAMES)	**National Institute of Pharmacy and Medical Products**		Before 2021		Executive President		
PNTL	**Timor-Leste National Police**		Before 2021 on adhoc				**YES**
	Organizaçao Estrela+		2021				**YES**
KP	**Associaçao Communidade Progresso**		2021		Executive Director		**YES**
	University of Tasmania		2023				**On line interview**
	Brandkind Ltd		2024				
MOYSAC (ex-SSYS)	**Ministry of Youth Sports Art and Culture**		Before 2021		General Director		-
			Before 2021		National Director for Youth		**YES**
	Fokupers		Before 2021		Executive Director		**YES**

SEI (ex-SEII)	**Secretary of State for Equality**		Before 2021		General Director		**YES**
MSSI	**Ministry of Social Solidarity and Inclusion**		Before 2021		General Director for Social Protection		**YES**
	Alola Foundation		Before 2021		General Director		**YES**
	Belun		2021		Executive Director		**YES**
	La Trobe University		2022				**YES (online interview)**
HAMNASA	**Hamutuk Nasaun Saudavel**		2023		Executive Director Program Manager		**YES**
PRADET	**Psychosocial Recovery and Development in East Timor**		Before 2021		Executive Director		**YES**

INETL (ex-GDS)	**Instituto Nacional de Estatistica Timor-Leste, I.P.**		Before 2021		President National Director		**YES**
PHD	**Partnership for Human Development Australia Timor-Leste (DFAT)**		Before 2021		Technical Lead for Health		**YES**
	Global Fund		2021				
	Government of Japan		2024				**NO (work too new)**
	Government of Portugal		2024				**NO**
NEDA	**Neighbouring Countries Economic Development Cooperation Agency**		2024				**NO**
	Indonesia Agency for International Development (Indonesian Aid)		2024				**NO**
KOICA	**Korea International Cooperation Agency**		2020		Deputy Director		**YES**

	Zonta International		2020				**YES**
	European Union for Spotlight Initiative		2020		Program Officer		**YES**
WHO	**World Health Organization**		N/A				**YES**
UNICEF	**United Nations Children's Fund**		N/A				**YES**
	UN Women		N/A				**YES**
IOM	**International Organization for Migration**		N/A				**NO**
AJTL	**Associação Jornalista Timor Lorosa'e**		2023		President of AJTL		**No**
MOE	**Ministry of Education**		N/A		General Director for Inclusion, Planning and Policy		**YES**
CPA	**Civil Protection Authority**		N/A				**NO**
SNAEM	**The National Ambulance and Emergency Medical Service**		???		General Director		
	Burnet Institute		???		**???**		**YES (online interview)**
APTL	**Midwifery Association of Timor-Leste**		???		**???**		**YES**


UNFPA

TERMS OF REFERENCE

UNFPA TIMOR-LESTE
4TH COUNTRY PROGRAMME EVALUATION
(2021 – 2025)

1st January 2024

1. Introduction

The UNFPA is the leading UN agency on sexual and reproductive health and youth and adolescents' development. Its mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

UNFPA Timor-Leste's programmes consist of targeting universal access to sexual and reproductive health and reproductive rights and the three transformative results -ending preventable maternal deaths, ending the unmet need for family planning, ending gender-based violence and all harmful practices. Our priority actions are thus three-folded: reducing maternal and perinatal mortality and morbidity, through the strengthening the primary health care system to deliver a high-quality integration of maternal and newborn health care including antenatal care (ANC) and postnatal care (PNC), Emergency Obstetric and Newborn Care (EmONC) Services, Family Planning (FP), HIV/STI, and Gender Based Violence (GBV). Reducing the unmet need for family planning and ensuring the safety and dignity of all women, girls, adolescents, youth and key populations, through the strengthening of laws against gender-based violence and the implementation of comprehensive sexuality education programmes that promote human rights and gender equality. Advocating for the availability, quality, timeliness and accuracy of statistical data that serve policy and decision-makers in addressing population and development issues, through the strengthening of the national capacity for the production and dissemination of quality databases, studies and investment cases in demographic disparities, socio-economic inequalities, health economics analytics, adolescents and youth and gender-based violence.

The UNFPA Timor-Leste country programme is implemented from 2021 to 2025. At the penultimate year, it is mandatory for the country office to conduct a final country programme evaluation per UNFPA Evaluation Policy to assess progress and evaluate the areas where the UNFPA Timor-Leste's implementation of the ICPD Plan of Action is lagging. The results of the evaluation will be a crucial step for designing the new country programme document, and consequently protecting the gains and identifying ways to accelerate transformative changes. The CPE will draw conclusions and provide a set of actionable recommendations for the next programme cycle.

The main audience and primary intended users of the evaluation are: (i) The UNFPA Timor-Leste CO; (ii) the Government of Timor-Leste; (iii) implementing partners of the UNFPA Timor-Leste CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) Asia and Pacific Regional Office (APRO); and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The evaluation will be managed by the evaluation manager within the UNFPA Timor-Leste CO, with guidance and support from the regional monitoring and evaluation (M&E) adviser at the APRO, and in consultation with the evaluation reference group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of terms of reference.

2. Background and context

Small island located in South-eastern Asia, the Democratic Republic of Timor-Leste was internationally recognized

as an independent state in 2002, following over four centuries of colonial rule by Portugal and a quarter century of severe occupation by Indonesia.

With a population of 1,341,737 according to the 2022 population census, 51% of Timor-Leste population are male and 49% are female, while 30% live in urban areas and 70% reside in rural areas. The 2016 DHS estimates a lower fertility rate at 4.2 children per woman. Compared to the 2015 census there is a decline in annual growth rate of 1.8. The Timor-Leste population growth is expected to exert increasing pressure on the economy, resources and social service alike.

Despite reaching lower middle-income economy status thanks to oil fund, a large portion of its population (42%) is still below the national poverty line. Unemployment is high, employment opportunities in the formal sector are limited, and job creation by the private sector falls far short of demand. Most of the population have no consistent earnings and many are subsistence farmers. Although SDG indicators show that living standards and human development have improved significantly, considerable disparities in health, education and wealth still exists.

To address inherited socioeconomic deficiencies, in 2010, Timor-Leste approved the national Strategic Development Plan 2011-2030 (SDP), a twenty year vision that reflects the aspirations of becoming a middle-upper income country by 2030, by eradicating extreme poverty and developing a sustainable and diversified economy not dependent on oil. This strategic plan also recognizes that young people are the future leaders, and it is they who will contribute to the social and economic transformation of the society. Youth aged 15-24, constitutes a very substantial part of the society, accounting for almost 21.5% of the total population and putting a strong economic pressure on the country and *in fine* on its social development.

The inadequacy of reliable data continues to pose serious challenges for planning at both central and municipal levels. It also serves as a major deterrent to the monitoring of national development frameworks and programmes, including the SDGs and other regional and global development initiatives.

Sexual and Reproductive Health and Rights

In Timor-Leste, sexual and reproductive health services face many challenges, such as inadequate resources, limited access to health facilities, and low levels of awareness and education about sexual health. Maternal mortality rate in Timor-Leste is 195 deaths per 100,000 live births, which is one of the highest in Southeast Asia. Access to modern contraceptives is also limited, with only 29% of women aged 15-49 using some form of modern contraceptive method. Teenage pregnancy rates are also high, with about 23% of women aged 15-19 having already given birth skilled health personnel assist 58% of deliveries, and facility delivery was at 42%. The proportion of women who give birth in a health facility varies widely across the country. The infant mortality rate in Timor-Leste was estimated at 56 deaths per 1,000 live births. This reflects insufficient care for mothers during pregnancy and delivery and poor access to health care. Seven out of 13 municipalities in the country have no functional emergency obstetric and newborn care. Access to health services in Timor-Leste and quality of services for mothers and babies are still major challenges in the country.

According to the 2016 DHS, the total fertility rate of the population was 4.2 – a decline from 5.7 in 2010 - with much higher fertility rates in rural areas (4.4) than in urban areas (3.5). Contraceptive prevalence of modern methods among married women was 24%. The demand for family planning (FP) was 51.3% and nearly one in four women aged 15 to 49 had an unmet need for family planning.

Despite progress in improving access to FP, only 47% of the demand among currently married women is being met. Lack of knowledge about fertility and contraception is still widespread amongst the population, as well as harmful gender norms that undermine women's ability to take control of their own bodies and their fertility. Capacity of health service providers to provide FP is still insufficient. So far, the GoTL left the procurement of modern contraceptives to partners such as UNFPA but is now showing signs of increased commitment to contributing domestic resources.

Overall, 47% of women and 66% of Timorese men have heard of HIV or AIDS. 2016 DHS results show that only 10% of women and 16% of men have comprehensive knowledge of the virus, and that 3% of women and men age 15-49 have ever been tested for HIV and received their test results. The same survey also shows that knowledge about where to get tested is declining. Condom distribution and availability is far from optimal, which undermines HIV prevention efforts. A concerning finding from the DHS is that 65 per cent of all women who had or suspected they had an STI sought no advice or treatment and 45 percent of men.

Up until recently, Timor-Leste was considered to have a low HIV prevalence rate (0.2%reported in 2015), with a higher prevalence among key affected populations, including sex workers (1.5%) and their clients, men who have sex with men (1.3%) and transgender persons (2.6%). Timor-Leste also faces specific vulnerabilities which may accelerate the transmission of HIV and sexually transmitted infections, such as high levels of population movement and social displacement (rural to urban and cross-border migration), high unemployment, low awareness of HIV and sexually transmitted infections and low condom use.

Adolescents and Youth

The youth population in Timor-Leste faces many challenges, including limited access to education and employment opportunities. The youth unemployment rate is estimated to be around 14%, and the NEET rate (neither in employment, education nor in training) is 20.3% . In terms of education, the net enrollment rate for primary school is high at 94%, but drops to just 34% for secondary school. Adolescent girls face particular challenges, including higher rates of early marriage and pregnancy, and lower levels of school enrollment and completion. Access to sexual and reproductive health services is also limited for young people, and there is a lack of comprehensive sexuality education in schools[1].

Timor-Leste is experiencing a youth bulge, with 60.7 percent of the total population younger than 25 years old. 33.3%t of the population is between the ages of 10 and 24, and youth aged 15-24 constitute 21% of the population.[2] School attendance of adolescents and young men and women has been increasing since Timor-Leste became independent[3] Youth unemployment is high (12.3%), above the national unemployment average (4.8%) as many young people seeking work cannot find employment and remain unemployed, with youth affected by lack of opportunity and perceived disadvantages and marginalisation.[4]

The 2016 TLDHS show that 23% of young women and 20% of young men aged 15-24 have received information on reproductive health.[5] Adolescents and youth lack information about sex and contraception due to religious

[1] Timor-Leste Labour Force Survey 2013

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

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

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

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

and cultural beliefs. Teenage pregnancy is high in Timor-Leste: 19% of girls are married before they turn 18 and 24% are already with a child by the time they turn 20.[6] 26% of women age 25-49 had first sex before the age 18[7]. The adolescent birth rate is 54 births per 1,000 women aged 15–19. The teenage pregnancy study suggests that teenage pregnancy in Timor-Leste is related to lack of information, knowledge and access to SRHR and contraception of girls and boys.[8] It is also related to lack of confidence and empowerment of girls, who suffer from unequal power balances in relationships. Adolescents and young girls and boys are also victims of domestic and gender-based violence, which will often affect the self-confidence and psychological health of girls and boys survivors.

Gender-Based Violence

Gender-based violence (GBV) is a significant problem in Timor-Leste, due to entrenched norms regarding women's and men's roles in society. In Timor-Leste, 59% of women aged 15-49 have experienced physical or sexual violence from an intimate partner. Also 41% of women reported they experienced sexual violence in their lifetime. Furthermore the DHS noted that 74% of women from age 15 to 49 agreed that a husband is justified in beating his wife in a particular circumstance or more; 53% of men from 15-49 agreed that a husband is justified in beating wife in a particular circumstance.

Timor-Leste women and girls are also subject to early and forced marriages and human trafficking. Although the legal age of marriage is 18 years for both men and women, the recent 2016 DHS shows that among women aged 20-24 years old in Timor-Leste, 2.6% percent were married before the age of 15, and 14.9% before the age of 18.[9] The 2018 Human Development Report (HDR) ranks Timor-Leste 132 out of 189 countries, with a gender inequality index estimated at 0.567, compared to 0.663 for males.[10] The employment gender gap in Timor-Leste is quite large: women in the work force represent 24.9% of the women of working age – compared to 52.5% among males.[11]

Timor-Leste has made progress towards gender equality and women's empowerment, particularly in terms of political participation. Women hold 38% of seats in the national parliament, and there is a gender quota for political party candidates. However, women still face many challenges, including high levels of gender-based violence, limited access to education and healthcare, and lower participation rates in the formal workforce.

3. UNFPA Country Programme

The UNFPA Fourth Country Programme Document (CPD4) for Timor-Leste for 2021-2025, detailing the planned collaboration between UNFPA and the Republic Democratic of Timor-Leste (RDTL) is aligned with the Timor-Leste's Strategic Development Plan (SDP 2011 – 2030), the International Conference on Population and Development Programme of Action (ICPD PoA), the Sustainable Development Goals (SDGs), and the 2021-2025 United Nations Strategic Development Cooperation Framework (UNSDCF) for Timor-Leste. The CPD4 was

[6] GDS, MoH and ICF (2016): Timor-Leste DHS (TLDHS).

[7] ibid

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

[9] General Directorate of Statistics (GDS), MoH and ICF (2016): DHS 2016.Azzopardi, Peter (2018): Adolescent and Youth Sexual Reproductive Health Scoping Report on Adolescent pregnancy in Timor-Leste. Brunette Institute, Australia for Partnership for Human Development Timor-Leste.

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

[11] ILOSTAT, https://www.ilo.org/ilostat

developed in consultation with government of Timor-Leste (GoTL) and partners taking into account the shift to a new business model of working in lower middle-income countries, such as Timor-Leste, i.e. focusing on advocacy and policy dialogue/advice, capacity development, knowledge management and some projects on service delivery.

The third country programme evaluation highlighted several key achievements: development of key technical and policy documents; development of in-school teaching materials on sexual and reproductive health and rights (SRHR), gender and gender-based violence (GBV) prevention; approval of the National Action Plan on Gender-Based Violence (NAP-GBV); and undertaking of the 2015 population and housing census and 2016 Demographic and Health Survey.

The evaluation identified lessons learned and made recommendations for developing the capacity of the Ministry of Health in safe motherhood, family planning, addressing gender-based violence, and improving adolescent sexual and reproductive health. It also recommended for continued strengthening of integrated sexual and reproductive health systems, including the logistics management capacity of the Ministry of Health, and technical support on collecting data, with increased emphasis on raising data literacy to enable the Government to obtain, interpret and utilize the data for policy and planning.

Drawing on the experience of previous programmes, the CPD4 supports the UNSCDF strategic priorities 3 (Early Childhood Development and Life-long Learning Outcomes and Skills) and 4 (High-quality Healthcare and Well Being). The overall goal of the 4th CPD in Timor-Leste is to support national efforts to achieve universal access to sexual and reproductive health and reproductive rights, in line with the UNFPA transformative results to end maternal deaths, unmet need for family planning, and gender based violence and harmful practices. It responds to the principle of leaving no one behind, focusing on women, adolescents and youth, particularly those living in rural areas, people with disabilities and key population groups.

The Implementation of CPD4 has been quite challenging due to COVID-19 pandemic which affected all countries around the world without exception. The restrictions imposed by the host country hampered the movements of staff from IPs and UNFPA during the implementation of programmes from mid-2020 when the COVID-19 pandemic hit the country. Major structural, conjectural and behavioural changes were observed across the world subsequent to the pandemic crisis and Timor-Leste could not escape from those shifts.

4. Objectives and scope of the evaluation

Objectives

The overall purpose of the Country Programme Evaluation (evaluation) for 2021-2025 is to: (i) enhance the accountability of UNFPA for the relevance and performance of the fourth country programme, (ii) provide the existing knowledge-base with evidence and lessons learnt to serve the design of the next programming cycle and the acceleration of the implementation of the ICPD PoA

The specific objectives of evaluation include:

- To provide a comprehensive and updated analysis of the CP4 context, focusing on multisector needs, population changes and dynamics (including youth bulge, ageing population or climate change), political and social dynamics between multiple level stakeholders, and capabilities and resources
- To provide an independent assessment of the relevance**,** effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of CPD4

including in humanitarian settings, emphasizing on the coherence and functional relations with the implementing partners and analysing positive and negative intended and unintended results and challenges

- To provide an assessment of the role played by the UNFPA country office (CO) in the coordination mechanisms of the United Nations Country Team (UNCT) with a view to enhancing the United Nations collective contribution to national development results and UNFPA contribution to the UNSCDF result groups
- To draw key lessons learnt from the past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle

Temporal scope

The Country Programme Document (CPD) and Country Programme Action Plan (CPAP) cover the period between 2021 to 2025. The evaluation will cover the period starting from 2021 to Q2 2024 (until the data collection).

Geographical scope

The evaluation will cover all implementation activities by UNFPA and implementing partners at national and sub-national levels.

Programme scope

This evaluation will cover the following thematic areas of the CP4: Sexual Reproductive Health and Rights, Adolescents and Youth, Gender Equality and Women's empowerment, and Population & Development and Humanitarian Action.

The evaluation will cover cross-cutting aspects such as human rights based approach, integration of the LNOB principle, disability inclusion, communication, partnerships and resource mobilization. Besides the assessment of the intended impact of the country programme, the evaluation also aims to assess UNFPA's positioning in Timor-Leste to address the emerging issues and other megatrends such as youth bulge and ageing population.

5. Evaluation Criteria

In accordance with the methodology for CPEs outlined in the UNFPA Evaluation Handbook (see section 3.2), the evaluation will examine the following four OECD/DAC evaluation criteria: relevance, effectiveness, efficiency and sustainability. It will also use the evaluation criterion of coherence to assess the extent to which the UNFPA Timor-Leste CO harmonized interventions with other actors, promoted synergy and avoided duplication under the framework of the UNCT. Furthermore, the evaluation will use the humanitarian-specific evaluation criteria of coverage and connectedness to investigate: (i) to what extent UNFPA has been able to provide life-saving services to affected populations that are hard-to-reach; and (ii) to work across the humanitarian-peace-development nexus and contribute to building resilience.

The evaluation is expected to answer these key preliminary evaluation questions under each criterion:

Relevance	EQ1. To what extent the Country Programme is aligned with the UNFPA strategic plan 2022-2025 priorities and accelerators and with relevant national SDG targets? EQ2. To what extent has UNFPA ensured that the varied needs and capacities of targeted populations, including women and girls, adolescents and youth, survivors of gender-based violence, people at risk of and living with HIV, and also of government and civil society organizations at national and local levels, have been taken into account in both the planning, implementation and monitoring of all UNFPA-supported interventions under the country programme action plan?

	EQ3. To what extent has the country office been able to respond to changes in national needs and priorities, caused by gaps in policies and data, protocols or external factors, or to shifts caused by crisis or major political changes?
Effectiveness	EQ4. To what extent have interventions led and supported by UNFPA changed the access to, and use of quality human-rights based integrated sexual reproductive health (maternal health, family planning, HIV/STI) services and gender-based violence response mechanisms? EQ5. To what extent has UNFPA ensured that the needs of young people (including adolescents) in all their diversities (age, location, gender, sexual orientation, ability, employment, marital status etc.) have been addressed in the planning and implementation of all UNFPA-supported interventions?
Efficiency	EQ6. Did UNFPA get the value for money for its intervention vis-à-vis the results achieved?
Sustainability	EQ7. To what extent has UNFPA been able to support implementing partners and beneficiaries (rights-holders), in developing capacities and establishing mechanisms to ensure ownership and the durability of effects? EQ8. To what extent did UNFPA achieve government ownership of various interventions (BEmONC, Safe Spaces, ANC-PNC, Family Planning, HIV, Census)?
Coherence	EQ9. To what extent is the UNFPA country office benefited from coordinating with other United Nations agencies and partners in the country to ensure complementarity, particularly in the event of potential overlaps?
Coverage & connectedness	EQ10. To what extent has UNFPA humanitarian action appropriately targeted at the varied needs of population groups facing life-threatening suffering, particularly those within groups that are hard-to-reach and "furthest-behind"? EQ11. To what extent has UNFPA established linkages between a short-term emergency intervention and the recovery phases to build capacity and resiliency of the humanitarian partners and beneficiaries?
Connectedness	EQ12. To what extent were activities of a short-term emergency nature carried out in a context that takes longer-term and interconnected problems into account?

