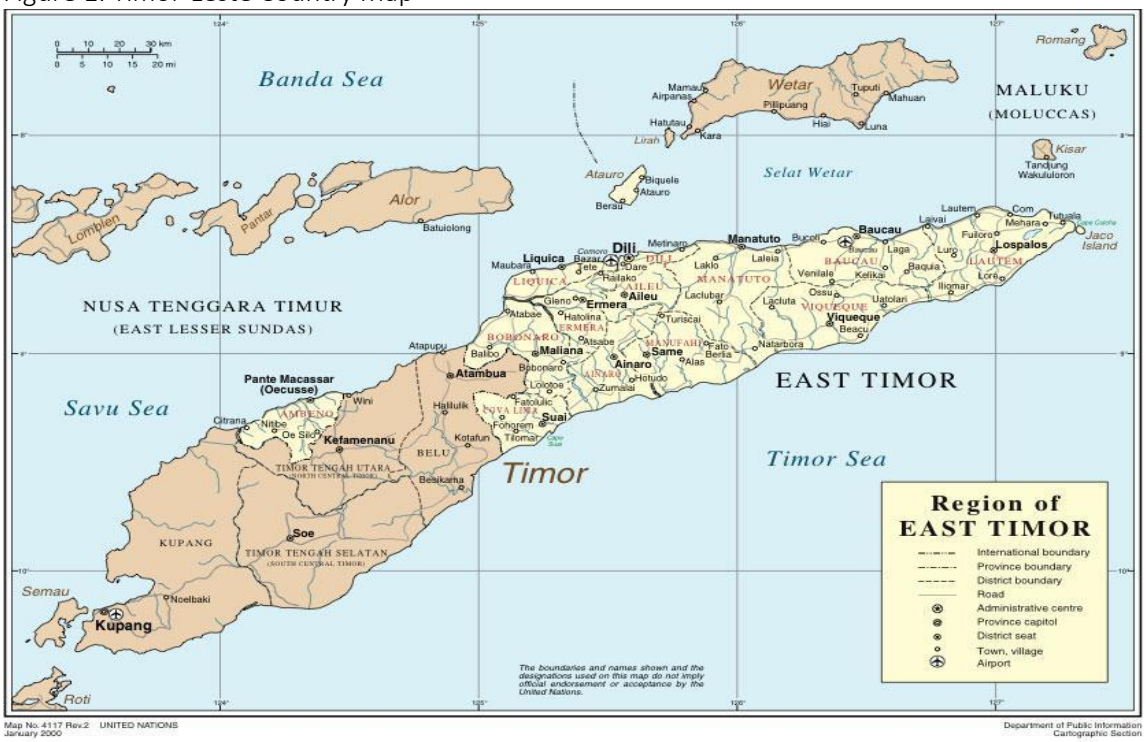
Goverment of Timor-Leste and UNFPA

4TH COUNTRY PROGRAMME EVALUATION **2021-2025**

March 2025

Figure 1. Timor-Leste Country Map



CPE Evaluation Team	
Position in the Team	*Name*
International Consultant Sexual and Reproductive health	Dr. Saramma Thomas Mathai, MD
National Consultant Adolescence and Youth	Amorim Vieira, B.A.
National Consultant Young Emerging Evaluator – Gender and Youth	Geovânia Guterres Ornai, B.A.
Team Leader International Consultant Population Dynamics, Coordination	Padma Karunaratne, Ph.D
Spotlight Initiative Case Study (Gender) – UNFPA	
International Consultant, Spotlight Initiative, UNFPA and UN Women CPE Joint Collaboration	Kirsty Milward, M.A.
CPE Evaluation Managers	
M&E Analyst, Co-evaluation Manager	Secondinho Salsinha
M&E Specialist, Co-evaluation Manager	Toky Razafimamonjy
ERG Members	

Country Representative a.i (Chair)	Bruce Campbell
Asst. Country Representative-Head of Programmes	Dr. Domingas Bernardo
DG, Ministry of Youth Sports Art and Culture	David Tomas de Deus
DG, Secretary of State for Equality	Armando da Costa
President, National Institute of Statistics	Elias dos Santos Ferreira
ND, Ministry of Health	Madalena S.F. Gomes
Director, Belun	Luis da Costa Ximenes
Director for Health & Nutrition, PHD	Armandina Gusmao-Amaral
Programme Manager, UN Women	Nuntana Tangwinit
Development Coordinator Officer and M&E, RCO	Lino T. Pina
International Operations Manager (IOM)	Pamela Aine
M&E Analyst (Secretary)	Secondinho Salsinha
M&E Specialist (Secretary)	Toky Razafimamonjy
Reproductive Health Programme Analyst	Dr Triana Oliveira
Programme Analyst for Gender	Dircio Ximenes
Programme Analyst for Population Dynamics	Egidio da Costa
Sexual and Reproductive Health Programme Analyst	Dr. Domingas Sarmento

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Abbreviations and Acronyms

ADB	Asian Development Bank
ANC	Antenatal Care
ANROWS	Australia's National Research Organisation for Women's Safety
APRO	UNFPA Asia and Pacific Regional Office
ASEAN	Association of Southeast Asian Nations
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
AY	Adolescents and Youth
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BPP	Birth Preparedness Plan
CCA TL	Common Country Analysis of Timor-Leste
CCM	Country Coordination Mechanism
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHCs	Community Health Centres
CO	Country Office
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organizations
CP	Country Programme
CP4	4th Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
CSE	Comprehensive Sexual Education
CSOs	Civil Society Organizations
CRVS	Civil Registration and Vital Statistics
DFAT	Federal Foreign Affairs and Trade Department of the Australian Government
DHIS-2	District Health Information System/Software
DHS	Demographic and Health Survey
DK	Dignity Kits
DPOHs	District Public Health Officers
DLADV	Domestic Law Against Domestic Violence
EmONC	Emergency Obstetric and Newborn Care
e-LMIS	Electronic Logistics Management Information System
EQA	Evaluation Quality Assessment
EQAA	Evaluation Quality Assurance and Assessment
ERG	Evaluation Reference Group
ESP	Essential Services Package
ET	Evaluation Team
EU	European Union
EVAW/G	End Violence Against Women and Girls
FOKUPERS	Communication Forum for Timorese Women (CSO)
FUAT	Follow-Up After Training
FP	Family Planning
GAPWG	Gender and Protection Working Group
GEWE	Gender Equality and Women's Empowerment
GBV	Gender-Based Violence