6. Methodology and Approach

The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided in the UNFPA Evaluation Handbook. The CPE will be conducted in accordance with the UNEG Norms and Standards for Evaluation, Ethical Guidelines for Evaluation, Code of Conduct for Evaluation in the UN System, and Guidance on Integrating Disability Inclusion, Human Rights and Gender Equality in Evaluations. The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analyzing data; (iii) specifically designed tools for data collection and analysis; (iv) an evaluation matrix; and (v) a detailed evaluation work plan and agenda for the field phase.

The evaluation matrix is centerpiece to the methodological design of the evaluation (see Handbook, section 1.3.1, and Tool 1: The Evaluation Matrix, pp. 138-160 as well as the evaluation matrix template in Annex C). The evaluation matrix will be drafted in the design phase and must be included in the design report and in the annexes of the final evaluation report.

Finalization of the evaluation questions and related assumptions. Based on the preliminary questions and the theory of change underlying the CP, the evaluators are required to refine the evaluation questions. In their final form, the questions should reflect the evaluation criteria and clearly define the key areas of inquiry of the CPE. The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur, based on the theory of change of the CP. This will allow the evaluators to assess whether the preconditions for the achievement of outputs and the contribution of UNFPA to higher-level results, in particular at outcome level, are met. The data collection for each of the evaluation questions and related assumptions will be guided by clearly formulated quantitative and qualitative indicators. If needed, the TOC can be revised to support the evaluation.

Sampling strategy. Building on the initial stakeholder map and based on information gathered through document review and discussions with CO staff, the evaluators will develop the final stakeholder map. From this, using concrete selection criteria, the evaluation team will select a sample of stakeholders at national and sub-national levels who will be consulted through interviews and/or group discussions during the data collection phase and also select a sample of sites that will be visited for data collection.

Data collection. The evaluation will consider primary and secondary sources of information. Primary data will be collected through semi-structured interviews with key informants, as well as group discussions with service providers and rights-holders and direct observation during visits to selected sites. Secondary data will be collected through review of documents and from administrative databases, such as DHIS2 and LMIS. A case study will be considered for specific topics as relevant.

Data analysis. The evaluators must enter the qualitative and quantitative data in the evaluation matrix for each evaluation question and each assumption. Once the evaluation matrix is completed, the evaluators should identify common themes and patterns that will help to answer the evaluation questions. The evaluators shall also identify aspects that should be further explored and for which complementary data should be collected, to fully answer all the evaluation questions and thus cover the whole scope of the evaluation (see HBK sections 5.1, 5.2). The methods for data analyses are expected to be explained in the CPE design report.

Validation mechanisms. The mechanisms to ensure the validity of collected data and information include (but are not limited to) systematic triangulation of data sources and data collection methods, regular exchange with the evaluation managers at the CO, internal evaluation team meetings to corroborate data and information for the analysis of assumptions, the formulation of emerging findings and the definition of preliminary conclusions; and the debriefing meeting with the CO and the ERG at the end of the field phase. (see Handbook, section 3.4.3, section 4.2). During the field phase, besides interviews, focus group discussions and workshops, the evaluators may conduct a collective corporate workshop with UNFPA's staff particularly for intersected programmes (SRH & Gender & Youth, Youth and Population Dynamics).

Theory-based approach. The CPE will adopt a theory-based approach that relies on an explicit theory of change, which depicts how the interventions supported by the UNFPA Timor-Leste CO are expected to contribute to a series of results (outputs and outcomes) that contribute to the overall goal of UNFPA. The evaluation team will be required to verify the theory of change underpinning the UNFPA Timor-Leste CPD4 and to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true.

Participatory approach. The CPE will be based on an inclusive, transparent and participatory approach, involving a broad range of key partners and stakeholders at national and sub-national levels. Particular attention needs to be paid to involve beneficiaries from the groups furthest behind, including PWDs.

Mixed-method approach. The evaluation will primarily use qualitative methods for data collection, including document review, interviews, focus group discussions, case studies, and observations during field visits, where appropriate. The qualitative data will be complemented with quantitative data to minimize bias and strengthen

the validity of findings. Quantitative data will be compiled through desk review of documents, websites and online databases, and possibly through surveys, to obtain relevant financial data and data on key indicators that measure change at output and outcome levels.

8. Evaluation process

The CPE unfolds in five phases: 1) preparatory phase 2) design phase 3) field phase 4) reporting phase and 5) facilitation of use and dissemination phase.

(i) Preparatory Phase

The CO Evaluation Manager will be responsible for

- Drafting of terms of reference (ToR) with input from RO M&E adviser
- Selection of potential evaluators by CO with input from RO M&E adviser
- Establishment of Evaluation Reference Group (ERG) for the CPE
- Compilation of initial documentation for the desk review by evaluators
- Stakeholders mapping and compilation of list of projects

(ii) Design Phase

The evaluation manager will assist the evaluation team with the following:

- Evaluation kick-off meeting upon the arrival of the evaluators in the country
- Desk review of background information and extensive documentation on the country context and CP
- Review and refinement of the theory of change underlying the CP (see Annex A)
- Formulation of a final set of evaluation questions
- Development of a final stakeholder map and a sampling strategy
- Development of a data collection and analysis strategy, work plan and agenda for the field phase
- Development of data collection methods and tools, their limitations and mitigation measures
- Development of the evaluation matrix (evaluation criteria, evaluation questions, related assumptions, indicators, data collection methods and sources of information)

The evaluators will prepare a design report at the end of the design phase with robust, practical and feasible evaluation approach, detailed methodology and work plan. The design report is developed in consultation with the evaluation manager and the ERG and submitted to the regional M&E adviser in UNFPA APRO for review and approval. The template for the design report is provided in Annex E.

(iii) Field Phase

In the field phase the evaluators will collect the data and information required to answer the evaluation questions during a period of 3 weeks. The evaluators will conduct a preliminary analysis of the data to identify emerging findings and present them to the CO and the ERG during a debriefing meeting. The meeting will serve as a mechanism for the validation and will enable the evaluation team to refine the findings, which is necessary so they can then formulate their conclusions and develop credible, relevant and actionable recommendations.

(iv) Reporting Phase

The evaluators submit a draft final evaluation report to the evaluation manager. The evaluation manager reviews and quality assures the draft report; the criteria outlined in the “Evaluation Quality Assessment (EQA) grid”

should be used to quality assure the report. Once considered of adequate quality (in consultation with the APRO M&E Adviser), the evaluation manager shares it with the reference group for comments (factual mistakes, omissions, misrepresentations, contextual factors) while respecting the independence of the evaluation team in expressing its judgement. In the event that the quality of the draft report is unsatisfactory, the evaluation team will be required to revise the report and produce a second draft. The evaluation report will be accepted as final by the CO in consultation with the APRO M&E Adviser.
At the end of the reporting phase, the evaluation manager and the regional M&E adviser will jointly prepare an internal EQA of the final evaluation report. The Evaluation Office will subsequently conduct the final EQA of the report, which will be made publicly available.

(v) Dissemination and Facilitation of Use Phase

The evaluation manager, together with the relevant officer in the country office, develops and rolls out a communication plan to share evaluation results with country and regional offices, relevant divisions at headquarters and external audiences. Overall, the communication plan should include information on (i) target audiences of the evaluation; (ii) communication products that will be developed to cater to the target audiences' knowledge needs; (iii) dissemination channels and platforms; and (iv) timelines. At a minimum, the final evaluation report will be accompanied by a PowerPoint presentation prepared by the evaluators summarising findings and actionable recommendations for the dissemination and use.

9. Expected outputs

The evaluation team will produce the following deliverables:

- An inception report using the template of Annex 1 including (as a minimum): a) a stakeholder map; b) the evaluation matrix (including the final list of evaluation questions and indicators); c) the overall evaluation design and methodology with a detailed description of the data collection plan for the field phase; and d) a detailed evaluation work plan and agenda for the field phase. Maximum 70 pages
- **PowerPoint presentation of the design report.** The PowerPoint presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the evaluation manager and the regional M&E adviser, the evaluation team will develop the final version of the design report.
- **PowerPoint presentation for debriefing meeting with the CO and the ERG.** The presentation provides an overview of key emerging findings of the evaluation at the end of the field phase. It will serve as the basis for the exchange of views between the evaluation team, UNFPA Timor-Leste CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected.
- A draft evaluation report using the template of Annex 2 (potentially followed by a second draft, taking into account potential comments from the evaluation technical committee and ERG);
- A final evaluation report;
- A PowerPoint presentation of the results of the evaluation for the dissemination events.

All deliverables will be in the English version of the final draft evaluation report is required.

10. Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to ensure the production of good quality evaluations at central and decentralized levels through two processes: quality assurance and quality assessment. Quality assurance occurs throughout the evaluation process, starting with the ToR of the evaluation

and ending with the final evaluation report. Quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report to assess compliance with a certain number of criteria. The quality assessment will be conducted by the independent UNFPA Evaluation Office.
The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the independent UNFPA Evaluation Office developed (see https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance). An essential component of the EQAA system is the EQA grid (see Handbook, and Annex F), which defines a set of criteria against which the draft and final evaluation reports are assessed to ensure clarity of reporting, methodological robustness, rigor of the analysis, credibility of findings, impartiality of conclusions and usefulness of recommendations.

11. Work plan

The table below indicates all the activities that will be undertaken throughout the evaluation process, as well as their duration or specific dates for the submission of corresponding deliverables. It also indicates all relevant guidance (tools and templates) that can be found in the UNFPA Evaluation Handbook.

Activities	Responsible person	Timeline
1.CPE		
1.1 Preparatory phase		
Finalize draft ToRs for CPE	Rep, M&E team	6 Nov - 24 Nov
APRO to review and to clear final draft ToRs for CPE	RMEA	20 Nov - 25 Jan
Recruitment of Consultants / Evaluation team (including interviews)	Rep, M&E team	5 Feb - 8 Mar
APRO to review and clear identity of consultants / Evaluation team	RMEA	8 Mar - 15 Mar
Send offer letter to consultants/Evaluation team	HR	15 Mar - 23 Mar
Evaluation reference group from IP and donors (ERG)	Gvmt, Rep, M&E team, ERG	26 Feb - 15 Mar
1.2 Design phase		
Setup of technical evaluation committee (to complement the reference group)	Rep, M&E team	26 Feb - 15 Mar
CO to prepare and send background documents and other materials	M&E team	15 Mar - 29 Mar
Consultants/Evaluation Team to send inception report	Evaluators	25 Mar - 12 Apr
Review and feedback on the inception report	ERG	12 Apr - 19 Apr
Presentation and validation of the tools, framework and methodology	Evaluators	12Apr - 26 Apr
Finalization and approval of the inception report	Evaluators, RMEA, Rep	22 Apr – 26 Apr
1.3 Data collection phase		
Corporate reflection workshop (kick-off workshop physical or virtual)	Evaluators	6 May - 10 May
Preparatory work for field mission (agenda for project visits, FGD and KII, logistics)	Evaluators, M&E team	13 May - 24 May
Field mission	Evaluators, M&E team	27 May - 14 Jun
Preliminary findings and recommendations	Evaluators, CO, IP	14 Jun -17 Jun
Debriefing meeting (Validation workshop)	Evaluators, CO, IP	14 Jun -17 Jun
1.4 Reporting phase		
Draft of the final report	Evaluators	17 Jun - 12 Jul
Provide feedback to the first draft report	CO, RMEA	15 Jul - 26 Jul
Second draft of the final report	Evaluators	2 Aug – 9 Aug
Stakeholders workshop to validate/revise the draft report (dissemination of CPE results through CPAP Annual Review meeting with UNFPA IPs)	ERG	14 Aug - 16 Aug
Validation and dissemination of the final report	Evaluators	19 Aug - 21 Aug
CO will send to APRO and APRO will send to EO with the draft EQAA	Rep, M&E team	22 Aug - 26 Aug
Review/implement the communication plan for sharing evaluation results focusing on the main findings, conclusions and recommendations	Rep, M&E team	27 Aug - 30 Aug

12. Profile of the evaluation team

The evaluation team will be composed of a Team Leader and two Team Members as specified below. It will consist of two (2) international expert and one (1) national expert who demonstrated expertise and experience in

- evaluation of other country programmes – at least three previous ones
- experience in programme formulation (at least two previous experiences, preferably with the UN)

Team leader – international consultant

The competencies, skills and experience of the evaluation team leader should include:

● Master's degree in public health, social sciences, demography or population studies, statistics, development studies or a related field.

● At least 10 years of experience in conducting evaluations in the field of international development, in Maternal and Reproductive Health, Gender and Women's Empowerment, Population and Development and evaluation methodology

● Extensive experience in leading complex evaluations commissioned by UN organizations and/or other international organizations and NGOs.

● **Demonstrated expertise in one of the thematic areas of the CP covered by the evaluation (see expert profiles below).**

● In-depth knowledge of theory-based evaluation approaches and ability to apply both qualitative and quantitative data collection methods and to uphold high quality standards for evaluation

● Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.

● Ability to consistently integrate human rights and gender perspectives and disability inclusion in all phases of the evaluation

● Excellent management and leadership skills to coordinate the work of the evaluation team, and strong ability to share technical evaluation skills and knowledge.

● Experience working with a multidisciplinary team of experts.

● Excellent ability to analyze and synthesize large volumes of data and information from diverse sources.

● Excellent interpersonal and communication skills (written and spoken).

● Work experience in/good knowledge of the region and the national development context of Timor-Leste

● Fluent in written and spoken in English. Portuguese or Bahasa Indonesian is an advantage.

Two Thematic Experts – (1 national and 1 international consultants)

The competencies, skills and experience of the thematic expert should include:

● Relevant Master's degree in the programmatic area of the evaluation (see details below)

● Substantive knowledge of the programmatic area of the evaluation such as
knowledge of SRHR, including HIV and other sexually transmitted infections, maternal health, and family planning

● Substantive knowledge of adolescent and youth issues, in particular SRHR of adolescents and youth

● Substantive knowledge on gender equality and the empowerment of women and girls, GBV and other harmful practices

● Substantive knowledge on the generation, analysis, dissemination and use of housing census and population data for development, population dynamics, migration and national statistics systems

● 5-7 years of experience in conducting evaluations, reviews, assessments, research studies in the field of international development

● Ability to ensure ethics, integrity and confidentiality of the evaluation process, incl. do no harm principle

● Ability to consistently integrate human rights and gender perspectives, and disability inclusion in all phases of the evaluation

● Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods

- Excellent analytical and problem-solving skills
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Timor-Leste
- Familiarity with UNFPA or other UN organizations' mandates and activities will be an advantage.
- Fluent in written and spoken in English. Portuguese is an asset

13. Management arrangements

The evaluation manager in the UNFPA Timor-Leste CO will be responsible for the management of the evaluation and supervision of the evaluation team in line with the UNFPA Evaluation Handbook. The evaluation manager will oversee the entire process of the evaluation, from the preparation to the facilitation of the use and the dissemination of the evaluation results. S/he will also coordinate the exchanges between the evaluation team and the ERG. It is the responsibility of the evaluation manager to ensure the quality, independence and impartiality of the evaluation in line with the UNEG norms and standards and ethical guidelines for evaluation. The evaluation manager has the following key responsibilities:

- Establish the ERG.
- Compile background information and documentation on both the country context and the UNFPA CP
- Prepare the ToR and annexes for the evaluation and submit them to the Regional M&E Adviser
- Provide secretariat support to ERG, convene meetings with the evaluation team and facilitate the interactions
- Launch and lead the selection process for the team of evaluators
- Identify potential candidates to conduct the evaluation
- Share the annexes of the ToR with the final selected evaluators and hold an evaluation kick-off meeting with the evaluation team and the regional M&E adviser if needed.
- Provide evaluators with logistical support for data collection
- Prevent any attempts to compromise the independence of the evaluation team
- Perform the quality assurance of all the deliverables submitted by the evaluators; notably the design report as well as the draft and final evaluation reports
- Coordinate feedback and comments of the ERG on the evaluation deliverables
- Undertake quality assurance of the draft design and evaluation reports with support from the regional M&E adviser
- Develop an initial communication plan and update it throughout the evaluation process
- Prepare the EQA of the final evaluation report in collaboration with the regional M&E adviser
- Lead and participate in the preparation of the management response.
- Submit the final evaluation report, EQA and management response to the regional M&E adviser, the EO at UNFPA headquarters.

The evaluation reference group (ERG) will follow closely the evaluation process. The ERG is composed of relevant UNFPA staff from the Timor-Leste CO, APRO, representatives of the national Government of Timor-Leste, implementing partners, as well as other relevant key stakeholders, including organizations representing vulnerable and marginalized groups.

The ERG has the following key responsibilities:

- Chaired by Representative or Assistant Representative.
- Support the evaluation manager in the development of the ToR, incl. the selection of preliminary EQ
- Provide feedback and comments on the design report.
- Act as the interface between the evaluators and key stakeholders of the evaluation, and facilitate access to key informants and documentation
- Provide comments and substantive feedback from a technical perspective on the draft evaluation report.

● Participate in meetings with the evaluation team.
● Contribute to the dissemination of the evaluation results and learning and knowledge sharing, based on the final evaluation report, including follow-up on the management response.

In addition, with the aim of ensuring coherence and coordination between UN Agencies, Heads of Evaluation Offices of the United Nations Evaluation Group are encouraging coordination between agencies in the planning and conduct of Country Programme Evaluations. The United Nations Evaluation Development for Asia and the Pacific (UNEDAP) has identified the following agencies that are conducting CPEs in Timor-Leste during the first quarter of 2024: UN Women, UNDP, UNFPA, and UNICEF. Therefore, the agencies will establish a coordination group and discuss concrete ways to coordinate the CPEs with the aim of both satisfying organizational mandate and needs, while minimizing burden on stakeholders and seeking opportunities for joint analyses.

BUDGET AND PAYMENT MODALITIES

The exact number of workdays and workload distribution will be proposed by the evaluation team in the design report and will be subject to the approval of the evaluation manager.

The evaluators will receive a daily fee according to the UNFPA consultancy scale based on qualifications and experience.
The payment of fees will be based on the submission of deliverables, as follows:
● 20%: Upon approval of the design report
● 40%: Upon submission of a draft evaluation report of satisfactory quality
● 40%: Upon approval of the final evaluation report and the PowerPoint Presentation of the evaluation results

In addition to the daily fees, the evaluators will receive a daily subsistence allowance (DSA) in accordance with the UNFPA Duty Travel Policy, using applicable United Nations DSA rates for the place of mission. Travel costs will be settled separately from the consultancy fees.

14. Bibliography and resources

UNFPA country programme

- Country programme document (CPD)
- Country programme action plan (CPAP)
- Country programme dashboard and results tracking (M&E)
- List of UNFPA interventions by country programme output and strategic plan outcome
- Annual work plans from 2021 to date
- Work plans progress reports
- Annual report 2021, 2022, 2023
- Donor reports
- Activity and Monitoring reports
- UNFPA Timor-Leste CPE 2020

Strategic context of UNFPA country programme

- UNFPA Strategic Plan 2022-2025
- UNSDCF Timor-Leste 2021-2025
- Common Country Assessment 2019, 2024
- UNCT Annual Report 2021, 2022, 2023

Wider country context relevant to UNFPA Timor-Leste

- Timor-Leste strategic development plan 2011-2030
- Timor-Leste National Health Sector Strategic Plan I and II
- Timor-Leste Demographic Health Survey 2016
- Final HIV Sentinelle Surveillance Plus 2018-19
- Timor-Leste Facility audit
- Strategic Planning for Timor-Leste PE-INSCIDA (HIV)
- Census 2022 final results
- CEDAW for youth Briefing note
- Climate risk country profile
- Timor-Leste World Bank Economic Report
- Timor-Leste social norms report
- Timor-Leste National Action Plan

15. Annexes

Note: The ToR with annexes will be made available to the consultants who have been recruited to conduct the CPE.

A - Theory of change
B - Stakeholder map
C - Evaluation matrix template
D - Establishing the list of UNFPA intervention
E - Outline of design report
F - Evaluation Quality Assessment grid
G - Outline of evaluation report (draft and final version)
H - UNFPA Evaluation Office editorial guidelines
I - Evaluation workplan
J - Ethical norms and standards

1. Outlines of the Inception Report

2. Outlines of the Final Evaluation Report

Annex 1

Outlines of the Inception Report

Cover page

UNFPA CPE: Name of the Country

Period covered by the evaluation

Inception Report

Date

Second page

Country Map (half page)

Table (half page)

EVALUATION team	
Titles/position in the team	Names

Third page

Table of contents

Section	Title	Suggested length
Chapter 1: Introduction		
1.1	Purpose And Objectives Of The Country Programme Evaluation)	1-2 pages max.
1.2	Scope of the Evaluation	
1.3	Purpose of the inception report	
Chapter 2: Country Context		
2.1	Development challenges and national strategies	4-6 pages max.
2.2	The role of external assistance	
Chapter 3: UNFPA Strategic response and programme		
3.1	UNFPA strategic response	5-7 pages max.
3.2	UNFPA response through the country programme	
3.2.1	The country programme	
3.2.2	The country programme financial structure	
Chapter 4: Evaluation Methodology and approach		
4.1	Evaluation criteria and questions	7-10 pages max.
4.2	Methods of data collection and analysis	
4.3	Selection of the sample of stakeholders	
4.4	Limitations and risks	
Chapter 5: Evaluation process		
5.1	Process overview	3-5 pages max.
5.2	Team composition and distribution of tasks	
5.3	Resource requirements and logistic support	
5.4	Work plan	

Total		20-30 pages max.

Annexes:

Annex 1 **EVALUATION** Concept note and/or Terms of Reference

Annex 2 EVALUATION matrix

Annex 3 Interview guides

Annex 4 List of UNFPA interventions

Annex 5 Stakeholders map

Annex 6 EVALUATION agenda

Annex 7 Documents consulted

Following page

Abbreviations and Acronyms

List of tables

List of figures

Following page

The key facts table

Annex 2

Outlines of the Final EVALUATION Report

Cover page

UNFPA Country Programme Evaluation: Name of the Country Period covered by the **EVALUATION** Final **EVALUATION** Report Date

EVALUATION team	
Titles/position in the team	Names

Second page

Country Map (half page) Table (half page)

Third page

Acknowledgements

Fourth page

Table of contents

Section	Title	Suggested length
Executive Summary		3-4 pages max.
Chapter 1: Introduction		
1.1	Purpose and objectives of the country programme evaluation	5-7 pages max.
1.2	Scope of the Evaluation	
1.3	Methodology and process	
Chapter 2: Country Context		
2.1	Development challenges and national strategies	5-6 pages max.
2.1	International guidelines and standards	
2. 3	The role of external assistance	
Chapter 3: UN/UNFPA Strategic response and programme strategies		
3.1	UNFPA response and UN response	5-7 pages max.
3.2	UNFPA response through the country programme	
3.2.1	Analysis of UNFPA country programme to date highlighting main achievements and main issues	
3.2.2	Analysis of country office capabilities and functioning	
3.2.3	The financial structure of the programme	
Chapter 4: Findings: answers to the Evaluation/evaluation questions		
4.1	Answer to **Evaluation** question 1	25-35 pages max.
4.2	Answer to **Evaluation** question 2	

4.3	Answer to **Evaluation** question 3	
4.4	Answer to **Evaluation** question X ….	
4.5	New areas of opportunity and assumptions/threats	
Chapter 5: Conclusions		
5.1	Strategic level	6 pages max.
5.2	Programmatic level	
5.3	Structural level	
Chapter 6: Recommendations		
6.1	Recommendations with scenario projection	4-5 pages max.
Total number of pages		50-70 pages max.

Annexes:

Annex 1 – Terms of reference

Annex 2 – List of persons/institutions met

Annex 3 – List of documents consulted

Annex 4 – The evaluation/evaluation matrix

Following page

Abbreviations and Acronyms

List of tables

List of figures

Following page

The key facts table

Following page

Structure of the country programme evaluation report

Spotlight Initiative Timor Leste – Case Study Report

For UN Women and UNFPA Timor Leste Country Programme Evaluations 2024

13th October 2024

Report prepared by Kirsty Milward

Acronyms

ACbit	Chega Assosiation! Ba Ita
ADTL	Association for People of Disability Timor-Leste
AJAR	Asia Justice and Rights
ALFELA	Legal Assistance for Women and Girls
APFTL	Alumni Association of the Youth Parliament
APFTL	Timor-Leste Youth Parliament Alumni ()
CBRN-TL	Community Based Rehabilitation Network – Timor-Leste
CHC	Community Health Centre
CNJTL	Timor-Leste National Youth Council Timor-Leste ()
CODIVA	Coalition for Diversity and Action
CPE	Country Programme Evaluation
CSO	Civil Society Organisation
CSQ	Case Study Question
CSRG	Civil Society Reference Group
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
FOKUPERS	Forum Komunikasaun Ba Feto Timor Loro Sa'e
GBV	Gender Based Violence
GRB	Gender-Responsive Budgeting
IIMS	Electronic Case Management System
INSPTL	National Institute of Public Health
IP	Implementing Partner
JSMP	Judicial System Monitoring Programme
KII	Key Informant Interview
KSTL	Konfederasaun Sindikatu Timor-Leste-KSTL {Trade Union Confederation)
LGBTQI	Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex
LNOB	Leaving No-One Behind
MHVF	Mane Ho Vizaun Foun
MoE	Ministry of Education
MoYSAC	Ministry of Youth, Sports, Art and Culture
MoH	Ministry of Health
MSSI	Ministry of Social Solidarity and Inclusion
NAP-GBV	National Action Plan on Gender Based Violence
NSC	National Steering Committee (),
OHCHR	Office of the High Commissioner for Human Right
PLWD	Person living with disability
PNTL	Timor Leste National Police
PRADET	Psychosocial Recovery and Development East Timor
ROM	Results Oriented Monitoring
RUNO	Recipient UN Organisation
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
SEFOPE	Secretary of State for Vocational Training and Employment
SEII	Secretary of State for Equality and Inclusion
SEI	Secretary of State for Equality
SI	Spotlight Initiative
SSYS	Secretary of State for Youth and Sports

T4E	Together for Equality
TLPDP	Timor-Leste Police Development Programme ()
UN-RC	United Nations Resident Coordinator
UNSDCF	United Nations Sustainable Development Cooperation Framework
VPU	Vulnerable Person Units
WWCTL	Working Women's Centre in Timor-Leste
YEE	Young Emerging Evaluator

Contents

Introduction

The Spotlight Initiative (SI) in Timor Leste, was part of a global programme launched in 2017 and working in 25 countries across 5 regions, with approximately US$ 500 million funded by the European Union (EU). The SI in Timor Leste worked from 2019-2023 in a partnership between the government of Timor-Leste, the United Nations (UN) and civil society to end all forms of Violence against Women and Girls (VAWG). The SI supported the Government in implementing national priorities – in particular the National Action Plan (NAP) on gender-based violence (2017-2021 and 2022 – 2032) – including by promoting multisectoral collaboration where all ministries were encouraged to bring their collective capacities to prevent and respond to violence.

The overall vision of the SI in Timor-Leste was that women and girls enjoy their right to a life free of violence, within an inclusive and gender equitable Timor-Leste. It used a comprehensive multi-sectoral, survivor-centred and do no harm approach to the implementation of interventions in six Pillars/Outcome Areas, taking an explicit approach to integrating the experiences of women and girls who face multiple forms of discrimination, in line with the SDG principle of Leaving No One Behind (LNOB). The programme was implemented jointly by five recipient UN Organisations (RUNOs): UN Women, UNICEF, UNFPA, UNDP and ILO with collaborations in specific activities from IOM. In addition to supporting work at national level, the programme worked in 3 focal municipalities: Ermera, Bobonaro and Viqueque. These were selected in a consultative process of programme design in 2019.

Joint Case Study Approach

This document reports the findings and conclusions of a joint case study of the Spotlight Initiative in Timor Leste. This was undertaken as an integral part of the concurrent Country Programme Evaluations of two of the implementing RUNOs: UNFPA and UN Women. The approach was driven by the evaluation coordination group set up to respond to the fact that UN Women, UNFPA, UNICEF, the UNSDCF and UNDP were all planning to begin conducting Country Programme Evaluations (CPEs) in Timor Leste during 2024.

The joint approach aimed to achieve a measure of coordination between agencies in the planning and conduct of Country Programme Evaluations, in response to guidance from the United Nations Evaluation Group. The main purpose of this coordination was to minimize the burden on stakeholders; to seek opportunities for joint analysis and therefore to maximise the robustness of the evaluative evidence.

The study was carried out between April and August 2024 by Kirsty Milward, an independent consultant specialising in gender responsive evaluation and contracted for this study by both UNFPA and UN Women. Primary data collection took place in Timor Leste from 3rd to 12th July 2024, in parallel with the in-country data collection period of the UNFPA CPE. Primary data collection for the case study was therefore integrated into the UNFPA CPE data collection schedule, and a number of interviews were shared across the two parts of the team. The case study lead also coordinated with the primary data collection phase of the UN Women CPE team, which took place 6th-16th May 2024, resulting in a number of shared interviews. Coordination meetings were also carried out with the team leaders of the concurrent Timor Leste UNSDCF evaluation and the UNICEF Timor Leste CPE.

Purpose, Objectives and Scope

The purpose of this case study was to capture key lessons learned and insights into the implementation of the SI in Timor-Leste over its full implementation from 1st January 2020 to 31st December 2023, as relevant to the joint agency approach and with a particular focus on the work of UN Women and UNFPA. The case study aimed in particular to:

- Provide targeted insights for the lead agencies and stakeholders to ensure sustainability of efforts despite the funding ending;
- Feed into learnings on how the UN system can work together to ensure coherence and amplify its efforts in partnership with stakeholders.

The assessment also aimed to demonstrate SI's accountability to stakeholders (with a focus on rights holders and communities, as well as CSOs); and contribute to evidence-based decision-making for programming and policy development by contributing to the existing knowledge base on ending violence against women and girls (EVAWG).

The case study had the following specific objectives:

1. To assess the internal and external coherence of the programme vis-a-vis the UN system: identify the value-added, if any, of its operation as a multi-agency joint programme, and identify contributions to Timor-Leste UNSDCF 2021 – 2025 outcomes.
2. To assess programme effectiveness, and especially how its operation as a multi-agency joint programme has contributed to results.
3. To identify the programme's sustainability approaches and assess how far these are contributing to the sustainability of existing results and future progress on EVAWG at the close of the programme.
4. To provide lessons learned and actionable recommendations to support UN positioning on its work on EVAWG moving forward.

The OECD criteria of coherence, effectiveness and sustainability were identified as the main areas of inquiry pertinent to the current knowledge needs of participating agencies. These were focused into the following key questions and sub-questions for the study.

Table 1: Case Study Questions

Criteria	Key Question	Sub-question
Internal and external coherence	1. What was the added value of the joint programming approach for progressing EVAWG in Timor Leste, and how did the different features of this model contribute to it?	1A. Were the roles of the different agencies (RUNOs) appropriately allocated, clearly defined, balanced and capitalized on agency expertise and value added? 1B. How far did the RUNO coordination mechanisms ensure harmonised support and a synchronised approach to the government? 1C. What were the challenges of this joint model, and how were these handled? What dimensions of coherence were challenging and/or require further development? 1D. What were the roles of the other collaborating agencies (besides the RUNOs) and partners? What was the extent and results of their collaboration?
Effectiveness	2. How far has the programme progressed the EVAWG agenda in	2A. How have synergies between agencies been developed and used to promote results?

	Timor Leste? Which results were enhanced by the joint programme approach?	2B. Which results may not have been achieved if the SI had not used a joint programme model? 2C. Did any models prove to be effective with potential for scale up? 2D. Were the coordination/management structure and processes conducive to and facilitated the achievement of results?
Human rights and gender equality	3. What strategies were used to implement the LNOB principle and how did this principle translate into results?	3A. How did joint programming enhance or influence the integration of the LNOB principle in the SI? 3B. Who was reached and what was the most effective way of ensuring meaningful engagement? 3C. What were the challenges and missed opportunities?
Sustainability	4. What were the separate and joint approaches to sustainability taken by the RUNOs?	4A. Which elements of the joint programme approach will continue to function after the project end to support future results and continue to prevent and respond to VAWG? 4B. What are the challenges to the sustainability of programme results and how can they be addressed?

Methodology

A primary objective of the case study was to coordinate with the two parallel CPE processes; the timeline was therefore arranged to cover the timelines of both CPEs, and to deliver inputs in stages. The process and analysis strove to apply key principles of a gender responsive and human rights-based approach. It therefore aimed to be inclusive, participatory, to ensure fair power relations, and transparency; and to analyse the underlying structural barriers and sociocultural norms that impede the realization of women's rights, including marginalized groups.

The case study took a theory-based approach using mainly qualitative methods. It drew on secondary and primary data sources. Methods included:

1. Document review, including of programme reports, Spotlight reviews and previous evaluations, financial records and management agreements.
2. Remote and face to face key informant interviews with programme staff, government officials, CSO partner staff, and programme beneficiaries at facility and community levels.
3. Focus group discussions with rights holders and field visit observations in two of the three intervention focus municipalities.
4. Analysis of select FGDs and KIIs carried out separately for the UN Women and UNFPA CPEs. These included FGDs carried out with stakeholders and rights holders in the 3rd intervention municipality of Bobonaro.

Data collection specific to the Case Study process included consultations with 90 stakeholders (40 M and 50 F) through 22 KIIs (12M, 33F) and 3 FGDs (28M, 17F). In addition, 3 FGDs (24M, 23 F) and 25 KIIs (14M; 22F; 2 Other) which had relevance to the SI were carried out by the UN Women CPE team, involving in total 85 further stakeholders. Together these included 175 (78M, 95F, 2 other)people: 12 government partners (2M, 10F), 17 UN System staff (4M, 13F), 31 implementing partner staff (8M, 21F, 2 Other), and 117 rights-holder beneficiaries (66M, 51F).

Interviews, FGD transcripts / extended notes and key secondary documentation were analysed against CSQs using social research methods in Miner QDA (Lite). Multiple lines of evidence informed the analysis for each finding / CSQ. Sources and methods of information were triangulated to ensure robust findings that can be used with confidence.

Limitations of the study

1. Resource constraints as well as the specific timelines of the various CPEs meant that the case study was contracted by and primarily focused on the work of UNFPA and UN Women. While efforts were made to include the activities and an understanding of the contributions of UNICEF, UNDP and ILO, to the SI, it is likely that these findings and conclusions have primary resonance for UNFPA and UN Women.

2. A drive to avoid duplication of respondents wherever possible, meant that some parts of the activity (for example activities in health facilities) were covered by primary data collection by the case study consultant in more detail than others (for instance, work under the SI related to UNFPA's Comprehensive Sexuality Education programme was covered by the wider UNFPA CPE). It is possible that this weighting has influenced the interpretation of data and subsequent articulation of study findings. Efforts were however made to balance this potential bias with thorough literature review and communication with the UNFPA CPE team.

3. Since planned UNFPA team included a Young Emerging Evaluator (YEE) and a National Consultant from Timor Leste who would accompany the two international team members as evaluators as well as providing integrated interpretation support, interpretation support to the case study lead was provided separately from in-house UNFPA staff. This staff member was familiar with the site visit locations which maximised efficiency of the visits, but had also been strongly involved in some SI activities in those areas. The independence of interviews and FGDs in specific locations (Viqueque, Ossu and Gleno hospital / CHCs) was compromised by this arrangement and information received was influenced by the prior acquaintance. However, it should be noted that the positive bias that might be expected was not clearly apparent; discussion of challenges and lack of progress was frank and constructive in all three locations. In other locations at community level and a more remote CHC (Uatu Lari) this bias was not apparent.

Overview of the Spotlight Initiative in Timor Leste

The SI aimed to institute a 'new way of working together' [1] in harnessing the expertise of individual agencies into collective focus on EVAWG in TL and leveraging each agency's opportunities and entry points. A dedicated SI team was established under the oversight of the UN Resident Coordinator (RC) with a Coordination Officer; Communication Officer and Monitoring and Evaluation Specialist of the RCO working with the Spotlight Technical Unit comprising the EVAW Specialist (UN Women), Finance Specialist (UNDP) and M&E Specialist (UNFPA). The Technical Unit and the RUNO programme teams were allocated separate premises[2] in which they would work in the same physical space. UN Women was designated with technical coherence leadership by the RCO.

[1] Spotlight Initiative Country Programme Document, Timor Leste, 2019, Updated October 2022.
[2] Widely referred to as the Coordination Unit

The programme worked in six pillars or Outcome Areas:

Outcome 1: Laws and Policies: Legislative and policy frameworks, based on evidence, and in line with international human rights standards, on all forms of VAWG and harmful practices are in place and translated into plans.

Outcome 2: Strengthening Institutions: National and sub-national systems and institutions plan, fund and deliver evidence-based programmes that prevent and respond to VAWG, including DV/IPV, including in other sectors.

Outcome 3: Prevention and Social Norms change: Gender inequitable social norms, attitudes and behaviours change at community and individual levels to prevent VAWG, including DV/IPV.

Outcome 4: (Response) Quality Services: Women and girls who experience VAWG, including DV/IPV, use available, accessible, acceptable, and quality essential services including for long term recovery from violence

Outcome 5: Data availability and capacities: Quality, disaggregated and globally comparable data on different forms of VAWG, including DV/IPV, collected, analysed and used in line with international standards to inform laws, policies and programmes

Outcome 6: Strengthening the Women's Movement: Women's rights groups, autonomous social movements and relevant CSOs, including those representing youth and groups facing multiple and intersecting forms of discrimination/ marginalisation, more effectively influence and advance progress on GEWE and ending VAWG, including DV/IP.

Rather than working in separate pillars organised according to their individual specialisms, the agreed division of labour among the RUNOs for the SI called for the specialisms of each RUNO to be combined under each pillar, as shown in Table 2 (except for Pillar 6 on strengthening the women's movement which was led by UN Women alone).

Table s: Agreed Division of Labour for the SI [3]

	Outcome 1 Laws and Policies	Outcome 2 Institutions	Outcome 3 Prevention	Outcome 4 Services	Outcome 5 Data	Outcome 6 Women's Movement
UN Women						
UNDP						
UNICEF						
UNFPA						
ILO						

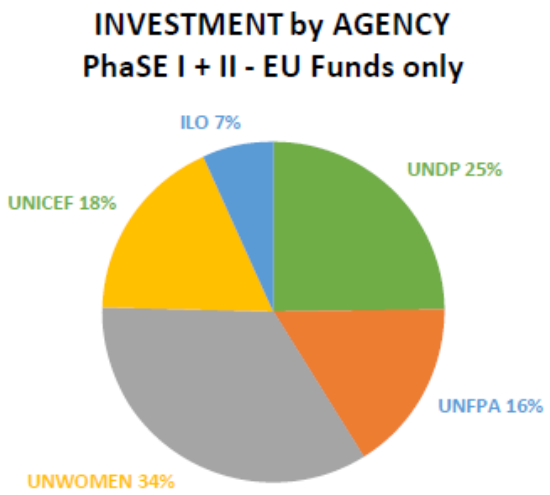
The overall budget for the initiative was set to be US $15,641,722 over the 4 years from January 2020 to December 2023. This included an investment of US $14,142,857 from the EU and US$ 1,498,867 from the RUNOs – primarily for staff and other personnel costs. Of this, the largest share was projected for Outcome 3 (prevention) at 28% ($3,049.504) and the smallest share was for Outcome 5 (Data) at 7% ($807,764) (See Figure 1 below).