GBViE	Gender-Based Violence in Emergencies
GDP	Gross Domestic Product
GDS	General Directorate of Statistics
GIS	Geographic Information System
GoTL	Government of Timor-Leste
GRB	Gender Responsive Budgeting
GTG	Gender Thematic Group/Gender Technical Working Group
HACT	Harmonized Approach to Cash Transfers
HAMNASA	Together for Healthy Nation (CSO)
HCT	Humanitarian Country Team
HCPs	Health Care Providers
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Viruses/ Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HNGV	National Hospital of Guido Valadares
HPs	Harmful Practices
IAWG	Inter-Agency Working Group
ICPD	International Conference on Population and Development
ICM	International Confederation of Midwives
ICS	Instituto Ciência Saude
ISC	Instituto Superior Cristal
IDPs	Internally Displaced People
IEC	Information, Education and Communication
ILO	International Labour Organization
IMR	Infant Mortality Rate
INETL	National Institute of Statistics of Timor-Leste
INFORDEPE	Institute for Training and Personal Development
INFPM	National Institute for Pharmacy and Medical Products of Timor-Leste
INSPTL	National Institute of Public Health of Timor-Leste
INCSIDA	National AIDS Institute of Timor-Leste
IOM	International Organization for Migration
IPs	Implementing Partners
IPV	Intimate Partner Violence
ISC	Higher Institute of Cristal (*Midwifery School*)
IUCDs	Intrauterine Contraceptive Devices
KOICA	Korea International Cooperation Agency
kNOwVAWdata	Initiative to Support and Strengthen Regional and National Capacity to Measure Violence Against Women
KP+	Progressive Community Association (A*ssociação Komunidade Progresu)*
LADV	Law Against Domestic Violence
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
LMIS	Logistics Management Information System
LNOB	Leave No One Behind
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MPDSR	Maternal Perinatal Death Surveillance and Response
M&E	Monitoring and Evaluation
MISP	Minimum Initial Service Package
MK	Maternity Kits
MoE	Ministry of Education
MoF	Ministry of Finance
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health

MoJ	Ministry of Justice
MoI	Ministry of Interior
MoYSAC	Ministry of Youth, Sports, Arts and Culture
MoU	Memorandum of Understanding
MSSI	Ministry of Social Solidarity and Inclusion
MTR	Midterm Review
NACP	National AIDS Control Programme
NAPVAW	National Action Plan on Violence Against Women
NAP-NYP	National Action Plan for National Youth Policy
NAP GBV	National Action Plan for Gender-based Violence
NGOs	Non-Governmental Organisations
NMR	Neonatal Mortality Rate
NSDP	National Strategic Development Plan
OECD/DAC	Organisation for Economic Cooperation and Development/Development Assistance Committee
ODA	Official Development Assistance
OPD	Out-Patient Department
OPG	Office of the Prosecutor General
PDO	Public Defender Office
PEP	Post-Exposure Prophylaxis
PHD	Australia-Timor-Leste Partnership for Human Development
PLWHA	People Living with HIV/AIDS
POA	Programme of Action
PO	Programme Officer
PRADET	Psychosocial Recovery & Development in East Timor
PSEAH	Protection from Sexual Exploitation and Abuse and Sexual Harassment
PNC	Postnatal Care
PNTL	National Police of Timor-Leste
PD	Population and Development
PHC	Primary Health Care
PwDs	People with Disabilities
RAEOA	Special Administrative Region of Oe-Cusse Ambeno
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security/Supply
SDGs	Sustainable Development Goals
SDP	National Strategic Development Plan
SEFOPE	Secretary of State for Training and Employment
SGBV	Sexual and Gender-Based Violence
S.M.A.R.T	Specific, Measurable, Attainable/Attributable, Relevant and Time-bound
SOPs	Standard Operating Procedures
SSE	Secretary of State for Equality
SP	Strategic Plan
SI	SPOTLIGHT Initiative
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRMNCAH	Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health
SSTC	South-South Triangular Cooperation
STI	Sexually Transmitted Infection
T4E	Together for Equality
TAF	The Asian Foundation
TICA	Thailand International Cooperation Agency
TL	Team Leader
TLDHS	Timor-Leste Demographic and Health Survey

TLDPM	Timor-Leste Development Partners Meeting
TLNSDP	Timor-Leste National Strategic Development Plan
TLPHC	Timor-Leste Population and Housing Census
ToC	Theory of Change
TPP	Third Party Procurement
ToR	Terms of Reference
ToT	Training of Trainers
TPP	Third Party Procurement
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNEDAP	United Nations Evaluation Development for Asia and Pacific
UNFPA	United Nations Population Fund
UN-OCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNSDCF	United Nations Sustainable Development Cooperation Framework
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
UN-SWAP	United Nations System-Wide Action Plan on Gender Equality and Women's Empowerment
UNTL	National University of Timor-Leste
USAID	United States Agency for International Development
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
VPU	Vulnerable Persons Unit
WHO	World Health Organization
WB	World Bank
WRA	Women in reproductive age
YEE	Young Emerging Evaluator
ZONTA	International Organization with the Mission of Advancing the Status of Women

Tables, Figures and Charts

Acknowledgement

The independent evaluation team wishes to express gratitude to all institutions and individuals for contributing to the successful completion of the UNFPA Timor Leste (2021-2025) 4th Country Programme Evaluation (CPE). We highly appreciate the strategic guidance and support of Mr. Bruce Campbell, UNFPA Representative, a.i., Dr. Domingas Bernado,Assistant Representative, Messrs. Secondinho Salsinha and Toky Razafimamonjy, Evaluation Managers (CPE), and all the Programme and Operations Officers. Thank you to all the CO staff for the technical input and logistical support extended throughout the evaluation despite the heavy load of other pressing commitments. Special gratitude to relevant ministries, departments and agencies, donors, CSOs and the communities that the team consulted during the CPE for their valuable input to this evaluation.

We are grateful and wish to thank the RCO, and UN Agencies UNDP, UNICEF, UN Women, and WHO, for providing their valuable input to the evaluation. Our gratitude goes to the municipal officials, hospital and health center staff, youth center staff, CSOs, teachers, students, women, and other groups we met in Baucau, Bobonaro, Ermera, Liquiça, Dili, and Viqueque municipalities and providing us with valuable information. Special thanks are extended to the Evaluation Reference Group (ERG) members who provided input during the design and preliminary results validation and final reporting processes. We thank everyone who contributed to this evaluation; without your support we could not have been able to complete this task. We regret our inability to mention all by their names. Finally, we are grateful for valuable input by all the reviewers, specifically Dr. (Ms) Oyuntsetseg Chuluundorj, UNFPA Asia and Pacific Regional Office (APRO) M&E Advisor for the guidance and constructive feedback. The team appreciates the UNFPA HQ evaluation department for the evaluation handbook which provided excellent guidelines on the design and conduct of this evaluation.

Box 1: Structure of the Timor-Leste's Country Programme Evaluation (CPE) Report

This report includes an executive summary, six chapters, and annexes following the structure recommended in the evaluation handbook issued by the UNFPA Independent Evaluation Office.