Figure 1: SI budget share across Outcomes and RUNOs

[3] Hera (2022) SI in Timor Leste, Mid-term Assessment Report (ROM review)

PHASE I + PHASE II COMBINED						
OUTCOME/PILLAR	UNDP Spotlight EU contribution (USD)	UNFPA Spotlight EU contribution (USD)	UNWOMEN Spotlight EU contribution (USD)	UNICEF Spotlight EU contribution (USD)	ILO Spotlight EU contribution (USD)	TOTAL USD Spotlight EU contribution (USD)
OUTCOME 1	495,471	-	394,455	202,694	139,699	1,232,318
OUTCOME 2	1,101,673	40,413	480,723	70,758	129,032	1,822,599
OUTCOME 3	140,811	506,654	1,050,647	1,503,710	145,228	3,347,049
OUTCOME 4	907,842	788,524	90,000	320,341	293,544	2,400,251
OUTCOME 5	144,065	369,914	184,075	-	-	698,054
OUTCOME 6	-	-	1,418,159	-	-	1,418,159
TOTAL PROGRAMME OUTCOME COSTS	**2,789,862**	**1,705,506**	**3,618,059**	**2,097,503**	**707,502**	**10,918,431**
PROGRAMME MANAGEMENT COSTS	489,971	446,886	918,454	259,724	184,157	2,299,193
Total Direct Costs	***3,279,833***	***2,152,392***	***4,536,513***	***2,357,227***	***891,659***	***13,217,624***
8. Indirect Support Costs (Max. 7%)	229,588	150,667	317,556	165,006	62,416	925,234
TOTAL Costs	**3,509,421**	**2,303,060**	**4,854,069**	**2,522,233**	**954,075**	**14,142,857**

Source: Spotlight Initiative, October 2022 (Original 2019) Country Programme Document, Timor Leste



The budget division by agency broadly reflected the division of roles and involvement in Outcome areas – with UN Women leading the technical coherence and Outcome 6 as well as contributing to other outcomes with the largest share at 34% (US$ 4,854,069) and ILO contribution only to Outcome 2 with the smallest share at 7% (US$ 954,075).

Implementation was divided into two phases. Phase one was expected to be 2 years until December 2021, but was granted a no-cost extension until June 30th 2022. [4] Implementation came to an end as expected in December 2023 and, at the time of carrying out primary data collection for this case study, had been closed for about six months. The Technical Unit and its shared space with the RUNO programme staff had been disbanded.

Implementation of the programme was affected by key contextual challenges which had not been anticipated by the risk matrix for the programme design. These include the onset of and ongoing effects of the Covid-19 pandemic from early 2020, and the crisis caused by flash floods in 2021. The programme responded to these challenges by adjusting modes of operation, but it is nevertheless highly likely that they had an impact on the achievement of overall results.

Over the course of the SI's lifetime, some key global and local reviews were undertaken involving the SI in Timor Leste. These include:

- A Mid-term Assessment Report of the SI in Timor Leste using ROM review (June 2022)
- A Case Study for the Thematic Assessment on 'Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind' and movement building, for which Timor Leste was one of 10 case studies, selected as a country programme in East Asia/Pacific region.

[4] Hera (2022) SI in Timor Leste, Mid-term Assessment Report (ROM review),

- A ‘top innovative and good practices’ contribution under Pillar 2: Institutional Strengthening in the ‘Compendium of Innovative and Good Practices and Lessons Learned’ (April 2024) entitled ‘Greater budget allocation in Timor-Leste for women’s rights and to end violence against women and girls’.

Findings from these reviews have been incorporated into this Case Study data.

Case study findings

Internal and External Coherence

CSQ 1: What was the added value of the joint programming approach for progressing EVAWG in Timor Leste, and how did the different features of this model contribute to it?

Finding 1: The joint programming approach

It is clear that the RUNOs succeeded in working to their strengths in the SI – but also that this driver likely contributed to an approach that was often siloed. There are positive examples of coordinated work, including in relationships with the government, and exchange of expertise on GEWE, but the programme did not fully capitalise on this opportunity to model and trial a strategically joined up approach at the high level.

Despite examples of the ‘added value’ of joined-up work, caveats in administrative harmonizing suggest the experience of Ministries and CSO partners with multiple RUNO partnerships, and the effectiveness of a joint approach to EVAWG was not fully optimized. These caveats contribute to a concern that the investment in multi-agency engagement and coordination required for a joint programming model of this size/scale could have been reduced in models led by less agencies.

Respondents for this case study fully agreed that the roles of the RUNOs worked to each of their strengths, specialisms and mandates, and in that sense were appropriately allocated.
The programme built on each RUNO's long-standing working relationships with the GoTLS and civil society to secure government and CSO’s engagement and buy-in for the programme, resulting in the successful engagement in the implementation of the programme of over 10 governmental ministries and at least 21 CSOs. UNFPA, for example, took a lead role with Ministry of Health (MoH) and the Secretary of State for Youth and Sports (SSYS), its longstanding government counterparts, as well as the National Institute of Statistics. Its role with the Secretary of State for Equality[5] (SEI), which led the National Steering Committee (NSC), was relatively minor.[6] The UN Resident Coordinator (RC) was responsible for the programme’s performance and co-chaired the NSC with the SEI; UN Women was the technical coherence lead, and maintained a strong historical relationship with the SEI through the programme, while also – in addition to roles in other pillars, had sole responsibility for Outcome 6 on Strengthening the Women’s Movement, building on its historical relationships with CSOs engaged in gender equality in Timor Leste.

Other non-RUNO UN Agencies played a minor part in the programme. In the inception phase, WHO supported developing communications materials on EVAWG. IOM coordinated the development of a VAWG protection response and quarantine facilities during the Covid-19 pandemic, and OHCHR partnered in events around the LGBTI pride month.[7] They were, variously, involved in coordination

[5] Formerly the Secretary of State for Equality and Inclusion (SEII)
[6] Interview
[7] Spotlight Initiative (2024) ‘Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration’ (Draft)

mechanisms including the Gender Equality and Women's Empowerment Coordination Group, the Gender and Protection Working Group, and UN Country Team meetings; IOM also attended the Gender Equality Coordination meeting. These activities added to the broad scope of the coordinated UN effort on EVAWG and drew on the strengths of each agency, contributing to the harmonizing of approaches to government and to advancing the LNOB agenda.

For the CSOs strongly involved in parts of the programme, Spotlight's comprehensive approach to EVAWG, and the Joint Agency model, provided opportunity to be engaged more widely across the UN, rather than only with specific partners[8], therefore establishing more diverse, and in some cases ongoing, relationships with the UN Agencies.

There is also consistent agreement among respondents that the SI considerably raised the profile of EVAWG as an issue at all levels from community to agency to government, and this was in part due to the multi-pronged approach from line ministries[9], supported by their multiple counterpart RUNOs in a coordinated approach.

There is less evidence that the joint model translated effectively into a truly synergised joined up approach to tackling EWAWG in Timor Leste, or added value to the programme above and beyond the value of each agency's specialisms. Joint work in most of the Outcomes did lead to examples of agencies drawing on each other's expertise – for example, in the approach to Outcome 1 (Law and Policies), which saw specific collaborations between UNDP and UN Women; and UN Women and UNICEF. For example, in support of the Ministry of Education, Youth and Sport on revisions to education curricula, UNICEF led on technical support with regard to lifeskills; UNFPA on reproductive health; and UN Women on EWAWG response.
However, siloed work cultures and limitations to coordination continue to be identified by respondents as an impediment to effective joint work; and therefore missed opportunities to synergise offered by the joint approach, for instance by focusing and layering work at community level, as further discussed in Finding 4).[10]

Coordination on the programme was achieved by various mechanisms. The **Technical Unit** – which used a joint space, shared with the RUNO programme staff, in the UN Compound dedicated to Spotlight- was generally regarded as a useful mechanism promoting day to day coordination and communication at least of an informal kind. However, this dedicated space was not used to its maximum potential: not all SI staff used it, including UNDP staff at some phases of the programme. ILO staff did not use it as it had no positions dedicated solely to SI work.[11] Use of the space which created added potential for day to day coordination was also circumscribed in the first years of the programme by limitations on physical proximity due to the Covid-19 pandemic, when staff either worked from home or on a rotation basis in the office space. In addition, the Unit did not, by its nature as a work space for programme staff, ensure the high level coordination by RUNO Representatives that might have driven a consistently joined-up programme approach or an effort to actively pursue synergies in their support to the government in implementing the NAP-GBV. [12] This high level 'joint thinking' was seen by respondents as mostly missing – producing, for example, missed opportunities in complementary and coordinated work in specific locations with selected

[8] Interviews, CSO stakeholders
[9] Interviews, CSO stakeholders, Government Stakeholders, UN Stakeholders,
[10] Interviews, UN Stakeholders; CSO Stakeholders
[11] Interview
[12] Interview, UN Stakeholders

communities (see Finding 3). This is perhaps exemplified in that, while each Outcome area had a Theory of Change from the design stage (with contributions from various RUNOs for each Outcome), there was no combined Theory of Change for the whole programme envisaging how the combined Outcomes would work together to eliminate VAWG (See Annex 4).

From the point of view of government, for the SEI, which led the steering group and was therefore in communication with all the RUNOs, the joint approach did ensure some harmonisation of the UN approach and relationship. Some cross-government coordination was also facilitated – for example, quarterly ministerial meetings were held; and in more granular terms there was progress in the coordination of GBV case management across the ministries responsible for the referral network. However, for most other Ministries other than SEI, the strategy of working to RUNO strengths meant that it was generally business as usual with their pre-established UN counterpart.

In addition, attempts to enhance alignment across the RUNOs through inputs such as the Technical Unit; the shared office space; a Finance Task Team and a Spotlight Operations Manual, did not ensure full administrative harmonization which continued to be overall governed by programmatic and financial responsibility as specified under each RUNO's own fiduciary standards and programmatic safeguards. From the point of view implementing partners who were in partnership with more than one RUNO, the joint model made little if any difference in administrative terms, as the systems and processes for establishing and maintaining partnerships (proposal calls, recruitment, disbursements, reporting templates and mechanisms) were mainly not aligned, despite overall alignment of the Quantum financial software system of UNDP, UNFPA and UN Women.[13] Partnerships with CSOs continued to use individualised project-based models, even where these carried forward historical relationships, although there was some variation to this framework for the Learning Consortium under Outcome 6 (See Finding 5).

Challenges of the Joint Programme model

Challenges to maximising the opportunities of the joint model included external ones, in particular that the potential of physical proximity in the shared office space to support coordination was fundamentally undermined by responses to the Covid-19 pandemic. Coordination takes time and is facilitated by proximity: Covid was a challenge to both of these as programme implementation, according to stakeholders, was considerably slowed in 2020 and 2021 during the height of the pandemic (followed by flash floods in April 2021) and then rushed in 2022 and 2023.

Internal challenges were equally significant. These include that the different and separated positioning and roles of the agencies mean that more attention was given to avoiding overlaps in mandates that to creating synergies through intentional / designed overlaps or linkages. Different strategic relationships with the main government counterparts for each agency means that harmonised ways of working are perceived as difficult to achieve. [14] In other words, the different agency 'cultures' built over the long term, which are indivisible from their distinct roles or comparative advantages, mitigate against joined-up approaches.

Increasingly, as funding mechanisms move from core to non-core and potentially donor-driven approaches, UN Agencies also compete for funds and visibility. At the same time, respondents for the case study suggest that there was little discussion of the differential power relationships that

[13] Interviews, UN Stakeholders, Government stakeholders, CSO Stakeholders.

[14] Interview, UN Stakeholder

exist between them in this competitive market, or of how this might influence their respective roles under a joint programme. [15]

A history of separated modes of work means that different agencies have developed different models and approaches for activities which (could) have much in common. In Spotlight, this was evident in different training approaches for engaging parents and communities in VAWG prevention work; and different prevention curricula for use in schools and youth groups. While these curricula were developed for different audiences, there were overlaps in stakeholder type introduced to them through SI, and some implementing partners found the parallel curricula frustrating. The programme's Mid Term Assessment reported informants' concerns that in community awareness work each agency organises and disseminates its own messages, and that the quality of information and presentation could be improved with a more concerted effort for joint communication.[16] Even following this report, the opportunity to harmonise these and other activities into a joint approach through the SI was not taken.[17]

Finally, there are concerns that in the context of these caveats in efforts to maximise the opportunities of the joint approach, the joint model at this scale may not, on balance, have added value in financial terms. The model involved 7% cost recovery budgets for each RUNO, amounting to US $925,234 (much of which could, with fewer UN Agencies, have been available directly for implementation).[18] Management costs for the 5 RUNOs also were budgeted at $2,307,291. Together these amount to 23% of the EU contribution.

Effectiveness

CSQ2: How far has the programme progressed the EVAWG agenda in Timor Leste? Which results were enhanced by the joint programme approach?

Finding 2. Progress made in EVAWG

The programme contributed to clear achievements, albeit with some limitations, under Outcome 1 (Laws and Policies) Outcome 2 (Strengthening Institutions), and Outcome 4 (Quality Services). Progress under Outcome 5 (Data) has been made but does not yet add up to a coherent and reliable system for quality data production on GBV. Under Outcome 6, important steps have been taken in strengthening CSOs and the women's movement, especially in terms of better inclusion of marginalized groups in programme implementation and in advocacy and advisory roles. Achievements under Outcome 3 (Prevention) are less clear, and are widely seen as the weaker link in programme outcomes. In the absence of up to date outcome level data on VAWG prevalence, it is challenging to counter these concerns.

Under **Outcome 1 – Laws and Policies**, progress was made in reviewing and strengthening existing policies and in new legislation. In 2022, under the leadership of the SEI and with technical inputs from the SI team, the third NAP-GBV (2022-2032) was approved by the Council of Ministries, and

[15] Interviews, UN Stakeholder, CSO Stakeholder
[16] Hera (2022) SI in Timor Leste, Mid-term Assessment Report (ROM review)
[17] Interviews, UN Stakeholder; CSO stakeholders
[18] Interviews, UN Stakeholders, CSO Stakeholders; Spotlight Initiative, October 2022 (Original 2019) Country Programme Document, Timor Leste p 174.

guidelines were developed to support implementation including, for example, instituting in-service training on GBV.

New legislation was introduced – a new Child Protection Law (Law for the Protection of Children and Youth in Danger); and in 2023, following advocacy from the programme, the ILO Convention on Violence and Harassment (No. 190), and its accompanying Recommendation (No. 206) were adopted to address workplace related violence, sexual harassment abuse and exploitation. A draft Law Against Violence and Harassment in the world of work was developed, and an agreement made with the Chamber of Commerce on prevention of violence in the workplace.

Products were developed to support government to implement the Law Against Domestic Violence Law No. 7/2010, including an analysis and presentation of the law by CSO Belun to Committee F (the women's caucus) in Parliament; and a Women's Charter was developed with the same group. Guidance was produced on documenting cases of violence and harassment in the public sector administration.

Since SI reporting was presenting a Joint Programme, and as per requirements, distinctions are not made in the documentation (Annual Narrative Reports) on the particular contributions of each RUNO to these achievements. However, detailed analysis of the Phase II budget, which according to requirements is allocated activity-wise and therefore reported by agency, suggests support to the Law for the Protection of Children and Youth in Danger was driven by UNICEF via a consultant and transfers to MSSI and National Parliament, and a 100% time Child Protection officer was dedicated to the Spotlight team.[19] Support to the ratification of C190 was driven by ILO [20] via staff time and transfers to the Public Service Commission. Support to implementation of the Law on Domestic Violence was driven by UNDP[21] with support from UN Women including via management of a grant to their IP, Belun.[22] Interview data suggests that these formal roles were backed to some degree by technical support on specific issues from other RUNOs.

Under **Outcome 2 – Strengthening Institutions**, progress was reported in embedding legal frameworks in operational processes and in strengthening human resource capacity. The SI worked with the Ministry of Social Solidarity and Inclusion (MSSI) on a programme for adolescent survivors of violence and at-risk groups and a Mental Health and Psychosocial support programme. UNICEF continued to contribute to pre-exisiting work on establishing a teacher training programme through the MoE on positive discipline and classroom management to prevent violence in schools; and UNFPA worked with the Ministry of Youth, Sports, Art and Culture (MoYSAC) and Secretary State of Youth and Sport (SSYS) on instituting a Comprehensive Sexuality Education curriculum in schools and communities. UNDP developed a handbook on GBV for justice actors at the Legal and Judicial Training Centre and the Pedagogical Council of the Legal and Judicial Training Center integrated gender equality and GBV as a subject into the curricular programme. MSSI was also supported to establish reintegration of survivors of violence.

SI reports note achievements in the process of strengthening capacity for advocacy on gender equality and EVAWG in budgeting processes. UNDP, UN Women and CSO FOKUPERS engaged with different levels of government and 23 civil society organisations to increase budget allocations for

[19] Six UNICEF budget lines list the Child Protection Law; in addition to allocations to UNICEF Child Protection staff
[20] Five ILO budget lines list C190
[21] Five UNDP budget lines under Activity 2.1.2
[22] One UN Women budget line lists the LADV.

preventing and ending violence against women and girls,[23] and strengthen capacity for engaging with and monitoring its implementation. The programme developed an innovative method that translated state budget execution and expenditures into simplified information using infographics and carried out gender-based violence prevention training with participants from the Municipal Gender Working Group, Sectoral Directors at the municipal and post-administrative level, and the Gender Working Group from different line ministries. This training included components of gender-responsive budgeting (GRB) and reached over 300 participants.

According to several SI documents, these activities contributed to reversing a downward trend in budget allocation to gender equality initiatives, seen between 2019 and 2020, when this budget dropped from 0.6 percent of the overall budget (10.4 million USD) to 0.1 percent (1.4 million USD) in 2020. By 2023, budget allocation to gender equality and social inclusion had increased to $203.78 million in 2022 and 259 million in 2023, or 8.2 percent of the overall budget. In this process, 18 sub-programmes included the Promotion of Gender Equality as a main aim.[24] Activities incorporating GRB elements included integrating VAWG and gender considerations into municipal workplans and budgets in the three focus Municipalities. However, caution may be needed when interpreting these budget allocations. According to the State Budget 2022 Approved Budget Overview Book 1[25] 2022 was the first year of Programme Budgeting, introducing a new Programme Budget 980, for the Gender Equality and Social Inclusion Programme, of $233.229.892. Under this, $ 58 million under the GESI programme is provision for Social Security (contributory and non-contributory). US$ 5,126,310 of the total GESI budget is also allocated from the Infrastructure Fund. Notwithstanding this lack of clarity on the details of the rise in gender budget allocation, it appears safe to claim that there has clearly been an overall rise in allocations to gender equality. A sharp increase in government's interest in using GRB as a tool to analyse the budget, evident in ongoing requests made for technical support, has also been reported.

Under **Outcome 4** (Quality Services), tangible progress reported in SI reporting was made in the provision of services to GBV survivors and strengthening of the referral network for responding to cases, and confirmed in some locations by stakeholder and beneficiary interviews and FGDs. UNFPA supported the establishment by the MoH of three safe spaces in Community Health Centres (CHCs) in each of the target municipalities. SOPs for safe spaces were finalized and the sensitization to health managers and health care providers was conducted along with the training of PEP kits for managing sexual violence.[26] Training was supported for forensic examiners to help ensure human resources for the safe spaces could fully support survivors, including to support subsequent legal processes. SOPs included the strengthening of the documentation of cases in safe spaces, and strengthening confidentiality procedures. Based on observations, FGDs and interviews for this case study, the safe spaces are not all fully functional yet and in principal have more capacity than is currently being used. An important challenge has been the training of forensic medical examiners, and sustainability issues have included the transfer away of the personnel trained in this key role.

[23] Spotlight Initiative (2024) Ending Violence Against Women and Girls, Spotlight Initiative Compendium of Innovative and Good Practices and Lessons Learned, April; Spotlight Initiative Annual Narrative Programme Report 2022; Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft); Interview, CSO Stakeholder.
[24] 2023 Annual Report; 2021 Annual Report; Spotlight Initiative Compendium of Innovative and Good Practices and Lessons Learned 2024.
[25] https://www.laohamutuk.org/econ/OGE22/books/BB1_EN_Aprovado.pdf
[26] UNFPA (2024) 2023 Annual Report – Timor Leste

Nevertheless, there is evidence that these challenges are being addressed, and procedures/ protocols beginning to be implemented. [27]

Vulnerable Person Units (VPUs) (safe spaces under PNTL (police) management) were established and equipped for temporary accommodation of survivors in Bobonaro, Viqueque and Ermera and supported to operationalise their response to survivors reporting to the units either individually or via the Suco level referral mechanism. Cost-shared activity between the SI and a sister programme Together 4 Equality (T4E) has provided trainings on sexual assault case management and interviewing, and the SI conducted a data management assessment and analysis, to strengthen case management. [28] Evidence collected for this study through observation, interviews and community FGDs suggests that these units are functioning, are well known and used for referrals by Suco Councils and community members, and provide a key step in response services. In 2022, 411 women and girls' survivors reported their case to VPU Unit.[29] However, questions over the onward financial maintenance of the services they provide are not resolved. [30]

Shelters / safe houses make up a key part of essential services functioning in Viqueque, Bobonaro and Dili and four other districts and are reported to be 'always full'[31] These have been and continue to be funded independently of Spotlight, partly via MSSI as well as directly from other international donors. Safe house staff collaborate with the SI programme regarding both referrals to the safe houses from VPUs and elsewhere, and in facilitating survivors' legal processes in collaboration with SI implementing partners.