Chapter 1, the Introduction, outlines the background, objectives, and scope of the evaluation, as well as the methodology used, including its limitations and the evaluation process. Chapter 2 presents the Timor-Leste country context, highlighting the development challenges related to UNFPA's mandate areas. Chapter 3 addresses the UN system's response, with a focus on UNFPA's country programme, and how it tackles national challenges in sexual and reproductive health and rights (SRHR), including the health response to gender-based violence (GBV), adolescents and youth, gender equality and women's empowerment and population and development, in the development and humanitarian settings. Chapter 4 provides the evaluation findings for each question outlined in the evaluation matrix (included in the annex1). Chapter 5 discusses the conclusions, and based on the conclusions, Chapter 6 offers recommendations at both the strategic and programmatic levels.

Annexes contain the obligatory documents for the CPE (evaluation matrix, list of documents consulted, list of persons met, data collection tools and terms of Reference). Also included are Spotlight Case Study Evaluation Report , Additional Information (Annex 5) and Stakeholder Map (Annex 6) related to CPE, for further reference.

Table 1. Key Facts and SDG Progress

Indicator	Information	Reference
Land		
Geographical location	Southeast Asia	
Land area	14,874 km^2, including Jaco Island	
Demographics		
Total population size	1,341,737 million	TLPHC 2022
Population size by sex	Male 51%. Female 49%	TLPHC 2022
Population size by rural/urban	Rural- 958.0 thousand (71.4 %) Urban-383.0 thousand (28.6 %)	TLPHC 2022
Population growth rate	1.8%	TLPHC 2022
Life expectancy at birth (by sex)	64.3 male. 69.2 women	TLPHC 2022
Under 5 mortality Rate	40 per 1000 live births	TL DHS 2016
Human Development Index (HDI) index/rank (2022)	Timor-Leste rank 140th 2022	UNDP Human Development Report 2021-2022.
Young People		
Proportion of population aged 10-19	309,477 (23%) Aged under 18 (42%) Aged under 25 (57%)	Timor-Leste at a Glance. UNICEF 2023
Health and Fertility (includes SDG indicators)		
Total fertility rate	4.2	TL DHS 2016
Adolescent Birth Rate (per thousand women)	7% of adolescent women aged 15-19 have begun childbearing	TL DHS 2016
Contraceptive prevalence rate (modern methods)	24% CPR, (increased from 21% in DHS 2009/10).	TL DHS 2016
Unmet need for family planning	25%, decreased from 32% in 2009/10 with 6% unmet need for limiting and 19% for spacing.	TL DHS 2016. Teenage Pregnancy in Timor-Leste 2017.

Proportion of births attended by skilled health personnel	Deliveries by skilled health personnel increased, from 30% in 2009-10 to 57% in 2016	TL DHS 2016 (or we can keep both to show the change between 2010 and 2016 - figures
Maternal Mortality Ratio	195 per 100,000 live births	-TL DHS 2016
HIV prevalence rate	General population is below 1%.0.2%. Sex workers - 1.5%; men who have sex with men - 1.3%; transgender - 2.6%.	Global AIDS Response Progress Monitoring Report 2015 2018. Report on Timor-Leste
Economic		
GDP per capita	2,389.30 USD.	World Bank 2022
Real GDP growth rate	1.1% per year over 2013-2022	GoTL General State Budget Report 2024
Unemployment rate	General 5.1%, Female 5.9%, Male 4.6%. Young aged (15-24) 9.6%	Timor-Leste Labour Force Survey. 2021
Inflation rate	8.7% in 2023	GoTL General State Budget Report 2024
Gini index	28.70% (2014)	World Data Atlas. Timor-Leste
Major economic activity	Oil extraction accounts for 80% of GDP	
Gender Equality/Gender-Based Violence		
Child Marriage: 15-19- and 20–24-year-old women with children	19% of women aged (20-24) married before 18. 24% with a child at age 20	Report: Teenage Pregnancy and Early Marriage in Timor-Leste. 2017
Lifetime and current prevalence of physical and/or sexual intimate partner violence by age group among ever-partnered women in those age groups	59 per cent of Timorese women (15-49 years) experienced physical and/or sexual violence by an intimate partner in their lifetime. 38% of women aged (15 to 49) experienced physical violence since age 15. 29% had experienced physical violence in the 12 months before the DHS survey (2016)	The Nabilan Baseline Study, 2016 (study results come from only 5 of 14 municipalities)

Global Gender Gap Index (2021)	0.917	UNDP Human Development Report 2021-2022.
Political		
Type of government	Democratic Republic. Semi-Presidential	U.S Department of State
Proportion of seats held by women in national parliament	40%	The World Bank. Gender Data Portal
Key political events (during period being evaluated)	Independent Declaration November 28, 1975	Timeline of Timor-Leste History. wikipedia.org
	Indonesian Invasion December 7th, 1975.	
	UN Sponsored Referendum August 30, 1999	
	Restoration of Independence 20th May 2002	

Executive Summary

In line with the UNFPA evaluation policy (2024), UNFPA Timor-Leste conducted an evaluation of its Fourth Country Programme (CP4) of Assistance to the Democratic Republic of Timor-Leste (2021-2025) engaging an external and independent team of evaluators.

The Programme: CP4 started with an indicative allocation (planned resources) of USD 6.4 million from regular (core) resources and USD 10.2 million from other (non-core) resources, totalling USD 16.6 million for the programme. Developed in consultation with the government and other partners, programme focused on advocacy and policy dialogue/advice, capacity development, knowledge management, service delivery, coordination, partnerships and South-South Triangular Cooperation (SSTC). Spanning across two strategic plan periods (SP 2018-2021 and 2022-2025), UNFPA Timor-Leste's country programme implemented for the period 2021 to 2025 consists of targeting universal access to SRHR and the three transformative results - ending preventable maternal deaths, ending the unmet need for family planning, ending gender-based violence and all harmful practices. To achieve this, CP4 included four outcomes (a) Sexual and reproductive health and reproductive rights (SRHR), (b) Adolescent and youth (AY), (c) Gender equality and women's empowerment (GEWE), and (d) Population dynamics and data (PD) with five outputs under these four outcomes. Programme interventions, in varying degree of focus and strength, extended across all 14 municipalities, including the Oecusse (RAEOA) special administrative region.

The evaluation aims to demonstrate accountability to stakeholders regarding performance in achieving development results and managing resources; support evidence-based decision-making; and contribute valuable lessons to the organisation's knowledge base. The CPE also draws conclusions and provides actionable recommendations for the next programme cycle (CP5), covering 2026-2030.

The evaluation assesses the relevance, coherence, effectiveness, efficiency, and sustainability of UNFPA support, as well as progress towards expected outputs and outcomes outlined in the CP4 results framework, including in humanitarian settings. Two evaluation criteria, Coverage and Connectedness were assessed for the humanitarian response. Extracting from key lessons learnt clear, forward-looking options that lead to strategic and actionable recommendations were made.