MSSI was supported to institutionalise the referral network of key individuals at village / Suco level trained to support local survivors to access appropriate services according to the specifics of the case. Trainings took place through Suco Councils (although in some cases trainings have not been renewed for new incoming Council members), and were backed up to some extent by wider community awareness sessions (See more in Finding 3) via different channels including use of media, knowledge products and face to face sessions which included information on the role of Suco Councils in referrals. Although data is not available on the precise responses of Councils to the cases they encounter, qualitative evidence from FGDs and interviews for this study [32] suggests that many of these systems are functioning. Although many GBV cases are resolved at community level, cases regarded as 'serious' including cases of sexual violence are regularly referred to VPUs and CHC safe spaces. Limited evidence from this study suggests research on how cases not referred to VPUs or Safe Spaces are defined, triaged and followed up would be an important contribution to further strengthening response mechanisms. How economic-based transactions such as bride price in some communities influence Council / referral behaviours - as the 'first responders' to IPV cases - is an important information gap and the respective roles of the Church, traditional and formal justice systems in influencing these responses. [33]

[27] FGDs benficiaries; Interviews, beneficiaires
[28] Spotlight Initiative Annual Narrative Programme Report 2022; Spotlight Initiative Annual Narrative Programme Report 2021
[29] As reported in Spotlight Initiative Annual Narrative Programme Report 2022.
[30] Interview
[31] Interview
[32] FGDS, beneficiaries; Interviews, beneficiaries.
[33] The 4th Periodic Report (2021) submitted by Timor-Leste to the Committee on Elimination of Descimination against Women (CEDAW) also raises the use of customary dispute resolution and non-customary ADR processes alongside the formal justice system, highlighting the importance of integrating traditional justice systems into the legal framework and ensuring their compatibility with formal justice systems. This Case Study

There is good evidence that achievements in provision of quality services and in establishing a referral network has been more effective in 'hub' towns in municipal centres. Despite some inroads – through, for example, the strengthening of grassroots CSOs via the Learning Consortium, - limited evidence from this study suggests that the programme did not succeed in establishing complete or consistently effective systems in harder to reach areas away from municipal centres.

Legal services were strengthened under the programme. The SI worked with CSOs AlFELA and JSMP for the provision of legal assistance to survivors and a legal outreach campaign in communities. Altogether 190 survivors received legal support. However, the time frame required for pursuing the legal process often extends into years – in part due to the limited size of the judiciary - and therefore beyond the project period of Spotlight. This is a threat to the progress of successful prosecutions, as funding required for accompanying cases has been insecure since the close of the programme – a situation which, being well understood, could have been responded to in programme design. For instance, in 2022, 311 cases were brought at the investigation levels at the Police and Public Prosecutor's Office, but in the same year, only 2 cases were brought to court and 2 convictions secured.[34] Some of these cases may have been withdrawn, but it is a reasonable assumption that some are still in process.

On **Outcome 5** – **Data availability and capacities** evidence is more mixed as to whether sufficient progress has been achieved to contribute to the evidence base on EVAWG for confident decision making and policy development.

Key steps have been taken: by 2022, UNFPA had conducted data literacy training with 256 people at municipality level in Ermera, Bobonaro, Viqueque and Dili to strengthen the knowledge of data producers from civil society, government institutions and local organizations, and ultimately to strengthen the quality and availability of prevalence and incidence data on GBV. UNFPA also facilitated developments to the reporting format for the HMIS, including indicators for GBV. [35] A preliminary assessment of the Information Management System (IMS) of PNTL identified gaps and provided recommendations for national stakeholders, and consultation were held with the Timor-Leste Police Development Programme (TLPDP) and VPUs on ways to address the gaps.

A large number of knowledge products have been produced over the course of the programme as enduring contributions to strengthening the evidence base for understanding and responding to VAWG. These include baseline information on existing systems and gaps – such as the Gender Justice Baseline Assessment; and the study on Law and Practice of the Criminal Procedure in cases of Gender-Based Violence in Timor- Leste; and training on Psychological Assessments for new Magistrate Students which will add to the knowledge base of incidence and types of GBV.

However, despite capacity building through data literacy trainings and technical support, government plans to undertake a DHS were changed in part due to the Covid-19 pandemic. As a result, key data users remain concerned that GBV data is not yet readily available or reliable.[36] Reporting data from CHC levels into this system has been initiated from functioning safe spaces,[37] but this data is unlikely to be comprehensive or widely available. Separately, CSOs working at various stages in the response mechanisms are collecting GBV incidence data, but it is unclear whether or

---

did not track progress in the development of a Traditional Justice Law regulating these relationships between these systems, undertaken by the Ministry for Legislative Reform and Parliamentary Affairs.

[34] Spotlight Initiative Annual Narrative Programme Report, 2022

[35] UNFPA (2024) 2023 Annual Report – Timor Leste

[36] Interviews

[37] Interviews, beneficiaries; FGDs Beneficiaries.

how this is synthesized or publicly available. A system to collect administrative data on VAWG was in place at baseline in line with international standards through the Electronic Case Management System (IIMS) implemented by the Ministry of Justice.[38] While data production through MoH, MoE and MSSI have been strengthened, limitations reported in 2022 include that these systems are not integrated and do not always match, and there is uncertainty regarding the routine/ systematic collection of VAWG data.

Under **Outcome 6** - **Strengthening the Women's Movement**, significant investment[39] was made in strengthening CSOs as programme implementers, as well as producers of evidence on which to base advocacy to strengthen policy. Twenty-three CSOs were included in the Learning Consortium under this Outcome, under the overall co-leadership of Asia Justice and Rights (AJAR); Asosiasaun Chega! Ba Ita and the National NGO Forum, with the overall objective of collaboration and coordination for EVAWG through improved CSO networking, sustainability and learning. Four members of the consortium also had organisation members on the CSRG[40] including the Association for People of Disability Timor-Leste (ADTL), and CODIVA (Coalition for Diversity and Action). Six Consortium members were also implementing partners AlFeLa, CODIVA, FOKUPERS, MHVF, Rede Feto, AJAR. [41]

The objectives of the Consortium were to promote collaboration with and between organizations, and to create an inclusive forum for this promotion. Some organisations in the Consortium were local and grass-root organizations not formally registered, and having limited operational and technical capacities to identify relevant and available funding opportunities and prepare competitive proposals. Further, many of these organizations lack human resources, credible finance mechanisms and systems and had no relevant policies in place to be eligible for funding by international donors, including the UN system.

Capacity building efforts undertaken by the Consortium included financial management, advocacy, strategies for women's empowerment, participatory action research (PAR), gender justice, discussion and training on how to shift gender inequitable attitudes, behaviours, and beliefs and cultural transformation; and organizational development. Virtual exposure trips were made to other EVAWG actors in the region (Indonesia, Sri Lanka, and Fiji). Organizations also receive technical and institutional mentoring outside of the training sessions.[42] Methods used for capacity strengthening, validated by stakeholders, included peer to peer knowledge sharing and learning, which was appreciated as an approach by respondents to this Case Study.[43]

While it is difficult to assess the contribution made to programme outcomes of this Consortium specifically, it is clear that CSOs in general – in their roles as implementing partners, and members of the CSRG, and as members of the Spotlight National Steering Committee – played significant roles in prevention activities at local and national levels; in key parts of the VAWG response cycle; and as advocates for gender budget allocation at national and municipal levels. Interview data for this case

[38] Spotlight Initiative Annual Narrative Programme Report 2022
[39] The overall budget for this Outcome was $1,416,622. By 2022, $1,076,460 had been committed to AJAR as leader of the Learning Consortium and $782,460 disbursed. In addition, as at December 2022, $3,907,118 had been committed in grant awards to CSOs as implementing partners and $3,124,408 had been disbursed (Spotlight Initiative Annual Narrative Programme Report 2022)
[40] CSRG members were recruited in their individual capacities – see also Finding 5.
[41] Analysis of list of Learning Consortium members
[42] Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)
[43] Interviews, CSO Stakeholders

study confirms that CSOs benefited from capacity building initiatives and found the Consortium model effective for this. The contribution of this Consortium to advancing the LNOB agenda is discussed in detail in Finding 5, below.

Finding 3 – Prevention and Social Norms change

Up to date outcome level data on GBV prevalence or trends is not yet available, so there is uncertainty around the overall success of prevention activity. Most commentators perceive change in attitudes and behaviours as the weak link with respect to the SI's contribution to EVAWG. In part this may be due to the short duration of actual project implementation (compared to the intergenerational nature of attitude and behaviour change) and in part due to the missed opportunities for synergising activity on prevention. Different IPs implemented different types of interventions in schools, with parents, with community leaders and with community members – but planning on precisely where these should take place was not conducted to maximise synergies or produce the layering helpful to social norm change. The opportunity to align or synthesise the different curricula used for these different target groups was not taken.

Prevention activities were varied and involved work by UNDP, UNFPA, UN Women, ILO and UNICEF, much of it through government and CSO implementing partners (including MSSI, Alola, Belun, Plan International-TL, JSMP (TV Talk shows) and sub-grantees through the Learning Consortium.

Activities included a Gender Norms study by UNFPA; the development of SBCC materials and the transfer of these to CSOs to develop community mobilization activities; the development and delivery of TV Talk Shows by JSMP; the development of a pocket guide for employers and workers, on the prevention and response to violence and harassment in the world of work; and of a Communications and Visibility Strategy led by the RCO and with coordinated inputs from all the RUNOS[44].

It also included a series of programmes supported by UNICEF, UN Women and UNFPA that all, in different ways, targeted young people and community leaders, recognising their potential long-term role in social and behaviour change for the prevention of VAWG. This took the form of trainings / sensitisation processes in communities, with parents, with community leaders and both in and out of schools with adolescents. UNICEF's Parenting Curriculum was delivered by MSSI staff in communities; UN Women's Connect With Respect curriculum was delivered by Alola Foundation and Mane ho Vizaun Foun (Men with a New Vision) in schools in the three municipalities; and UNFPA's Comprehensive Sexuality Education, working with the MoE and MoYSAC was delivered by Alola, Belun and FOKUPERS both in schools and to out of school young people through youth groups. UNICEF also supported MoE through a ToT to teachers on positive discipline and classroom management.

However, several of these programmes encountered challenges. Agreement on the roll out of UNFPA's CSE curriculum in schools (by FOKUPERS) using the Boys and Girls Circle manual, which include gender equality and lifeskills components was delayed by concerns about its integration by MoE. By 2022, it had reached 16 schools in the target municipalities.[45] The focus on lifeskills using the Health Relationship Manual with out of school young people went ahead through Alola

[44] Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)

[45] 2022 Spotlight Initiative in Timor-Leste Annual Narrative Programme Report; the curriculum has currently – i.e. during and following the SI - covered 47 schools in these municipalities.

Foundation and Belun, but on a reduced timeline. The delivery of UN Women's Connect with Respect in schools was affected by schools' closures due to the Covid-19 pandemic, resulting in examples of its roll out that were rushed and shortened. In addition, these extra-curricular courses were not strongly integrated into the school timetable, and in some cases were scheduled on Saturdays /non-school days, causing addition travel for students and low attendance. There were also reported gaps in management of the programme: the teacher training for teachers to deliver the sessions was reduced from 5 to 3 days during the election period; and handbooks were only provided to the teachers delivering the programme, reducing possibilities for wider interest by teachers in schools or materials to reinforce the new knowledge of students.[46] Community sensitisation activities did not achieve 100% coverage in target Municipalities, leaving information gaps, especially in remoter areas.[47] Case study evidence suggests that support services and/or referral systems in [some] schools were not strengthened, therefore leaving children experiencing violence without clear response mechanisms. [48]

Notwithstanding implementation challenges, many activities were rolled out, albeit on short timelines and with minimal follow-up[49] - but data on the effectiveness of these activities is scarce. DHS data from 2016 found that 53% of men and 73% of women thought it is justifiable for a man to beat his wife. Plans for a new DHS – which might have begun to evidence any change in attitudes - in 2021, and expectations of this again in 2022, did not materialize. While a VAWG prevalence study is said to be due in 2026 which might evidence change, and SI did contribute to supporting the SEI to strengthen the M&E framework for the NAP GBV, currently there is no Outcome level data for this work. While some programmes (trainings and sensitisation events) did conduct pre and post assessments to understand changes in knowledge about GBV, no data was collected to understand changes in attitudes and practices related to GBV. [50]

Evidence from community FGDs and interviews with government and CSO stakeholders for this case study is consistent with pre/post-test findings of increased knowledge among training / sensitisation participants: FGDs and KIIs suggest in various ways that community awareness of GBV as a crime and knowledge of the appropriate response procedures has improved,[51] including for key figures in Suco Councils who are involved in the referral network. But evidence of any deeper change involving behaviour and attitude change was not clear.[52] While a few individuals described changes towards more positive attitudes to gender equality in general, others described how 'minor' GBV cases continue to be mostly not registered, as they are resolved within the family or community. Others described how the legal obligation to carry through due process of a registered case may be a deterrent to registration of the case.[53]

Missed opportunities

[46] Interviews, Beneficiaries
[47] Interview, Beneficiaries
[48] FGD, Beneficiaries; Interview, Beneficiaries.
[49] The relatively short planned implementation timeline was further compressed by the shifts in implementation format, mode, and frequency as a result of the COVID-19 pandemic outbreak and the 2021 flash floods which affected the programme's target municipalities (Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)
[50] Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)
[51] FGDs Beneficiaries
[52] Interviews, beneficiaries; Interview, Government Stakeholder; FGD Beneficiaries; Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft);
[53] Interviews, beneficiaries; FGDs Beneficiaries

Evidence from interviews and FGDs for this study suggest that missed opportunities for maximising the effectiveness of prevention activities include gaps in coordination in the implementation of programmes at community levels[54], and potentially gaps in the community level analysis resulting in some key (economic) drivers of GBV – and therefore potential solutions - remaining unaddressed. [55] More concretely, there was a clear missed opportunity to plan prevention activities so that messaging at different levels held by different community members might 'speak to each other' or be reinforced through social networks, in methodologies known to support social norm change.[56] For instance, from the point of view of implementing partners, planning for precisely where to hold community awareness interventions at Suco level was driven primarily by the expertise and geographical expertise of partners alongside a strong requirement to avoid duplication with other activities/ implementing partners, rather than an appreciation of how different activities might reinforce one another. A lack of coordination meant that IPs were sometimes unaware of whether they might be in contact with community members who had engaged with SI interventions in other ways – such as whether the schools selected for Connect with Respect were in locations where parents in communities were engaged in the Positive Parenting training or community awareness activities. [57]

In part this was due to gaps in cross-government collaboration. Schools identified to receive the Connect with Respect opportunity were selected at first on the basis of the incidence of cases of GBV / sexual violence; but later this selection of schools by the MoE was influenced by the order in which they re-opened after Covid-19 related closures. In Bobonaro municipality, the five schools selected were said by implementing partners to be very far away from each other.[58] Similarly, community selection by MSSI for UNICEF's parenting curriculum – which had begun prior to the SI programme – was carried out according to the priorities of the ministry. [59]

Missed opportunities to create synergies for effectiveness through the layering of interventions (perhaps in key locations) were at the first level caused by coordination gaps; but even where coordination did take place, the strategic seeking out of synergies was missing.

Finding 4 - Synergies

Finding: Despite important gaps described in Finding 4, there are examples where synergies have supported results, including the simple fact of a high profile multi-stakeholder programme succeeding in considerably raising awareness of that the profile of VAWG and ending GBV. Results in policy and services are likely to have benefitted from coordinated work because it produced clear profile for EVAWG and the added value of concerted action. For services, it mattered that work happened at the same time. These examples of added value, however, mainly followed from the design of the joint implementation timeline, rather than from strategic planning on how to fully maximise this opportunity to synergize.

[54] Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)
[55] Interview, Beneficiaries
[56] Interviews, UN Stakeholders; CSO Stakeholders. See for example Cislaghi, B., Denny, E.K., Cissé, M. et al. Changing Social Norms: the Importance of "Organized Diffusion" for Scaling Up Community Health Promotion and Women Empowerment Interventions. Prev Sci 20, 936–946 (2019); UN Women, UNFPA and DFAT 2016 - Preventing violence against women and girls through social norm change learning paper from the asia-pacific forum on preventing violence against women and girls: evidence and tools for social norm change 1-2 December 2015, Bangkok p 49.
[57] Interviews, CSO Stakeholders
[58] Interviews, CSO Stakeholders
[59] Interview, UN Stakeholder

Synergies resulting from the joint programme model have at some points been achieved, in part simply because of the scale of the programme, and because through the joint programme model, the different dimensions of the programme were being **implemented at the same time**. This situation of five RUNOs, 17 government institutions and 23 CSOs being engaged concurrently / in the boundaries of the project timespan undoubtedly contributed to an increased awareness of and profile of VAWG in Timor Leste, about which stakeholders consistently agree.

Concurrent implementation by the RUNOs, ministries and CSOs was an important factor, for example, in strengthening the complex referral system, which involves an complex array of stakeholders in different roles and specialisms. This included, for example, creating linkages between CHC safe spaces and VPUs; and between CHCs/VPUs and the safe houses. It was also important in the case of the coordinated work on gender budgeting involving UNFPA, UN Women and UNDP.

Synergies were on occasion also achieved by good, collaborative joint work, such as consultation across the RUNOs to design a film on adolescents and GBV prevention;[60] and by pooling specialisms for the development of key materials, such as the additional modules on GBV and a more transformative approach to gender roles which was integrated into UNICEF's parenting curriculum.

They were also connections made and used by RUNOs across the CSO network which were made possible by the density of organisations activated by the programme. For example, the programme facilitated links between the worker's organisation KSTL and ALFELA, which was supporting women in the legal process. These links were useful in efforts to register cases of violence and harassment in the workplace and secure legal and psychosocial support.

Other synergies were similarly a factor of the density of activities. Some CSOs reported cross fertilizations over the strands of work they were implementing in concurrent SI projects. For example, one CSO reported that the strengthening / learning activities they engaged with as a member of the Learning Consortium were immediately applied in the improvement of their community level Awareness and Prevention training materials. Another reported that their research and implementation activities both provided data and material for the advocacy work they were concurrently conducting.

Overall, however, these synergies were piecemeal and – perhaps more importantly – not planned for beyond drawing on the separate expertise of each RUNO. They were relatively rarely driven by planning or intent to maximise the opportunity to make the work add up to more than the sum of its parts. One exception was the phase II planning workshop conducted by the technical unit in May 2022, which aimed to consolidate the results of Phase I and assess their impact beyond the programme's timeline. It included participation from SEI, the EU Ambassador, and the EUD focal point for civil society, human rights, democracy, and gender. While this may have been a helpful foundation to Phase II of the programme, it did not address the absence of a causal understanding or model of how synergies might advance the programme's objectives.

Human Rights and Gender Equality

CSQ3: What strategies were used to implement the LNOB principle and how did this principle translate into results?

Finding 5 – Leaving No-One Behind

Above and beyond the central focus on survivors and women and girls at risk of violence, the main strategy for implementing the LNOB principle was in the strong involvement of a diverse group of

[60] Interview, UN Stakeholder

CSOs in the programme. This included attention to ensuring the representation of diversity in the coordination mechanisms for this involvement – the CSRG.

While there is some way still to travel in ensuring inclusion in services (e.g. comprehensive accessibility) and attitudes to some marginalised groups, key steps were successfully taken during the program, including creating some space for diversity; increased visibility for LBGTIQ+ groups, and increased consultation with PLWD organisations.

Consistently reaching communities marginalized by remoteness with any density of response services or prevention activities has remained a challenge and warrants more concerted strategies to rectify.

The SI design had a strong strategy for engaging CSOs in the programme, and to include CSOs representing diverse groups in this engagement. The two main frameworks for this engagement, aside from as implementing partners receiving project grants, were the Civil Society Reference Group (CSRG) constituted for the programme, and the Learning Consortium.

The CSRG consisted of 17 members. Although these members were recruited as individuals[61] in order to preclude any conflict of interest in the case of their organisations being otherwise eligible for grant funding through the programme, most members were engaged in various civil society groups and organizations.[62] This included women's rights organizations, girls' rights organizations, human rights and feminist activists, and faith-based service providers. At least two (CNJTL and APFTL) were organisations having a focus on youth, one (CODIVA) represents LGBTIQ+ groups and issues, and two organisations work with persons with disabilities (PLWD). In their capacity as CSRG, with a dual role of advising the SI and working as partners to help achieve its goals, members from these organisations were involved in monitoring of the programme during joint and independent monitoring visits, [63] as well as in regular meetings concerning the programme.

This CSRG framework was found by many to be effective in promoting the issues of marginalized groups in the programme, and was valued by respondents to this case study. For example, in this capacity, a CSRG member of CBRN-TL which works with PLWD monitored and commented on the work in inclusive health carried out by a UN Women IP in Ermera, and commented on UN and partner reports, especially concerning PLWD involvement. CBRN also facilitated response services to survivors with disabilities, including to the safe houses.[64]

Similarly, the CSRG included a member from CODIVA which works on diversity and LGBTI issues, an involvement credited with leading to increased attention for diversity issues, and contributing to increased awareness of these. During Spotlight, CODIVA became a member of the GBV referral networks coordinated by the Ministry of Social Solidarity and Inclusion (MSSI).

[61] This is contrary to CSRG guidance which states that these should include "*organisations representing young women and groups facing intersecting forms of discrimination*" – quoted in Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'.

[62] Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'

[63] Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'; Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)

[64] Interview

The Learning Consortium was a second framework to embed inclusive LNOB approaches.
CODIVA was a member of this Consortium as well as having a member on the CSRG, like three other organisations (ACBit, MHVF and PRADET). The Learning Consortium was the output of Outcome 6, involving 23 CSOs with the aim of strengthening capacity of CSOs to respond to and prevent VAWG, including processes of peer to peer exchange and learning, networking and local implementation. This included capacity building in which CODIVA and organisations of PLWD provided capacity building to other consortium members.[65]

CBRN-TL and CODIVA were also formal implementing partners under Outcome 4 – activities they conducted included, for example, CODIVA awareness raising on LGBTIQ+ issues at Suco level in Viqueque, including through a local radio talk show and with the National Police at district level. CODIVA also helped deliver trainings on VAWG, domestic violence, and intimate partner violence to organisations working in the world of work to help participants better support women who are disproportionally affected by violence and harassment in the workplace.[66]

In combination, these frameworks have meant that the SI was the context for a strengthening relationship between CBRNTL and government ministries concerning PLWD, and for specific strengthened focus – for instance, in the Ministry of Education, Youth and Sports, there has been increased engagement to broaden the focus of the Department of Inclusion from a focus mainly on disability to also include LGBTIQ+. This change has been driven by greater recognition of a link between LGBTIQ+ issues and violence in schools, in part strengthened by greater advocacy on this issue by LGBTIQ+ groups supported by Spotlight. UNICEF also integrated a topic on parenting children with disabilities into their parenting curriculum. Other marginalised groups were included implicitly but without any particular focus or adaptations for accommodation – for example, sex workers. [67] The Learning Consortium made it possible to engage small, local and non-registered organizations in the programme, increasing its reach and capacity in remote areas.

As the sole agency implementing Outcome 6, UN Women played a pivotal role in establishing this representation, and its coordination of SI was significant in driving awareness of and contact with marginalised groups among partners (especially LGBTIQ+) – several UN, government, and CSO stakeholders mention UN Women as a key figure of this.[68]

There is interview evidence from stakeholders that the joint programme structure had some synergistic effect supporting the LNOB principle across the RUNOs by amplifying the visibility of CSOs to other RUNOs – including of those representing marginalized groups, such as CoDIVA.[69] This was partly supported by data collected through the programme, which included some intersectional disaggregation.[70] The programme is widely credited by diverse stakeholders with creating space for

[65] Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'
[66] Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'
[67] Interview, CSO Stakeholder
[68] Interviews, Government stakeholder; UN Stakeholder; CSO Stakeholder
[69] Interviews, UN Stakeholders; CSO Stakeholders
[70] Interviews, UN Stakeholder, CSO Stakeholder; Belun (2023) UNFPA and the Spotlight Initiative Timor-Leste, Quarterly/Final Q2 Report Phase 2 2023; Belun (2023) UNFPA and the Spotlight Initiative Timor-Leste, Quarterly/Final Report Phase 2 2023

and awareness of diversity, especially of LGBTIQ+[71], and the Mid-term assessment survey found that 95% respondents believed that all relevant stakeholders were included in the programme.

There were also some issues for further attention in implementing LNOB principles. As noted by the Thematic Assessment, globally some SI programmes faced challenges in ensuring the engagement of CSRG members who were based in remote and less connected areas, and in areas with poor internet connectivity. The voluntary nature of CSRG membership – where CSRG were offered expenses compensation but not paid – meant that members from more established and funded organisations were more able to fulfil their roles.[72] Data collected for this case study is consistent with this analysis but insufficient to draw specific conclusions in the case of Timor-Leste. The Thematic Assessment also notes that engaging CSRG members as individuals – which was the case in Timor-Leste – meant that it was not clear whether and how members from structurally marginalised groups were 'representing' their constituencies, and if there were any expectations in terms of consulting with and feeding back to their constituencies. Limited evidence from this case study suggests that while representation of different groups on CSRG was an important step, this did not yet consistently amount to equal voice and/or equal ability to fully participate for these groups. [73]

The 2023 Narrative Report also notes that although there is general UN guidance on LNOB, no discussion took place between RUNOS to embed this in the programme. Amplifying this guidance could have supported even stronger progress in establishing LNOB.

More concretely, data for this Case Study suggests that implementation in more remote communities was notably weaker than in the Municipal centres and nearby areas, especially at the level of provision of quality services, and in community engagement.

Sustainability

CSQ4: What were the separate and joint approaches to sustainability taken by the RUNOs?

Finding 6. – Approaches to sustainability

The programme had a strong approach to sustainability, prioritising government leadership of the project and centralising support to implementing the NAP-GBV. A joint sustainability strategy was also implemented from Phase II. There was a strong focus on strengthening capacity in government institutions, and a significant investment in capacity strengthening for CSOs through Outcome 6. There are a number of promising signs for sustainability including the continued functioning of the inter-ministerial coordination mechanism, a continued increase in budget allocation for GESI between 2022 and 2023, and a measure of confidence in current capabilities among CSOs.

There are also caveats, some large: while 'at risk' response services (such as VPU maintenance) may find funds from government sources – or through continued UN programming and unrelated donor funds; it is less clear how community prevention activities will be continued with a new focus on dense coverage in order to consolidate and expand whatever inroads have been made into shifting social norms.

[71] Interviews, Government stakeholder; UN Stakeholder; CSO Stakeholder

[72] Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'; UN processes only allow expenses to be reimbursed when interacting in individual capacity. Since participaiton was voluntary in nature this was the best that the programme could accommodate.

[73] Interview, CSO Stakeholder; limited evidence from CSRG survey

A strong line on sustainability was built into the structure and tools of the programme, which focused centrally on supporting government to implement the NAP-GBV and on strengthening capacity in government institutions. The SEI, which led the steering committee, and other government stakeholders were solid advocates of gender equality, and with a strong mandate to continue progressing the NAP's implementation. 17 government institutions were supported with capacity strengthening, through training, and/or through the development of and institutionalisation of curriculums, such as the Parenting Curriculum, which is being successful scaled up by the Ministry of Social Solidarity and Inclusion to 3 others municipalities with their own resources. The GBV training module at the Legal and Judicial Training Centre has also been incorporated into their official curriculum. The National Police is reported to be working towards including the SI's trauma-sensitive approach training into their official curriculum. Furthermore, training of teachers focused on positive disciplining and classroom management coordinated by the INFORDEPE, will be scaled up to schools outside of the 3 municipalities of Spotlight. UN Women is continuing to work towards institutionalisation of the Connect with Respect Framework. A Memorandum of Understanding (June 2020 – June 2024) under the Spotlight Initiative and T4E programme (KOICA supported GBV programme) was signed with the Ministry of Education on "Promoting Gender Equality and Respectful Relationships for School-Based Prevention of Violence Against Women and Girls", and the Minister recently announced its institutionalization. The GBV training delivered to health workers by INSPTL (National Institute of Public Health) supported by UNFPA is also ongoing.

There was also a clear focus on the government budget cycle in activities under Outcome 2, and a renewal of prior work with CSOs to lead advocacy on gender budgets and to monitor the budget cycle. These approaches resulted in some tangible signs of gender equality in general having ongoing traction in government processes, including the placement of two gender advisors in National Parliament (providing support to Commission / Committee F, a Women's Caucus on legislation), and at the Secretary of State for Equality.[74] New positions were created in national institutions at municipal level, including three gender specialists placed in the Municipality Authority Planning Unit in 2021. As detailed in Finding 2, There has also been ongoing impact on budget allocation, with the SI reporting an increase from the 2022 to 2023 allocations from US$ 233 million to $259. However, as mentioned, further understanding is needed on what these allocations are intended to cover, and how far the full amount therefore contributes directly to gender equality objectives, as well as specifically to EVAWG. [75]

The programme was also designed with a clear focus on strengthening the capacity of CSOs, with a budgeted investment of US$ 1.4 million under Outcome 6 for strengthening CSOs and the women's movement. The Learning Consortium model for this investment allowed the inclusion of marginalised groups such as PWLD and LGBTI, as well as grassroots organisations working at sub-municipal levels (See also Finding 5). The process undertaken by Consortium members included a focus on generating learning across the membership on independently developing project proposals to secure ongoing funds from development partners and/or government funds. Together with capacity strengthening undertaken under project partnerships by implementing partners, this support involved 21 CSOs. While formal data (such as pre and post test data) on the results of these capacity building activities has not been documented, respondents for this case study perceived capacity building efforts to have been very positive in a general way, with some specific examples of

[74] Spotlight Initiative (2024): SI in Timor Leste, Sustainability Strategy; Interview, Beneficiaries;.
[75] Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)

effects such as strengthened training materials; increased skills for formulating project proposals; and stronger and more diverse links with other CSOs.

The programme also had a multi-pronged focus on, and investment in, young people as the future creators of new social norms regarding GBV, and contributions to this focus from at least three RUNOs with their complementary mandates. These included the delivery of UNFPA's Comprehensive Sexuality Education curriculum among youth groups; rolling out UNICEF's parenting curriculum in communities; and UN Women's Connect with Respect curriculum in schools.

A Sustainability Strategy[76] was developed and introduced from June 2022, more than 18 months before the end of the programme, through which the implementation of recommendations for sustainability were prioritised. Government and civil society stakeholders were consulted for the Strategy's development, in processes including sustainability planning at national and municipal levels on which activities would or would not continue.

In these ways, the programme was set up to deliver a sustainable approach, and there are positive indications at several levels that specific advances made by the programme will be maintained, including for example (so far small) municipal government allocations for the maintenance of VPUs, and coordinated advocacy for their maintenance from Commission F in parliament. [77]

Nevertheless, there are caveats. An important one is concerning the stability of capacity investment in government institutions in a context in which changes in government bring changes in staff positions at all levels, impacting, for instance, the availability of trained forensic examiners deployed in the Safe Spaces in CHCs established with support from UNFPA. Recent reductions in the budget to INSPTL coupled with a training schedule so far covering less than a third of relevant health staff with GBV training, threaten the maintenance of key quality services and the VAWG referral network. Similarly, changes at community level Suco Councils associated with political change mean that local GBV awareness training need consistent renewal; or new systems are required through which previously trained council members can mentor newly appointed members.

From a legal perspective, while the SI has supported strengthening of the judicial system to end impunity for VAWG, the relatively short duration of the programme and the relatively long cycle of several years often taken for prosecution and conviction, means that CSO AlFela's work in supporting and accompanying survivors though the legal process is at risk even before many of the prosecutions achieved during the programme have completed their progress. This is particularly significant because where prosecutions lose momentum, the crucial step towards prevention of GBV that can be achieved through establishing a real deterrent has been missed. [78] A proposed justice sector reform which is in preparation under the guidance of a justice sector reform committee has identified legal redressal for survivors as a critical priority. This process if enacted promptly may give scope for maintaining momentum to establish this deterrent.

Some achievements from the programme will be maintained or further progressed through ongoing funding to the RUNOs including to advance signature interventions – for example, in advancing legislation, GRB and maintaining GBV services. The strategy among the RUNOs of working to strengths meant that much of the focus of each RUNO was on pre-existing programmes in support of

[76] Spotlight Initiative (2024): SI in Timor Leste, Sustainability Strategy
[77] Interview, Beneficiaries
[78] Interviews, CSO stakeholders. For instance, in 2022 there were 311 cases at the investigation levels at the Police and Public Prosecutor's Office. In the same year, 2 cases were brought to court and 2 convictions secured. (Spotlight Initiative Annual Narrative Programme Report 2022).

line ministries' ongoing work - for example, UNICEF had been working with MSSI on its Parenting Curriculum since 2016. Some work consisted of integrating GBV components into programmes which are already integrated into government budgets, such as the Youth Parliament programme, and life skills curricula. [79] In some cases, particular interventions will be taken up by UN Agencies based on their mandates: for example, UN Women through its core resources is supporting SEI to take forward the SI work which includes technical advice on the NAP GBV, GRB etc.

At community level, the institutionalisation of the parenting and the Connect With Respect curricula stands to ensure that some prevention activities continue. But it is less clear, without a strategy to achieving density and overlap of messaging, how prevention activities at community level will progress and scale with sufficient density to secure measurable results. Much of this work is currently funded through the KOICA - Together for Equality programme, through which UN Women, UNFPA, IOM and UNDP have continued work through 2024 on quality services, policy, and social norms. This programme is due to close in November 2024. Similarly, the Zonta programme until the end of 2024 funds UNFPA to support essential quality services and the referral network. The SI's sustainability strategy notes that the edutainment series on gender stereotypes is available to communities on public platforms such as YouTube, and proposed the establishment of a high level multi-sectoral alliance on EVAWG chaired by the CSO Unit to promote coordination on ongoing activities including prevention activities.[80] However, information on the progress of this alliance has not been available to this Case Study.

Conclusions and Lessons Learned

1. On the Joint Programme model (Finding 1, Finding 4)

While there were examples of the added value of joint programming, these were mainly related to the size of the programme and that implementation was by multiple stakeholders at the same time, rather than to any specific strategizing to achieve synergies. A more intentional approach to creating the synergies that this opportunity offered could have strengthened results, particularly in the area of prevention of VAWG / social norm change.

The opportunity to align or integrate different curricula for working with community or school groups was not taken; strategic thinking on how to align or merge these curricula, or create an overall curriculum with linked components for different community groups, may have contributed to synergies in the prevention work and could be considered for future joint programmes with components addressing social norms.

As per the operations rules and requirements for the global Spotlight programme, administrative alignment or processes for applications, recruitment, and reporting by implementing partners working on multiple activities was mostly not available. Aligning these process could create efficiencies in the context of joint programmes, but – perhaps more importantly – could create a context for identifying synergies and create an enabling environment for them to be pursued and explored (rather than, in effect, avoided). For issues with multi sector and multi stakeholder relevance, known to be challenging to address, such as VAWG, pursuing synergies is not so much an added extra, but an essential strategy.

[79] Interviews, UN Stakeholders.
[80] Spotlight Initiative (2024): SI in Timor Leste, Sustainability Strategy.

More thorough consideration at the design stage of what new ground could be advanced by working together in an integrated way might begin the process of defining and harnessing the potential added value of joint programmes. For example, this might require advocacy with donors on the benefits of maximising effectiveness in concentrated locations over potentially diluting effectiveness while maximising reach. It might also require explicitly locating project theories of change within longer-visioning theories which place short term achievements within a longer trajectory of combined effort. While the intent to combine efforts in an integrated way needs to be backed by integrated administrative systems and open discussion of relative merits and power, without intent, there is no horse to pull the cart.

2. On sustaining achievements in VAWG response and strengthening prevention (Finding 2, Finding 3, Finding 6)

Important advances have been made in the EVAWG agenda, and civil society has been fully involved and engaged in this process, but the process is far from complete. It will be challenging to prioritise future steps before a data system that is functioning to systematise data from different sources has made more progress.

Nevertheless, it is clear that commendable, but nascent, advances in strengthening a multi-actor linked GBV response system must be protected. Amongst other areas for attention, this will require a) institutionalisation of GBV response training for Suco Councils so that new Council members are well informed; b) problem-solving issues of qualified staff availability, especially forensic examiners, for the full functioning of safe spaces; c) maintaining nascent confidential GBV data collection systems established in safe spaces and VPUs; d) institutionalising essential services operating budgets for the maintenance of VPUs; e) sustaining legal assistance for survivors on time frames align with the likely legal process - so that the asset of a working response system can fully evolve into the vital dimension of publicly known convictions, act as a deterrent, and therefore make a key contribution to VAWG prevention.

Roll out of the many activities for GBV prevention encountered several challenges and was not ideally coordinated either through curricula or through selection of target communities for maximum effectiveness. While for the dimension of VAWG prevention in particular it is difficult to be confident that results either were or were not positive since the success of these activities has not been measured, it is nevertheless pertinent that results may have been supported by an appreciation at the design stage that behaviour change messaging reinforced from a variety of sources is regarded as an important strategy for shifting social norms. Understanding of the effectiveness of a layered approach to addressing social norms was not written into the design, and therefore coordination efforts were focused on the widely-known issues of avoiding duplication. Prevention of GBV and social norms change are known to be challenging in any context globally. The SI and other joint programmes offer opportunities for advancing the truly coordinated and multi-faceted work required to meet this challenge. The UN system, with its well respected human and diplomatic assets, could make significant contribution to advancing work on GBV prevention. But this will require a new step in joint programming - from contributing expertise as individual specialised agencies to seeking out synergies across specialist areas and aligning / synthesising approaches to the communities in which all the agencies have somewhat differing interests.

3. A promising model for LNOB in a sustained EVAWG process (Finding 5, Finding 6)

Advancing LNOB was well embedded into programme design, which sought out cross-fertilization among CSOs; set out for representation from marginalized groups in key coordination bodies; and

facilitated access by these groups to government in advisory roles. It is widely agreed that more general visibility of some groups can be credited at least partly to the programme. Recognition is a key milestone for marginalized groups, and although there is still ground to cover in terms of accessibility of GBV services to marginalized groups, this was a key step. The 3-pronged model offered here of 1) strong investment in a peer led collective CSO learning process 2) high levels of implementing and advocacy activity by CSOs and 3) formal representation of CSOs as an advisory and monitoring body to the programme, along with access to government- led coordination bodies shows promise as a balanced and dynamic approach to establishing a strong role for civil society in the long term prevention of and response to VAWG.

Although there are risks to some activities and components to the programme, the strong approach to sustainability means that important legacies are likely to endure and find footing in future opportunities. The biggest risk is perhaps that as the sister programmes T4E and Zonta come to a close later this year, prevention activities in particular will be difficult to sustain, particularly in the highly coordinated form in which they are most likely to be effective. The investment in CSOs is a legacy that can be deployed as an asset in this, and many have continuing relationships with UN agencies based on their mandate - but it will be important to maintain the advisory and monitoring roles that were established through Spotlight.

Recommendations

For UN joint programming approaches

(**Based on Conclusion 1**)

1. Theories of change and design of joint programmes – especially large joint programmes – could /should specifically consider how synergies might function, and how they can best be facilitated. In this, it will be necessary to think through what amounts to a duplication of efforts and what amounts to a positive synergy which can maximise effectiveness.

2. For the management of (large) joint programmes, consider further methods and tools for administrative alignment, particularly in the approach to implementing partners carrying out multiple tasks / activities. These might include aligned partner recruitment systems, coordinated implementation planning/mapping, and joint reporting templates, or – further – jointly managed composite projects which would specifically invite synergies.

3. Consider pathways towards the synthesising of curricula which substantially share objectives, focus areas and sometimes target groups. A modular format with options for specific target groups within an overarching framework relevant to all, which ensures common messaging and opens up a framework for synergies across modules, could be one model to consider. This is particularly relevant to joint programmes, but also has pertinence for UN harmonizing in general and beyond the framework of Joint Programmes.