Audience: The primary intended users of the evaluation include the UNFPA Timor-Leste Country Office (CO); the Government of Timor-Leste; implementing partners (IPs) of the UNFPA Timor-Leste CO; rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth and key populations); the United Nations Country Team (UNCT) and Resident Coordinator's Office; Asia and Pacific Regional Office (APRO); and donors. The evaluation results will also be of interest to a wider group of stakeholders, including: other UN agencies, UNFPA headquarters divisions, branches and offices; UNFPA Executive Board; academia; and local civil society organizations (CSOs) and international non-governmental organizations (NGOs) and inter-agency groups.

Temporal Scope: The Country Programme Document (CPD) and Country Programme Action Plan (CPAP) cover the period from 2021 to 2025. The evaluation encompassed the period starting from January 2021 to July 2024 (up to the data collection phase).

Geographical Scope: The evaluation included all implemented activities by UNFPA and its implementing partners at national and sub-national levels.

Thematic Scope: The programme scope covered the thematic areas of the CP4: Sexual Reproductive Health and Rights (SRHR) including health response to Gender-based violence (GBV), Adolescents and Youth (AY), Gender Equality and Women's Empowerment (GEWE) inclosing GBV, Population and Development (PD) and Humanitarian Response. The evaluation also addressed crosscutting aspects such as human rights-based approach, integration of the Leaving No One Behind (LNOB) and Reaching the Furthest First principle, disability inclusion, communication, partnerships, results-based programme planning, monitoring and reporting, and resource mobilisation.

Methodology: Evaluation addressed ten questions under each of the OECD DAC evaluation criteria, relevance, coherence, effectiveness, efficiency, sustainability, and in humanitarian context, coverage and connectedness. Employing theory based and mixed method approaches, this evaluation considered the CP planning documents that reflect the programme's design, including its theory of change and results framework. CPE employed an inclusive, transparent and participatory methodology, involving a broad range of key partners and stakeholders at national and sub-national levels. The evaluation team (ET) performed a stakeholder mapping to identify both UNFPA direct and indirect partners those who play a significant role in relevant outcomes in the national context. Key stakeholders identified in the stakeholder map and those consulted included UNFPA CO staff, national and municipality level staff, implementing partners and other UN agency staff, donors, CSOs and beneficiaries of the interventions. In total 215 (97M/118F) were interviewed. The Evaluation Reference Group/ERG (list given in the report) was involved through the evaluation process to provide input, validate findings, and to contribute to recommendations.

Data source: Evaluation utilised both secondary and primary data sources based on the evaluation questions, employing a mix of quantitative and qualitative data from various origins. Relevant documents (listed separately Annex 2) served as key secondary sources. The CPE team coordinated with the international gender consultant during data collection for the joint Spotlight Initiative evaluation to avoid duplication of efforts.

Data Collection and analysis: Adhering to UNEG/UNFPA ethical standards for evaluations, data were collected at national and sub-national levels through individual face-to-face interviews, group interviews, and focus group discussions, all adopting a participatory approach. Observation of facilities and services were made during field visits. Thus, this evaluation employed a mixed-methods approach, triangulating data sources and data collection methods data to minimise bias and strengthen the validity of findings. CPE did not use artificial intelligence (AI) in data collection or analyses. There were no major limitations, except that current country's administrative and survey-based information systems provided disaggregated data only by sex and age. Intersectionality approach to identify intersecting identities could not be done with limited disaggregated data and changes in the development conditions of specific target populations of CP4, such as people with disabilities, specifically women, and the poorest segment of society across the programme sites could not be analysed. Furthermore, behaviour change data were limited to report change process or progress with any concrete evidence. Descriptive, content, and contribution analyses were used where it was needed and appropriate. Available secondary data was used for descriptive analyses and content analysis was performed using qualitative data.

Sampling: A purposive sample of field sites was identified for data collection based on a criteria agreed by the ET. Based on these criteria and discussions with CO staff, the ET selected six municipalities:

Baucau, Bobonaro, Ermera, Liquiça, Dili, and Viqueque. Field visits were planned in a logical geographic sequence to maximise efficiency, considering travel time and road conditions.

A convenient sample of beneficiaries participated in informal group discussions and focus group discussions to provide insights on service quality, accessibility and utility. The evaluation also drew on monitoring reports – such as quarterly reports, project-specific, annual reports - submitted by IPs and UNFPA staff. Triangulating data collection methods mitigated the weaknesses of any single method, enhancing the validity of the findings. The Spotlight Initiative (SI) case study was carried out between April and August 2024 by an independent consultant specialising in gender responsive evaluation, contracted by both UNFPA and UN Women. Primary data collection for SI coincided with the UNFPA CPE's in-country data collection period, which allowed shared interviews between the two teams. Coordination also occurred with the UN Women CPE team via online meetings held with the team leaders of the concurrent evaluations, with findings from these evaluations serving as supplementary data sources for the CPE.

Key findings: CP4 interventions are aligned with the three transformative results, the six accelerators and the relevant national SDG targets. The objectives and strategies of the CP4 thematic programme areas are consistent with relevant national and sectoral policies in the development and humanitarian contexts. CP4 design identifies the needs of vulnerable and marginalized groups, including women and girls, adolescents and youth, survivors of gender-based violence, but less evident in the implementation. Only in the Human Immunodeficiency Viruses (HIV) control and prevention programme it was evident that people living with HIV (PLWHA), Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQi), transgender etc., have been identified and fully integrated in the implementation. IPs' needs and capacities are considered and capacity enhancement for relevant areas has been accomplished.

CP4 has dedicated over one third of its budget on capacity building. While most of the capacity building efforts received high recognition and positive feedback, the efficiency and the sustainability of some of these interventions need consideration. While a coherent strategic plan for capacity building was not evident, such a plan would have been more effective and efficient given the cross-cutting nature of the interventions and the type of participants to avoid duplication of efforts. While the LNOB principle is integrated in designing programmes, it lacks intersectionality approach to provide an analysis of interconnected social categories. Capacity development plans did not show evidence of inclusive learning. This would need extra resources and allocations for development of materials and delivery of training catering to those with learning challenges/disabilities.

The initiatives for addressing adolescents and youth's sexual and reproductive health (ASRH) services are inadequate and ASRH faces many challenges shaped by the Timor-Leste social-cultural, political and infrastructure landscape, which led to limited, or no access to SRH services, at both national and municipal levels.