For advancing EVAWG in Timor Leste

(**Based on Conclusion 2**)

4. For GBV prevention work in particular, there is new ground to be broken on how to maximise the effectiveness of social norms change work. How change messages have the potential to reinforce

each other – and are therefore amplified - through social networks and groups is an important dimension to build into the design of approaches and the selection of target communities. In the planning of joint work, stronger appreciation of this principle should be carefully taken into account. This will involve considering and balancing the inclination to maximise reach in terms of numbers, with the potential added effectiveness of applying denser, more coordinated activities with a smaller overall reach.

5. Prioritise problem-solving risks to the sustainability of the physical and human assets that have been built in the GBV response system. In this, continued close coordination of UN agencies in their different specialisations is essential, as all the pieces of the response puzzle are required for the whole cycle to function – therefore use existing UN coordination mechanisms such as the GTG and the UN PSEA coordination group to keep EVAWG fully on the agenda. Looking beyond UN Coordination will be particularly important for GBV response work, since a number of elements (e.g. Safe Houses) are currently supported by donors in coordination with government ministries: the gender equality and women's empowerment coordination group (GEWECG) will be a key mechanisms in this.

6. Consider urgently how to carry forward prevention efforts so that the progress that may have been made through the effects of the SI and sister programmes do not reverse. This means seeking resourcing for further developing this dimension in a concerted way, and building on the community level knowledge gains that have been made through the programme, to turn these more clearly into changes in attitudes and behaviours.

7. Build on progress in establishing competencies for GBV data collection by prioritising the synthesis of dispersed data sources, and take action to make synthesised data publicly available to support decision making by government and civil society. Comprehensive data giving indication of trends in incidence/prevalence, service quality and case management (including confidentiality) could drive future innovation in fully addressing the complex issues in EVAWG.

8. For deeper analysis of drivers and response to VAWG, take full account of the complex economic dimensions to it. This might involve ensuring economic drivers or interactions associated with GBV at community level are fully understood; and might include linking EVAWG efforts to economic empowerment initiatives.

(**Based on Conclusion 3**)

9. Build on the asset of strengthened CSOs going forward. Many CSOs already have good access to communities, and linkages to government decision making have been strengthened. But a coordination dimension to the work of CSO's appears to be weak, or overridden by drivers to fulfil (weakly coordinated) implementation obligations associated with funding. Consider strengthening commitment to progressing the high level multi-sectoral alliance on EVAWG chaired by the CSO Unit proposed in the SI's Sustainability Strategy, and/or establishing an EVAWG focus group within the civil society advisory group to the UNSDCF or the GEWECG. Linking CSOs focused on EVAWG to government, UN partners and donors as strong allies, advocates and implementers in EVAWG will be essential dimensions in this exercise.

10. Build on the achievements made during the SI to strengthen strategies for the inclusion of the perspectives and voices of LGBTIQ+ and groups representing and / or led by people living with disabilities in continued activity to progress EVAWG. Important steps have been taken to link these

groups to other CSOs and to government. Future steps should include ensuring that inclusion goes beyond simple representation to amount to full participation in advocacy and advisory roles.

Annex 1: Documents reviewed

Belun (2023) UNFPA and the Spotlight Initiative Timor-Leste, Quarterly/Final Report Phase 2 2023

Belun (2023) UNFPA and the Spotlight Initiative Timor-Leste, Quarterly/Final Q2 Report Phase 2 2023

Fokupers (2022) Quarterly Narrative Report Q2, September.

Hera (2022) SI in Timor Leste, Mid-term Assessment Report (ROM review)

KOICA, UNFPA, IOM, UN Women, UNDP (2021) 'Together for Equality – Preventing and Responding to Gender Based Violence (GBV) in Timor Leste', Project Brief

Social Development Direct and Spotlight Initiative, n.d. Information sheet: Assessing the Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'leaving no one behind and movement building

Social Development Direct and Spotlight Initiative, (2024) Thematic Assessment: Assessing Spotlight Initiative's contribution to the engagement of civil society, the implementation of 'Leave no one behind', and movement building'

Spotlight Initiative (2020) Inception Narrative Progress Report – Spotlight Country Programme in Timor-Leste

Spotlight Initiative (2020) Timor Leste, 2020 Country Programme Results

Spotlight Initiative (2021) Annual Narrative Programme Report 2020, Programme Title: Spotlight Initiative In Timor-Leste

Spotlight Initiative (2021) Global Annual Narrative Progress Report January-December 2021

Spotlight Initiative (2021) Timor Leste, 2021 Country Programme Results

Spotlight Initiative (2022) 'Mapping of Quantitative and Qualitative Data on Violence Against Women and Girls' Report Summary.

Spotlight Initiative (2022) Annual Narrative Programme Report 2021, Programme Title: Spotlight Initiative In Timor-Leste

Spotlight Initiative Annual Narrative Programme Report 2022, Programme Title: Spotlight Initiative In Timor-Leste

Spotlight Initiative (2022) Timor Leste, 2022 Country Programme Results

Spotlight initiative (2022) Timor Leste, Halo Ligasaun ho Respeitu: Prevensaun ba violénsia bazeia ba jéneru iha eskola

Spotlight initiative (2022) Timor Leste, Ligasaun ho Respeitu Prevensaun ba violénsia bazeia ba jéneru iha eskola sira

Spotlight Initiative (2023) Final Evaluation Planning Report, 28th July

Spotlight Initiative (2024) 'Final Narrative Programme Report, January 2000-December 2023, Entire Programme Duration' (Draft)

Spotlight Initiative (2024) Ending Violence Against Women and Girls, Spotlight Initiative Compendium of Innovative and Good Practices and Lessons Learned, April

Spotlight Initiative (2024): SI in Timor Leste, Sustainability Strategy (Draft)

Spotlight Initiative Timor-Leste Coordination Unit (Country Program Steering Committee) Terms of Reference

Spotlight Initiative, Brief: Final Evaluation of the Spotlight Initiative

Spotlight Initiative, October 2022 (Original 2019) Country Programme Document, Timor Leste

Spotlight Initiative: Spotlight Initiative Mid-Term Assessment, Terms of Reference (TOR)

Spotlight Initiative: Terms of Reference, Timor-Leste Civil Society National Reference Group (CS-NRG)

UNFPA (2022) 2021 Annual Report – Timor Leste

UNFPA (2022) Alola and Zunto Q3 Progress report

UNFPA (2023) 'Summary of Q3 Partner Review Meeting' Timor-Leste 26th September

UNFPA (2023) 2022 Annual Report – Timor Leste

UNFPA (2023) CPD Results Dashboard, - 4th Country Programme TLS 2021-2025, March

UNFPA (2024) 2023 Annual Report – Timor Leste

UNFPA (2024)' Presentation for Q1 2024 Partner Review Meeting' April.

UNFPA Asia and Pacific Regional Office (APRO) (2019) Strengthening National Capacities of Health Sector in Papua New Guinea and Timor-Leste to Deliver Survivor-Centred Response to Gender Based Violence Survivors (2020- 2022), Proposal for submission to Zonta International Foundation

UNFPA, List of UNFPA TLS Intervention 2021-2024 (GPS data).

Annex 2: Stakeholders consulted.

	Organisation	Designation	Method – INT / FGD	Gender	
1.	Alfela	Executive Director Programme Officer	INT	FF	
2.	Alola Foundation	Women's Research Center Coordinator, Advocacy Program District Coordinator	INT	FF	
3.	Belun	Director Gender Officer and Programme Manager, women engagement Finance manager	INTG	F	MM
4.	Belun	Field Officer, Viqueque	INT	F	
5.	FOKUPERS	Executive Director Advocacy coordinator DMEL Field Officer, Advocacy	INTG	FFF	M
6.	Gleno, Ermera CHC	Midwife Medical Doctors x 2	INTG	FF	M
7.	Gleno, Ermera VPU	Chief of VPU Legal Assistant, AFELA VPU officer MSSI Focal Point	INTG	FF	MM
8.	ILO	Spotlight Focal Point	INT	F	
9.	INSPTL (National Institute of Public Health)	Training Director Trainer, Focal point for GBV-Health training programme Trainer Trainer Trainer	INTG	FFFFF	
10.	Ministry of Health	Gender Officer; GBV Trainer, Medical Forensic examiner; and Mentor Former Head of Maternal and Child health	INTG	FFF	
11.	Ossu CHC	Medical Doctors	INT	f	m
12.	Plan International,	Executive Director, Chair of CSRG	INT	F	
13.	Pradet	Director	INT	M	
14.	Secretary of State for Equality and Inclusion	Director General Representative of National Director for Gender and Inclusion Policies of SEI, Beijing Platform	INT	F	M
15.	Suco Uma Qui'ik, Viqueque Municipality	Community Members	FGD	F	9xM
16.	Uato Lari CHC	Head of CHC, Former Head of CHC Medical Doctor Midwife	INTG	FF	MM
17.	Uma Mahon (Safe House)	Coordinator	INT	F	

18.	UN	Resident Coordinator	INT	F	
19.	UN Women	Former Spotight coordinator	INT	F	
20.	UNDP	Spotlight Focal Point	INT	M	
21.	UNFPA	Spotlight Focal Point	INT	M	
22.	UNICEF	Spotlight Focal Point	INT	FF	
23.	Viqueque	Community Leaders	FGD	9xF	14xM
24.	Viqueque CHC	CHC/hospital health providers	INTG	F	MM
25.	Viqueque CHC	CHC/hospital health providers	FGD	7xF	5xM

Annex 3: Case Study Matrix

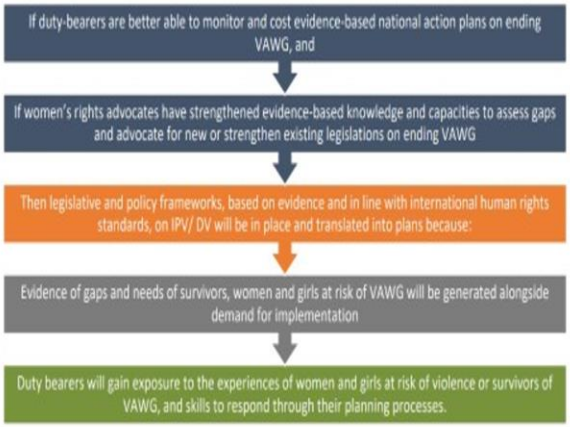
Criteria	Key question	Sub questions	*Specific actual question suggestions*	*Literature review*	*Other CPE data*	UN Women	UNFPA	ILO/UNDP /UNICEF	Coordinatin unit	Govt.	CSOs - Ips	CSOs - advisory committe	Other
Internal and external coherence	1. What was the added value of the joint programming approach for progressing EVAWG in Timor Leste, and how did the different features of theims model contribute to it?	1A. Were the roles of the different agencies (RUNOs) appropriately allocated, clearly defined, balanced and capitalized on agency expertise and value added?	*Were there some roles which could have been more appropriately allocated?* *In retrospect, is there anything you would change about the balance of roles?* *What was the added value of each RUNO?* *Did their roles in the programme play to their strengths?*	✓		✓	✓	✓	✓	✓	✓		
		1B. How far did the RUNO coordination mechanisms ensure harmonised support and a synchronised approach to the government?	*Did you work with one or more RUNOs under Spotlight? Where you worked with more than one, how far was there linkage or coordination between the streams?* *Did the RUNOs operate in a coordinated and harmonised way in your work with them?*	✓					✓	✓	✓	✓	
		1C. What were the challenges of this joint model, and how were these handled?	*How well did the joint programme model work, in your opinion? What were the challenges? How were these handled?*	✓	✓	✓	✓	✓	✓	✓		✓	
		What dimensions of coherence were challenging and/or require further development?	*What would you do in a future similar programme to enhance the synergies between different elements of the programme?*		✓	✓	✓	✓	✓	✓			
		1D. What were the roles of the other collaborating agencies (besides the RUNOs) and partners? What was the extent and results of their collaboration?	*What roles were played by WHO, IOM etc? What was the pupose of their collaboration?*	✓		✓	✓		✓	✓			
Effectiveness	2. How far has the programme progressed the EVAWG agenda in Timor Leste? Which results were enhanced by the joint programme approach?	2A. How have synergies between agencies been developed and used to promote results?	*In what ways were synergies between agencies specifically identified or used?*		✓	✓	✓	✓	✓	✓			✓
		2B. Which results may not have been achieved if the SI had not used a joint programme model?	*Were there any achievements which could not have been achieved except by collaboration of agencies (and therefore their partners)?*		✓	✓	✓		✓	✓	✓		
		2C. Did any models prove to be effective with potential for scale up?	*What were the most effective parts of the programme?* *Which parts of the programme do you see as particularly promising for scaling up?*	✓		✓	✓		✓	✓	✓		
		2D. Were the coordination/ management structure and processes conducive to and facilitated the achievement of results?	*How far did the existence of the coordination unit and other coordination mechanisms specifically support acheivements?* *Which results may not have been achieved if there had been no coordination unit?*			✓	✓	✓	✓	✓	✓		
Human rights and gender equality	3. What strategies were used to implement the LNOB principle and how did this principle translate into results?	3A. How did joint programming enhance or influence the approach to LNOB?	*Was there any sharing or learning about different marginalised groups across the RUNOs?* *Were RUNOs approaches to inclusion similar or different?*		✓	✓	✓	✓	✓		✓	✓	
		3B. Who was reached and what was the most effective way of ensuring meaningful engagement?	*Which agencies facilitated or emphasised access to what types of marginalized groups?* *How did agencies establish engagement with marginalized groups? Which methods worked best?*			✓	✓	✓	✓	✓	✓		
		3C. What were the challenges and missed opportunities?	*What were the challenges of including [different types of] groups for other agencies?*			✓	✓	✓			✓	✓	✓
Sustainability	4. What were the separate and joint approaches to sustainablity taken by the RUNOs?	4B. Which elements of the joint programme approach will c	*What are the next steps for the legislative change process, eg for the Ciminal Procedural Code; Law on Justice Organisation; Child Protetcion Bill; Domestic Workers Bill ? How will these be achieved? What challenges will the process face?*			✓		✓		✓			
			?			✓	✓	✓		✓	✓	✓	
			How will the inclusion of content about reduction of violence in schools be continued in teacher training?					✓		✓			
			How will advocacy and social behaviour change inititatives (eg about early pregnancy) be continued?					✓			✓	✓	
			How will Comprehensive sexuality education be further progressed?				✓				✓		
			How will the safe spaces be continued?				✓			✓	✓		
			What are the next steps for progressing [the draft law on] prvention of violence and harassment at work?					✓		✓	✓		
			Are any programmes currently planned which have a similar level of RUNO collaboration? *Are any programmes currently planned that envisage a similar model to structure collaboration (ie a coordination group and shared space)*			✓	✓	✓	✓				
		4C. What are the challenges to the sustainability of program	*What is the progress with establishing the Multi-Sectoral Alliance for EVAWG at the Vice PMO*			✓	✓		✓	✓			
			What are the levels of financial ownership of eg recurring costs such as training of magistrates			✓		✓		✓	✓		
			How is it anticipated that knowledge products will continue to be used?	✓	✓	✓	✓	✓		✓	✓		

Annex 4: Spotlight Initiative TL Theories of Change for each Outcome

Outcome 1 - Legislative and Policy Framework

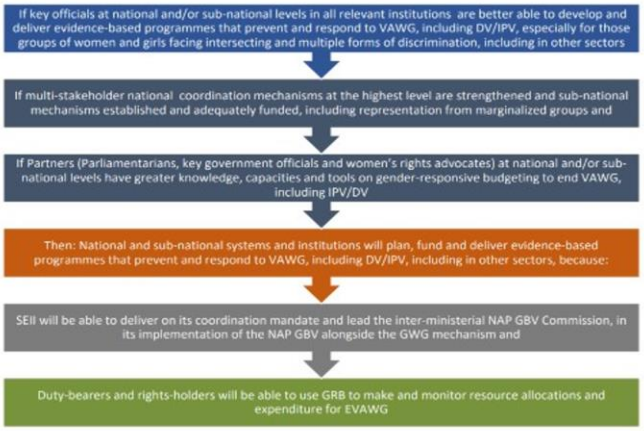
Outcome: Legislative and policy frameworks, based on evidence, and in line with international human rights standards, on all forms of VAWG and harmful practices are in place and translated into plans.

Theory of Change:



Outcome 2 - Strengthening Institutions

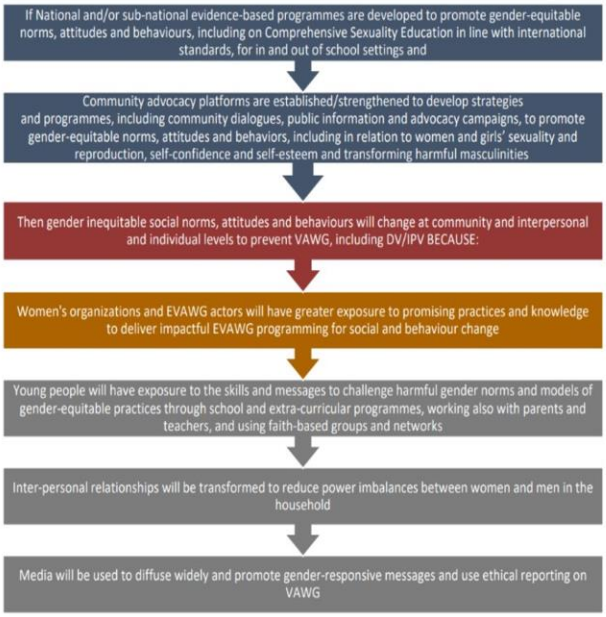
Outcome: National and sub-national systems and institutions plan, fund and deliver evidence-based programmes that prevent and respond to VAWG, including DV/IPV, including in other sectors.



Outcome 3 - Prevention and Social Norm Change

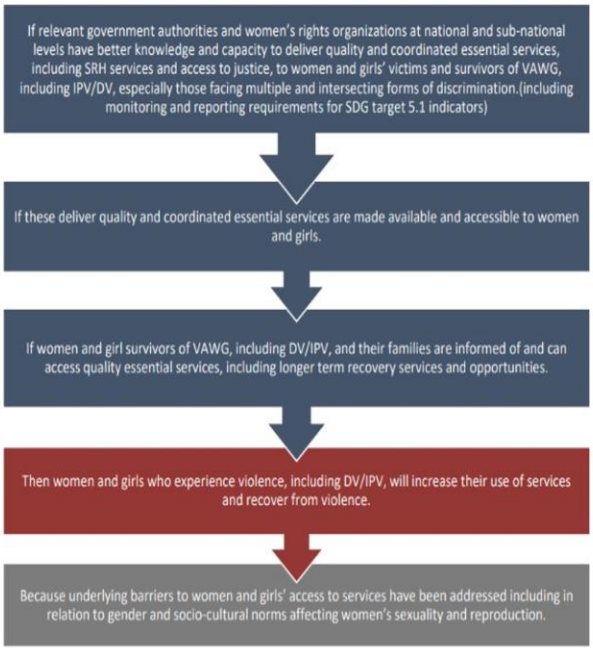
Outcome: Gender inequitable social norms, attitudes and behaviours change at community and individual levels to prevent VAWG, including DV/IPV.