In all four outcome areas, sexual and reproductive health and rights (including health response to gender-based violence (GBV), adolescents and youth, gender equality and women's empowerment, and population and development (with six outputs) the expected targets were achieved, except for a few delays mainly due to the time lost during covid-19 pandemic. In some cases although the targets are achieved, the quality of the results was questionable and some well-functioning initiatives were interrupted by financial resource limitations. There is also an issue with the data visibility and utilization and the setting of indicators to measure progress of the outputs. Although the outputs are achieved, or even overachieved, in some cases the impact it would have had on the final outcome or the link to the

expected results is not clear, indicating that there are some limitations in the indicator selection for both outputs and outcomes and the design of the initial results framework. Thus, the mere achievement of the output indicators may not measure a real impact on the final beneficiaries. There were data gaps which made it difficult to track if intended results were achieved. The four output areas work independently, although there are cross-cutting themes that could get all programme officers' attention for enhanced effectiveness and efficiency.

The current programme cycle (CP4) had to face two unexpected emergencies – covid-19 pandemic and major floods that affected the entire country. Country office provided humanitarian support in both situations and resumed back to regular work plan responsibilities. It is commendable that despite these setbacks the Country Office managed the CP4 implementation efficiently, with the existing human resources and partnership with government and non-government development partners. Partnership with the government and working in line with national policies and strategies, without creating external parallel structures, there is likelihood of the sustainability of UNFPA's development initiatives. Streamlining capacity enhancement efforts based on a comprehensive plan could have further enhanced the programme's effectiveness and efficiency contributing to sustainability. UNFPA's coordinated work with other UN agencies has shown efficient and effective mode of implementation avoiding overlaps and maximizing the expertise within the country office.

Conclusions: Midst of COVID 19 pandemic and the other humanitarian emergencies, CP4 maintained relevance to the national strategies, UNFPA mandate, and SP strategies. In general, UNFPA took into consideration the needs of the population, with some exception to the inclusion of those furthest left behind, and managed to achieve most of the planned results under the four CP outcomes contributing to the transformative results. UNFPA's overall contribution to capacity enhancement of implementing partners is commendable; however, the absence of a comprehensive plan is a missed opportunity.

As the lead agency for family planning (FP), UNFPA has significantly contributed to strengthening and expanding quality FP services, particularly in increasing access to modern contraceptive methods and supply systems with focus on remote areas, and ensuring services and supplies (in the humanitarian context during the pandemic and floods. Challenges remain in ensuring universal access due to restrictions under the National Family Planning (FP) Policy, which also affects access of vulnerable groups such as People Living with HIV/AIDS, adolescent girls and unmarried women. UNFPA's leadership in enhancing supply chain management and advocacy efforts has led to increased use of domestic resources for RH commodities including contraceptives and reduced stockouts.

In maternal health, UNFPA's systematic efforts to enhance access to quality Emergency Obstetric and Newborn Care (EmONC), coupled with stringent certification measures, have secured substantial donor funding. While CP4 has contributed to improving maternal care during pregnancy, much more needs to be done in improving quality of care. Implementation of Maternal Perinatal Death Surveillance and Response (MPDSR) in all the municipalities is significant but not effective due to quality and timeliness of response. As the sole agency supporting midwifery, UNFPA's contributions are significant not only in terms of contributions to critical human resources but also in improving maternal and reproductive health.

The absence of ASRH services under the CP is surprising given the country's significant youth bulge and the critical role these services play in harnessing the demographic dividend. This also undermines UNFPA's leadership in youth initiatives under the UNCT and its related outcomes. UNFPA's technical assistance to the government has enabled the promotion of comprehensive sexuality education (CSE) for adolescents in and out-of-school environment addressing some of the ASRH issues.

Given the low level of awareness on HIV, sexually transmitted infections (STI) and SRH in general, the delay of full integration of CSE into the formal education system and out-of-school young people could have serious implications. Geographical barriers and inadequate infrastructure further hinder service delivery, leaving marginalized groups underserved and in need of greater visibility and advocacy. Furthermore, physical, cultural, and linguistic barriers continue to hinder women's and girls' access to reproductive health services.

Women and adolescent girls in remote areas remain a priority under CP4, but reaching them is a challenge. Although at-risk groups, such as people with disabilities and LGBTQI individuals are included, these efforts have been limited in scope and lack disaggregated targets. UNFPA made significant contributions to reaching Key Populations with preventive service packages and HIV testing through its partnership with a CSO. However, support for integrated SRH services is a weak programme component, particularly integration of HIV/AIDS.

UNFPA's leadership in the comprehensive health sector response to GBV, leveraging both its own resources and joint programme funding, has significantly expanded service access. Its contributions are recognized beyond the MOH, particularly for its role in supporting the National Action Plan on GBV. The joint UN initiatives employing a multi-dimensional approach successfully brought together key CSOs, government sectors, and UN agencies. This collaboration enhanced awareness of GBV prevention and the elimination of all forms of violence against women and girls. However, many individuals may still be missing essential services and awareness programmes.
CP4 humanitarian short-term emergency response was commendable given the limited capacity. Longer-term and interconnectedness aspects were less focused in the humanitarian approach and could be stronger.

UNFPA support to the National Institute of Statistics Timor Leste (INETL) on data generation through national and other large surveys such as Census, DHS, and other survey data are crucial for the entire development community, informing planning, policy and decision-making. However, there are development partners who are not using these data for planning and the availability of data needs to be more publicized and accessible. Data marketing strategy for enhanced data utilization is currently missing.

Establishment of a sound theory of change (TOC) aligning to the SP 2022-2025 could have provided a useful opportunity to be more focused on measuring the transformative results and reformulating the indicators to demonstrate the causal linkages with the transformative results. Missing the SP alignment opportunity and a midterm review, CO continued to monitor progress using the results framework with poorly designed indicators (only some). Although the basic elements were not missed and CP4 interventions are in line with the current SP, for M&E purposes inclusion of specific, measurable attainable, relevant and time bound (SMART) indictors could have been useful.

Recommendations: Recommendations stemming from the conclusions have been validated at meetings with **the** ERG and CO programme staff and APRO. As an outcome of these validation meetings evaluation team selected priority recommendations that are strategic and programmatic.

Strategic Recommendations:
(1) Design Related- the development of theory of change and results framework for CP5 to help establish the causal pathways to achieve the planned results via meticulous planning and assessing the evaluability of the programme (before implementing the CP5).

(2) Data-Driven Development: UNFPA to emphasize its comparative advantage as a data agency and support data for development. Maintain the UNFPA role, as in the past, with more support to advocating for the availability, accessibility and utilization of data for evidence-based policy dialogue, planning, and monitoring. Applying intersectionality approach could examine intersecting identities to gain a deeper understanding of social inequalities to help plan and work towards creating a more equitable society.

(3) Integration of Rights-based Approaches and Leave No One Behind (LNOB) principle*:* CP 5 to focus on rights-based approaches to policy and service delivery and supply systems emphasising quality, expanding contraceptive choices and access to meet the needs of the vulnerable including adolescents, PWD, PLWHA and LGBTQI and advocating for sustained national investments based on evidence.

(4) Integration of ASRH and SRH services in Health Sector Response to GBV: CP 5 to continue to focus on the health sector response to GBV, focusing on integration with SRHR and ASRH services, while developing a deep understanding of the root causes and gender and cultural norms related to GBV and addressing them for long-term solutions to prevent GBV. Support GBV case management and referral system with a good forensic service in place.

The programmatic recommendations are:
(1) Life Course Approach to the Demographic Dividend through Adolescent and Youth Empowerment: In alignment with the National Youth Policy and RMNCAH strategy, revitalise previous efforts to deliver adolescent and youth-responsive SRH services while continuing to expand CSE programs. These efforts aim to empower adolescents and maximize health and economic benefits. Strengthen UNFPA's technical assistance and visibility on youth empowerment through advocacy and support to the government (Ministry of Educating and Ministry of Youth, Sports, Arts and Culture) and CSOs for both in-school and out-of-school CSE programs.

(2) Multi-sectoral Approach to addressing GBV: CP5 to strengthen a multi-sectoral response to GBV by enhancing referral networks, formalizing inter-agency roles, and standardizing survivor-centred, trauma-informed SOPs across key sectors. Focus on addressing harmful norms, empowering CSOs, and establishing a centralized data system to ensure evidence-based, impactful interventions.

(3) Maternal Health: CP 5 to continue supporting the health system strengthening for maternal and newborn health through (a) improving availability and access to Basic Emergency Obstetric and Newborn Care (BEmONC), focusing on hard-to-reach areas and strengthening the neonatal component; (b) skills in antenatal, intrapartum and postnatal care as per WHO recommendations; (c) quality and timeliness of MPDSR reviews and actions; and (d) strengthening capacity for midwifery services in the country as per ICM standards and human resource needs of the country.

4) Primary health care system to provide integrated SRH services: Strengthen the capacity of the primary health care system to provide integrated SRH services through diverse service delivery platforms, ensuring seamless access during both developmental and humanitarian phases and,

(5) Application of humanitarian-development nexus approach to decrease risks and vulnerabilities.

Chapter 1: Introduction

In line with the UNFPA evaluation policy, UNFPA Timor-Leste conducted an evaluation of its Fourth Country Programme (CP4) of Assistance to the Democratic Republic of Timor-Leste (2021-2025). This external and independent evaluation was carried out by a team of evaluators in accordance with the UNFPA Evaluation Policy (2024), the UNFPA Evaluation Handbook (2024), United Nations Evaluation Group (UNEG) norms and standards, and additional guidelines addressing disability, gender, and humanitarian response. Managed by the Timor-Leste Country Office (CO) in collaboration with the Evaluation Reference Group (ERG), and Regional Monitoring and Evaluation (M&E) Adviser from the UNFPA Asia and the Pacific Regional Office (APRO), and (with oversight from the Independent Evaluation Office (IEO) of UNFPA Headquarters), the overall objectives of the CPE are stated below.

1.1 Purpose and Objectives of the Country Programme Evaluation

The evaluation aims to demonstrate accountability to stakeholders regarding performance in achieving development results and managing resources; support evidence-based decision-making; and contribute valuable lessons to the organisation's knowledge base. The CPE also draws conclusions and provides actionable recommendations for the next programme cycle (CP5), covering 2026-2030.

As the current country programme (CP) is implemented from 2021 to 2025, it is recommended that the country office conduct a final evaluation in the penultimate year to assess progress and identify areas where the implementation of the International Conference on Population and Development (ICPD) Plan of Action is lagging. This CPE is included in the UNFPA's Quadrennial Budgeted Evaluation Plan. The evaluation results are crucial for designing the new country programme document, ensuring the protecting of gains and identifying ways to accelerate transformative changes. The objectives of the evaluation stated in the TOR are as follows with no changes made to the stated objectives in the CPE:

- To provide a comprehensive analysis of the CP4 context, focusing on multisectoral needs, demographic changes (including youth bulge, and climate change), political and social dynamics among multiple level stakeholders, and capabilities and resources.
- To independently assess the relevance, effectiveness, efficiency, and sustainability of UNFPA support, as well as progress towards expected outputs and outcomes outlined in the CP4 results framework, including in humanitarian settings. The evaluation emphasises coherence and functional relationships with implementing partners while analysing positive and negative intended and unintended results and challenges.
- To extract key lessons learnt from the past and current cooperation and provide clear, forward-looking options that lead to strategic and actionable recommendations for both the UNCT and UNFPA CO in the next programming cycle.

The primary intended users of the evaluation include: (i) The UNFPA Timor-Leste CO; (ii) the Government of Timor-Leste; (iii) implementing partners (IPs) 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 and key populations); (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 other UN agencies, UNFPA headquarters divisions, branches and offices; the UNFPA Executive Board; academia; local civil society organizations (CSOs) and international non-governmental organizations (INGOs) and inter-agency groups. The evaluation results will be disseminated as appropriate through both traditional and digital communication channels.

1.2 Scope of the Evaluation

Temporal Scope: The Country Programme Document (CPD) and Country Programme Action Plan (CPAP) cover the period from 2021 to 2025. The evaluation encompassed the period starting from January 2021 to July 2024 (up to the data collection phase).

Geographical Scope: The evaluation included all implemented activities by UNFPA and its implementing partners at national and sub-national levels.

Thematic Scope: The programme scope covered the thematic areas of the CP4: Sexual Reproductive Health and Rights (SRHR), Adolescents and Youth (AY), Gender Equality and Women's Empowerment (GEWE), and Population & Development (PD) and Humanitarian Action. While humanitarian work was not part of the work plan at the start of the CP4, two major humanitarian emergencies (Covid-19 pandemic and floods) had to be attended to during CP4. Hence, the humanitarian response forms part of this CPE and are being included for the evaluation.

The evaluation also addressed cross-cutting aspects such as human rights-based approach, integration of the Leaving No One Behind (LNOB) and Reaching the Furthest First principle, GEWE, disability inclusion, communication, partnerships, results-based programme planning, monitoring and reporting, and resource mobilisation.

The evaluation questions and assumptions for verification are detailed in the Annex 1, Evaluation Matrix. ET did not use Artificial Intelligence (AI) in the evaluation process except when needed for translation and paraphrasing.

Table 2. Evaluation Criteria and Corresponding Evaluation Questions*

Evaluation Criteria and Evaluation Questions	
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, LGBTQI, people at risk of and living with HIV, and other marginalised groups, needs of government and civil society organisations 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?
Effectiveness	EQ3. 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? EQ4. 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	EQ5. Did UNFPA get the value for money for its intervention vis-à-vis the results achieved?

Sustainability	EQ6. 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? EQ7. To what extent did UNFPA achieve government ownership of various interventions (BEmONC, Safe Spaces, ANC-PNC, Family Planning, HIV, CSE and Census)?
Coherence	EQ8. To what extent has 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	<u>Coverage</u> EQ 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"? <u>Connectedness (linked to sustainability as well)</u> EQ10. 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?