Theory of Change



Outcome 4 - Quality Services

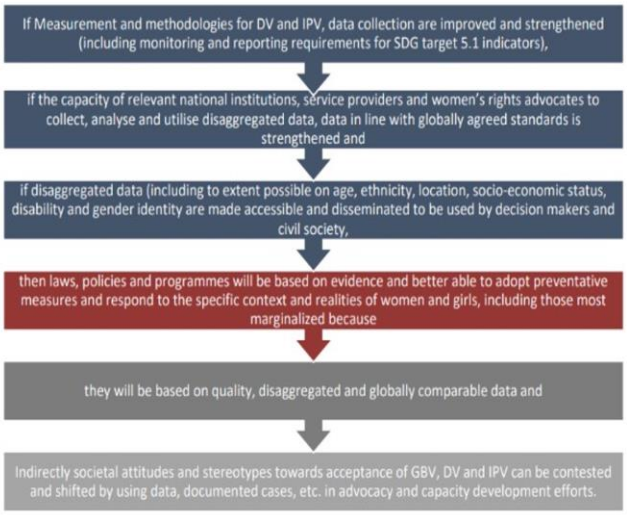
Outcome: Women and girls who experience VAWG, including DV/IPV, use available, accessible, acceptable, and quality essential services including for long term recovery from violence



Outcome 5 - Data availability and capacities

Outcome: Quality, disaggregated and globally comparable data on different forms of VAWG, including DV/IPV, collected, analysedand used in line with international standards to inform laws, policies and programmes

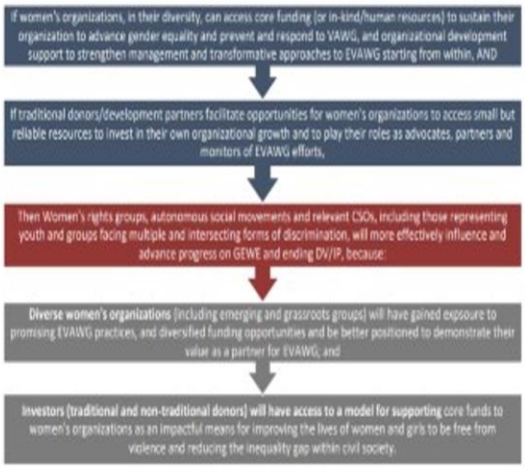
heory of Change



Outcome 6 - Strengthening the Women's Movement

Outcome: Women's rights groups, autonomous social movements anc relevant CSOs, including those representing youth and groups facing multiple and intersecting forms of discrimination/marginalisation, more effectively influence and advance progress on GEWE and ending VAWG, including DV/IP.

Theory of Change



Annex 5: Case Study Terms of Reference

Terms of Reference
Joint Case study on Spotlight for Timor-Leste Country Portfolio Evaluations

1. Introduction

With the aim of ensuring coherence and coordination between UN Agencies, Heads of Evaluation Offices of the United Nations Evaluation Group are encouraging coordination between agencies in the planning and conduct of Country Programme Evaluations. The United Nations Evaluation Development for Asia and the Pacific (UNEDAP) has identified the following agencies that are conducting CPEs in Timor Leste during 2024: UN Women, UNFPA, UNICEF, the UNSDCF evaluation and potentially UNDP. Therefore, the agencies have established a coordination group to discuss concrete ways to coordinate the CPEs with the aim of both satisfying organizational mandate and needs, while minimizing burden on stakeholders and seeking opportunities for joint analyses. Ultimately, through more coordinated processes, the agencies will lessen the burden on the country stakeholders and produce a more robust set of evaluative evidence.

The coordination group has identified a joint case study as an opportunity for collaboration within the CPE processes through an in-depth look at the Spotlight Initiative, which included all the participating agencies. UNFPA and UN Women have agreed to move forward with the joint case study by committing the resources and time of respective teams to support the conduct of the joint case study. The joint approach will assess how participating UN agencies, with a focus on UNFPA and UN Women, are delivering on EVAWG in Timor-Leste, ensuring coherence. It will also ensure that evaluation resources are utilised effectively through cross-collaboration.

2. Spotlight in Timor-Leste

The Spotlight initiative, funded by the European Union (EU), worked in partnership between the government of Timor-Leste, the United Nations (UN), civil society to end all forms of Violence against Women and Girls (VAWG). Along with these partnerships, the initiative aimed to engage communities and survivors. This initiative was supporting the Government in implementing national priorities and promoting multisectoral collaboration where all ministries are encouraged to bring their collective capacities to prevent and respond to violence. With the aim of ensuring alignment with the plans of the Government of Timor-Leste, a partnership agreement was established between the Secretariat of State for Equality (SEI) and the Spotlight Initiative Timor-Leste Coordination Unit.

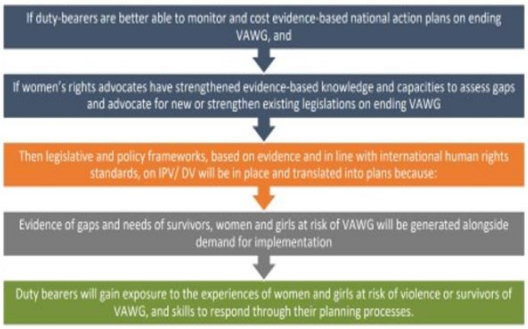
The SI in Timor-Leste used a comprehensive multi-sectoral, survivor-centred and do no harm approach to the implementation of interventions in the six Pillars/Outcome Areas, taking an explicit approach to integrating the experiences of women and girls who face multiple forms of discrimination, in line with the SDG principle of Leaving No One Behind (LNOB). These pillars/outcomes have been presented in figure 1, along with their respective theories of change.

Figure 2: Theories of Change

Outcome 1 - Legislative and Policy Framework

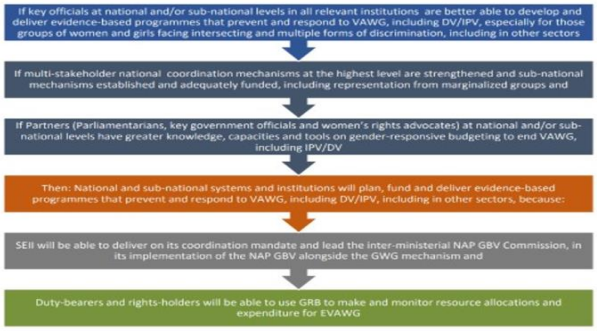
Outcome: Legislative and policy frameworks, based on evidence, and in line with international humanrights standards, on all forms of VAWG and harmful practices are in place and translated into plans.

Theory of Change:



Outcome 2 - Strengthening Institutions

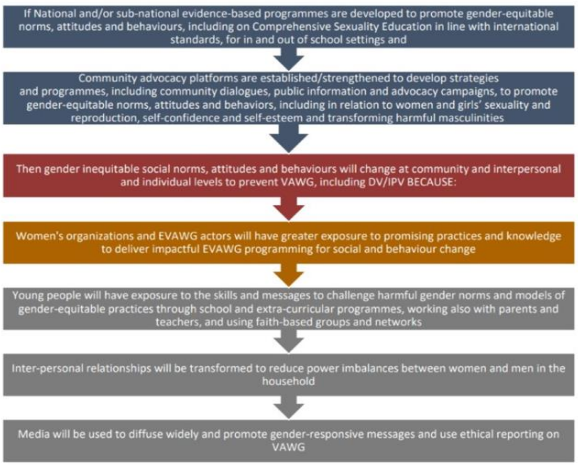
Outcome: National and sub-national systems and institutions plan, fund and deliver evidence-based programmes that prevent and respond to VAWG, including DV/IPV, including in other sectors.



Outcome 3 - Prevention and Social Norm Change

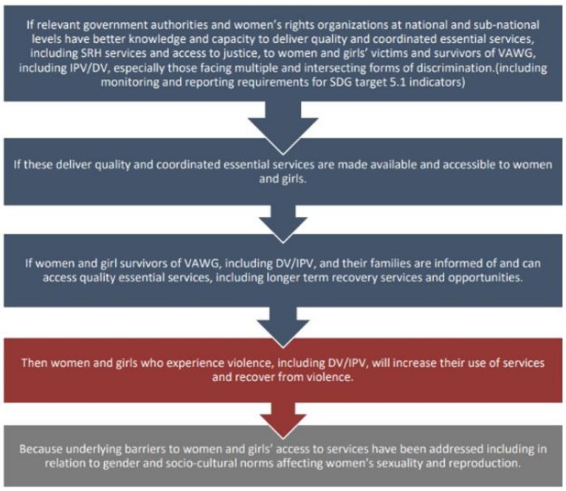
Outcome: Gender inequitable social norms, attitudes and behaviourschange at community and individuallevels to prevent VAWG, including DV/IPV.

Theory of Change



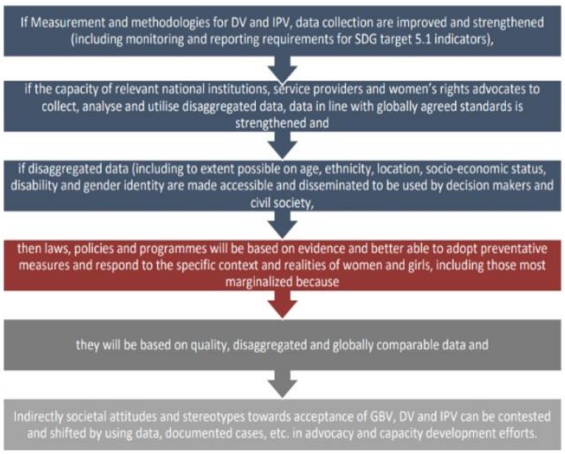
Outcome 4 - Quality Services

Outcome: Women and girls who experience VAWG, including DV/IPV, use available, accessible,acceptable, and quality essential services including for long term recovery from violence



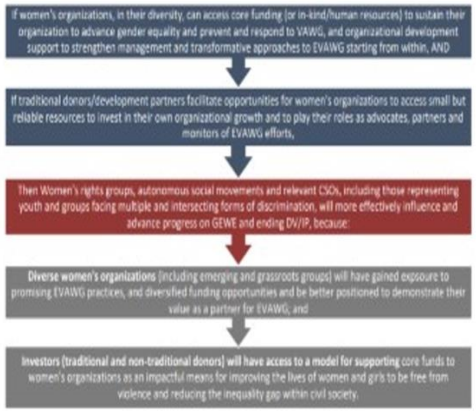
Outcome 5 - Data availability and capacities
Outcome: Quality, disaggregated and globally comparable data on different forms of VAWG, including DV/IPV, collected, analysedand used in line with international standards to inform laws, policies and programmes

heory of Change



Outcome 6 - Strengthening the Women's Movement
Outcome: Women's rights groups, autonomous social movements anc relevant CSOs, including those representing youth and groups facing multiple and intersecting forms of discrimination/marginalisation more effectively influence and advance progress on GEWE and ending VAWG, including DV/IP.

Theory of Change



The SI Secretariat conducted a thematic assessment as part of the mid-term review focused on *Assessing the extent to which Spotlight Initiative has meaningfully engaged civil society, including particularly local and grassroots group; the Initiative's implementation of 'leaving no one behind' (LNOB) and its support to movement building.* The thematic assessment complements recent and ongoing assessments and evaluations, including the mid-term assessments of Spotlight programmes and the final evaluation of the Initiative.

3. Purpose and scope of the case study

The purpose of this case study is to capture key lessons learned and insights on the implementation of the SI in Timor-Leste, as relevant to the joint agency approach. The case study will aim to:

- Provide targeted insights for the lead agencies and stakeholders to ensure sustainability of efforts despite the funding ending.
- Feed into learnings on how the UN system can work together to ensure coherence and amplify its efforts in partnership with stakeholders.

The assessment also aims to demonstrate SI's accountability to stakeholders (with a focus on rights holders and communities, as well as CSOs); and contribute to evidence-based decision-making for programming and policy development by contributing to the existing knowledge base on ending violence against women and girls (EVAWG).

4. Key stakeholders

As part of this case study, the team will engage with representatives from the following groups of stakeholders:

- Spotlight initiative personnel
- Spotlight initiative recipient UN Organisations (RUNOs)
- Civil society reference group members
- Government and CSOs (WROs and feminist groups)
- Other stakeholders working to eliminate VAWG at all levels
- Rights holders and programme participants

5. Objectives and scope of case study

The case study will focus on the Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC) evaluation criteria which have specific pertinence to the objectives on the case study and the current knowledge needs of participating agencies. Therefore, the criteria of coherence, effectiveness and sustainability will be the main areas of inquiry. The criteria of relevance, efficiency and human rights and gender equality will be included in so far as they relate to the central focus of coherence, effectiveness and sustainability.
The case study has the following objectives:

1. Assess the internal and external coherence of the programme vis-a-vis the UN system: identify the value-added, if any, of its operation as a multi-agency joint programme, and identify contributions to Timor-Leste UNSDCF 2021 – 2025 outcomes.
2. Assess programme effectiveness, and especially how its operation as a multi-agency joint programme has contributed to results.
3. Assess how the joint programme approach enhanced or hampered the programme's approach to LNOB.
4. Identify the programme's sustainability approaches and assess how far these are contributing to the sustainability of existing results and future progress on EVAWG at the close of the programme.
5. Provide lessons learned and actionable recommendations to support UN positioning on its work on EVAWG moving forward.

Scope:

The case study will review the programme over its full course from 2020 to 2023, and cover programme activity and results related to the three Municipalities of focus: Viqueque, Bobonaro, Ermera, as well as in Dili as the home of governance and centre of SI implementation.

It will consider the six Outcome areas of 1)Legal and Policy Framework 2) Institutions 3) Prevention and Norm Change; 4) Quality Services; 5) Data; and 6) Women's Movement, and will coordinate with both previous and currently ongoing evaluation / review exercises [81] in order to prioritise these in relation to knowledge gaps.

6. Methodology

The case study process and analysis will apply the key principles of a gender responsive and human rights-based approach. These will therefore be inclusive, participatory, ensure fair power relations, and transparent; and analyse the underlying structural barriers and sociocultural norms that impede the realization of women's rights, including marginalized groups: such as persons with disabilities, and other groups that suffer from intersecting forms of discrimination (based on LGBTIQ+ status, ethnicity, and/or race).

The case study will employ a non-experimental, theory-based approach using mixed qualitative and quantitative methods and will serve as a primary source of information informing the Country Programme Evaluations of the UN agencies participating in the joint case study.

The case study will draw on secondary and primary data sources. Methods will include document review, including of programme reports, Spotlight reviews and previous evaluations, financial records and management agreements. Primary data will include both remote and face to face key informant interviews with programme staff, government officials, CSO partner staff, and donor representatives. It will also include face to face interviews, field visit observations and focus group discussions with rights holders.

Programme staff will be consulted to provide guidance on the purposive selection of municipality/ies for primary data collection, based on the activity in each municipality and the degree of involvement of each of the RUNOs.

[81] The MTA report for Timor Leste in 2022; the ongoing final Spotlight evaluation; and ongoing Timor Leste Country Programme evaluations by UN Women, UNFPA and UNICEF.

NVivo qualitative analysis software will be used to analyse interviews and focus group discussions. Multiple lines of evidence will inform the contribution analysis. Sources and methods of information will be triangulated to ensure robust findings that can be used with confidence. Data collection methods and processes will be gender-responsive and data should be systematically disaggregated by sex and, to the extent possible, disaggregated by age, geographical region, ethnicity, disability, migratory status and other contextually relevant markers of equity. Specific guidelines should be observed, namely the UNEG guidance on Integrating Human Rights and Gender Equality in Evaluations (2014) and UN Disability Inclusion Strategy Evaluation Accountability, 2019.

8. Case Study Key Questions

Case study questions will be grouped around the criteria and focus on the main objectives.

Criteria	Key Question	Sub-question
Internal and external coherence	1. What was the added value of the joint programming approach for progressing EVAWG in Timor Leste, and how did the different features of the model contribute to it?	1A. Were the roles of the different agencies (RUNOs) appropriately allocated, clearly defined, balanced and capitalized on agency expertise and value added? 1B. What were the challenges of this joint model, and how were these handled? What dimensions of coherence were challenging and/or require further development? 1C. What were the roles of the other collaborating agencies (besides the RUNOs) and partners? What was the extent and results of their collaboration?
Effectiveness	2. How far has the programme progressed the EVAWG agenda in Timor Leste? Which results were enhanced by the joint programme approach?	2A. How have synergies between agencies been developed and used to promote results? 2B. Which results may not have been achieved if the SI had not used a joint programme model? 2C. Did any models prove to be effective with potential for scale up? 2D. Were the coordination/management structure and processes conducive to and facilitated the achievement of results?
Human rights and gender equality	3. What strategies were used to implement the LNOB principle and how did this principle translate into results?	3A. How did joint programming enhance or influence the integration of the LNOB principle in the SI? 3B. Who was reached and what was the most effective way of ensuring meaningful engagement? 3C. What were the challenges and missed opportunities?
Sustainability	4. What were the separate and joint approaches to sustainability taken by the RUNOs?	4A. How far will the key drivers of results developed by the programme continue to influence progress on EVAWG in TL? 4B. Which elements of the joint programme approach will continue to function after the project end to support future results and prevent and respond to VAWG? 4C. What are the challenges to the sustainability of programme results and how can they be addressed?

9. Timeline and Key Deliverables

The case study will take place between March and August 2024. A detailed timeline is in the table below. Meetings between the case study team leader and the participating agency leads will take place at key touchpoints throughout the process. An estimated 25 days is required for the case study team leader (as outlined below).

Final deliverables for the case study include:

1. The Method Note based on the TOR – 2 days
2. Summary of data collection – including data collection – 10 days
3. A de-brief presentation – including data analysis – 8 days
4. A case study report drafted and validated by key stakeholders (Evaluation Management Group and Reference Group) – 5 days

Indicative timeframe and deliverables

Phase	Mar	Apr	May	June	July	Aug
Preparation						
Desk review						
Data collection & Analysis phase						
Data Collection						
Analysis						
Report Phase						
Debrief Presentation						
Draft case study report						
Final case study report						

8. Management Arrangement

The Timor-Leste Inter-agency CPE Coordination Group will serve as a reference group for this case study. The UN Women Regional Evaluation Specialist will take the lead on the coordination along with UNFPA Timor-Leste CO Gender Programme Analyst - Manager of the SL Initiative.
The inter-agency group is an integral part of the evaluation management structure and is constituted to foster synergy between agencies, identify potential areas for collaboration, such as joint stakeholder mapping, joint case studies, etc. The group aims to contribute to coherence and lessen the burden of offices receiving evaluations. The Inter Agency Timor-Leste CPE Coordination group is composed of CPE evaluation managers, including the following:

Name	Title, Organization	Contact Details	Confirmation
Sabrina Evangelista	Regional Evaluation Specialist, UN Women	Sabrina.evangelista@unwomen.org	Yes
Secondinho Salsinha	M&E Analyst, UNFPA Timor-Leste	salsinha@unfpa.org	
Toky Razafimamonjy	M&E Specialist, UNFPA Timor-Leste	razafimamonjy@unfpa.org	
Dircio F.X. Ximenes	Gender Programme Analyst, UNFPA Timor-Leste	dximenes@unfpa.org	
Oyuntsetseg Chuluundorj	Regional M&E Adviser, UNFPA APRO	oyuntsetseg@unfpa.org	

UN Women and UNFPA will contribute to the overall costs and quality assurance of the joint case study. One international evaluation expert with expertise in gender and EVAWG will lead the case study and work in collaboration with the CPE teams of the participating agencies. Data collection will take place in-person by the

respective CPE teams and the case study lead will join as possible. Ideally, each CPE process divides the data collection to ensure synergies, for example each team could focus on one pillar; or visit a different province where SI was implemented; and the case study lead will compile data collected from across these visits. The case study lead will work with the national consultants recruited as part of the CPE teams to undertake data collection as agreed between the CPE Team Leaders.

The non-participating agencies will pull on the findings from the joint case study as input to the overall synthesis reports of each CPE / CF evaluation or as part of the CCA process. The case study leader will review the respective CPEs to ensure accuracy.

Ethical code of conduct

Each agency have developed processes for ensuring adherence to the UNEG Ethical Guidelines. These documents will be annexed to contracts. All data collected by the team members must be submitted to the evaluation manager in Word, PowerPoint or Excel formats and is the property of each agency. Proper storage of data is essential for ensuring confidentiality. The UNEG guidelines note the importance of ethical conduct for the following reasons:

1. Responsible use of power: All those engaged in evaluation processes are responsible for upholding the proper conduct of the evaluation.
2. Ensuring credibility: With a fair, impartial and complete assessment, stake- holders are more likely to have faith in the results of an evaluation and to take note of the recommendations.
3. Responsible use of resources: Ethical conduct in evaluation increases the chances of acceptance by the parties to the evaluation and therefore the likelihood that the investment in the evaluation will result in improved outcomes.

The value add of the case study is its impartial and systematic assessment of the programme or intervention. As with the other stages of the evaluation, involvement of stakeholders should not interfere with the impartiality of the case study report. The CPE evaluation team leaders haves the final judgment on the findings, conclusions and recommendations of the CPE report, and the team must be protected from pressures to change information in the report.

The primary focus of discussions with rights holders will be on understanding how the Spotlight Initiative supported programming has affected their own life without referring specifically to any affect (positive or negative) around violence. Nevertheless, the case study leader will develop a protocol for ensuring “do no harm” and protecting persons from repercussions related to discussing topics related to violence. Any national processes required for gaining ethical approval will also be followed. The participating agencies will support this process.