* TOR provided 12 evaluation questions (EQs) and the handbook suggests a limit of 6-8 questions. However, in the absence of a mid-term review for CP4, ten questions were selected considering the utility value of the findings to the country office. No question was omitted completely. In EQ3 of the TOR, the major changes due to external factors during CP4 were humanitarian emergencies that were fully addressed under EQ 9 and 10. Original EQs 10, 11, and 12 given in the TOR were combined to form two questions (EQ 9 and 10) without omitting the any parts of the original questions. These were explained to the ERG during the CPE design validation.

1.3 Evaluation Approach

The evaluation was guided by various standards, among others: Integrating Human Rights and Gender Equality in Evaluation, guidelines on Disability Inclusion, UNEG Norms, and Standards for Evaluation in the UN System, and UNEG Ethical Guidelines. The evaluation adhered to evaluation principles of independence, impartiality, credibility and utility. Adopting a transparent, inclusive, and participatory approach that is responsive to gender and human rights, the CPE analysed how CP4 advanced the rights of targeted populations, particularly women and marginalised individuals, and supported them in claiming their rights. It also investigated the extent to which CP4 strengthened accountability mechanisms and promoted transparent review and dialogue.[1]

The evaluation utilised data disaggregated by age, sex, and vulnerable groups, where available, to ensure that findings were inclusive, gender-responsive, and targeted. The evaluation team engaged with the country office and the ERG to gather feedback during both the design phase and after data collection, validating the design and preliminary findings.

Employing theory-based and mixed method approaches, this evaluation considered the CP planning documents that reflect the programme's design, including its theory of change and results framework. The theory-based approach allowed the team to investigate in detail the expected pathways of change, including the assumptions that underpin the causal chains and linkages within the CP's Theory of Change

[1] Explained under data collection methods section

(TOC). This analysis was essential for the evaluation design, data analysis, and the formulation of conclusions and recommendations.

TOC that was designed in the final year of the previous Strategic Plan (SP) 2018-2021 and implemented through the second SP cycle 2022-2025 was reviewed and revised after discussions with the programme staff. The alignment of the three transformative results within the current programme context was examined and missing links were added to update the existing TOC.

Participatory approach: CPE employed an inclusive, transparent and participatory methodology, involving a broad range of key partners and stakeholders at national and sub-national levels. The evaluation team (ET) performed a stakeholder mapping[2] to identify both UNFPA direct and indirect partners those who play a significant role in relevant outcomes in the national context. These stakeholders included Government representatives, CSOs, UN agencies, bilateral donors, and most importantly, the programme beneficiaries.

CO staff provided a stakeholder map that represent the national and local government, UN Agencies, donors, development partners, and most importantly, programme beneficiaries (see Annex 6). ET consulted extensively with the CO staff and presented to the ERG at the design stage to finalise the list of stakeholders for interviews, focusing on major stakeholder categories across CP4 four programme themes, ensuring representation across all three strategic (SP) outcome areas. While the sample was not representative, it was purposively selected to reflect relevant interventions and participants. However, the team ensured that all interventions evaluated were discussed with relevant responsible stakeholders to obtain their views. The selection of beneficiaries was done both ET as well as CO and in some cases CSOs. Due to the limited time in the field, ET had to meet with the beneficiaries selected by the IPs which may have caused some selection bias. ET made it a point to meet with beneficiaries those who were present at service centers, however, in-depth interviews could not be held due to time constraint as these were not pre-planned and needed to be fair by those who volunteered to be interviewed -these women came to attend the clinic. Adult men could not be interviewed except for the male students. CPE benefitted by the extensive group meetings and focus group discussions with the health staff covering all those engaged in health response to GBV arranged as part of the SI case study. For detailed discussion is included in Annex 3 list of persons met.

The main government partners in CP4, based on discussions with CO and the stakeholder map, are INETL, INFPM, INCSIDA, INSPTL, MoH, MoYSAC, MSSI, and SEI. Other development partners include IOM, ILO, UNICEF, UN WOMEN and WHO. Key CSOs are BELUN, Estrela+, and HAMNASA, with Fokupers and Alola implementing a limited number of interventions. Main beneficiaries, while depend on the type and level of interventions, the final targeted beneficiaries are women of childbearing age, pregnant women and newborn, adolescent and youth both girls and boys, GBV survivors, PLWHIV, PWDs, LQBTQI, student populations, and community groups. To serve these target populations, health care providers, uniformed personnel, teachers and municipal level service providers do benefit by UNFPA supported interventions, mainly via capacity development interventions. Key stakeholders were involved through the evaluation process to enhance ownership and build local capacity, providing input, validating findings, and contributing to recommendations. During the design phase, the team sought their feedback (list of those met in Annex 3), particularly from beneficiaries in vulnerable groups, including PWDs and their representatives, such as CSOs working with them. Every effort was made to include key stakeholders in the evaluation process, either as sources of data (primary/secondary) or through their representation in the ERG.

[2] see more information under section 1.3.3

To ensure coherence among UN agencies, the United Nations Evaluation Development Group for Asia and the Pacific (UNEDAP) established a coordination group, consisting of UN Women, UNFPA, UNICEF, and UNSDCF evaluation team leaders who were scheduled to conduct CPEs in Timor-Leste during 2024. This initiative aimed to meet organisational mandates while minimising the burden on stakeholders and identifying opportunities for collaborative analyses within the CPE processes and identified the Spotlight Initiative (SI) as a joint case study opportunity, involving UNFPA and UN Women. Objective of this collaboration was to assess how participating agencies address ending violence against women and girls (EVAWG) in Timor-Leste, ensuring coherence and effective use of resources. An international evaluation expert led the SI case study in partnership with the UNFPA CPE team and SI report is included in Annex 6 for readers' reference. UNFPA CPE team also coordinated with the country framework (UNSDCF) evaluation team leader to integrate findings related to coherence criteria, where appropriate. UNICEF evaluation did not coincide with the two CPEs, given the timeline of fieldwork.

1.3.1 Contribution Analysis and Theory of Change

The SP 2022-2025 identifies six outputs: policy and accountability, quality of care and services, gender and social norms, population change and data, humanitarian action, adolescents and youth integrating sexual and reproductive health – including gender-based violence prevention – into national policies, development frameworks and universal health coverage. CP4 has four overarching outcomes (see Table 5 on CP4) and five outputs established during the Country Programme Document (CPD) preparation, all aimed at achieving three transformative results. CP4 started in 2021 and spanned across two strategic plans, and as such, there was limited adaptation in programme planning to align with the new Strategic Plan (SP 2022-2025), however, all elements related to the three transformative results are embedded in CP4. CO and IPs had employed a mixed mode of engagement with service delivery, policy, advocacy and capacity development to achieve the results defined in the results framework. CO staff clarified the links from outputs to outcome levels, and detailed presentations of CP4 programme interventions by outcome area were done by the CO programme staff. Evaluability of the CP4 was further assessed through document reviews and discussions with programme staff.

CO presented the TOCs constructed at the beginning of the CP and ET made use of them for developing the design report. SRHR comprise the largest component of country programme, and the team reconstructed the SRHR TOC and it is presented in a separate schematic diagram annexed with additional information (Annex 5). As explained above, TOC for CP4 did not explicitly align with the three transformative results or integrate the six accelerators (human rights-based and gender-transformative approaches; innovation and digitalization; partnerships, South-South and Triangular Cooperation (SSTC) and financing; data and evidence; the principle of leaving no one behind and reaching the furthest behind first; and resilience and adaptation, along with complementarity among development, humanitarian and peace-responsive efforts) during its development. However, most of these elements were embedded in the plan. For example, human rights-based gender transformative approaches were integrated in all programme components and CP4 supported the first ever digitalized census, and there is evidence on a successful SSTC partnership. Please also refer to the discussion under the relevance criteria.

TOCs were further refined following discussions with CO programme officers during the full CPE team's in-country visit. A half-day workshop was conducted with relevant programme officers and other staff members to reconstruct the TOCs, including critical assumptions and risks, as needed. Due to the problem with legibility, the TOC schematic diagrams are not included in the main report; the power point presentation illustrating the TOC for each of the CP4 outcome is attached with Annex 5.

TOC helped in understanding the causal connections and provided an opportunity to assess progress towards outcomes, allowing for credible conclusions about the contribution made by CP4 to observed results. While attribution was not measured, an outcome-based contribution analysis guided the ET to understand how and why interventions made a difference, for whom, and whether the engagement methods were appropriate. CPE utilised existing evaluations and resources on relevant topics and programme areas, employing qualitative and quantitative methods based on the availability of secondary data. (Reconstructed TOCs on each outcome are in Annex 5).

1.3.2 Methods for Data Collection and Analysis

Data Sources

The evaluation utilised both secondary and primary data sources based on selected evaluation questions, employing a mix of quantitative and qualitative data from various origins. Key stakeholders identified in the stakeholder map and those consulted included UNFPA staff, service providers, programme beneficiaries (rights holders), and individuals impacted by UNFPA-supported programmes. Relevant documents (listed separately Annex 2) served as key secondary sources. The CPE team coordinated with the international gender consultant during data collection for the joint Spotlight Initiative evaluation to avoid duplication of efforts.

A convenient sample of beneficiaries participated in informal group discussions and focus group discussions to provide insights on service quality, accessibility and utility. The evaluation also drew on monitoring reports – such as quarterly reports, project-specific, annual reports - submitted by IPs and UNFPA staff. Triangulating data collection methods mitigated the weaknesses of any single method, enhancing the validity of findings.

The Spotlight Initiative[3] (SI) case study was carried out between April and August 2024 by an independent consultant specialising in gender responsive evaluation, contracted by both UNFPA and UN Women. Primary data collection for SI coincided with the UNFPA CPE's in-country data collection period which allowed shared interviews between the two teams. Coordination also occurred with the UN Women CPE team via online meetings held with the team leaders of the concurrent evaluations, with findings from these evaluations serving as supplementary data sources for the CPE. UNICEF CPE was not in the same implementation phase for sharing information.

Data Collection Methods

Primary data were collected at national and sub-national levels through individual face-to-face interviews, group interviews, and focus group discussions, all adopting a participatory approach. Observations of facilities and services were made during field visits. UN Women administered a stakeholder survey for the gender theme group (GTG) and CSOs. CPE team incorporated these findings where appropriate. ET allowed respondents including implementing partners, civil society, programme participants, and donors to discuss the programme freely and suggest improvements relevant to their contexts. Data Collection tools are attached in Annex 4.

Secondary data were gathered through a documentary review, encompassing CP related documentation, national policies, strategies, action plans, national statistics, evaluations, and reports

[3] Spotlight Initiative: Case Study 2024

(quarterly, project-specific, annual, and trip reports) submitted by IPs and UNFPA staff. A detailed list of documents reviewed is provided in Annex 2. Quantitative data were compiled through desk reviews, online databases, and surveys to obtain financial data and key indicators measuring change at output and outcome levels.

Thus, this evaluation employed a mixed-methods approach to data collection, combining qualitative and quantitative data to minimise bias and strengthen the validity of findings. Validation of results was achieved through stakeholder meetings, including debriefings with UNFPA staff, ERG members, and implementing partners.

Data Analysis

The evaluation team (ET) organised both qualitative and quantitative data in an evaluation matrix corresponding to each evaluation question and assumption. This matrix served as the guiding structure for data analysis, helping to identify common themes and patterns that addressed the evaluation questions. Descriptive analysis was conducted to understand the contexts in which the programme evolved, describing the types of interventions and other programme characteristics. Quantitative analysis, where feasible, focused on interpreting data from programme annual reports, studies, and financial reports, contingent on the availability, quality, and comparability of primary and secondary data.

Content analysis of documents, interview notes, and focus group discussions was performed to identify emerging trends and themes relevant to each key evaluation question. These insights formed the basis for preliminary observations and findings. Given the nature of the data collection methods, major analysis primarily involved content analysis of qualitative data. Contribution analysis assessed the extent to which the country programme contributed to expected results. The team sought evidence to validate the theory of change and to identify any logical or informational gaps. Qualitative data, secondary quantitative data, and findings from existing reports were triangulated to draw conclusions. Special considerations were made to include perspectives from boys, girls, men, women, and marginalised groups, as specified by CO staff and IPs during CP4 design and implementation.

Artificial Intelligence (AI) was not used for data collection, analyses or any steps in the evaluation process in the CPE except for translation (from Tetum to English) and paraphrasing in a few instances.

Data Quality

All evaluation findings were substantiated by evidence, with data triangulated across various sources and methods. The evaluation team (ET) cross-compared information obtained from different data collection methods—such as desk studies, individual interviews, discussion groups, and focus groups—ensuring thorough analysis through double or triple-checking of results. For instance, evidence from interviews with government staff was compared with insights from beneficiaries and secondary data sources. This triangulation upheld data quality, while validation of preliminary findings by key stakeholders (CO staff and ERG) further enhanced data integrity, reducing the risk of factual errors or misinterpretations and ensuring that no critical evidence was overlooked. Zero draft was shared and reviewed by the CO for factual accuracy before being shared with the ERG.

Maintaining Ethical Standards

CO provided the team members guidelines on ethical standards and upon understanding the standards ET signed the documents. ET adhered to evaluation principles of independence, impartiality, credibility

and utility. CO informed the stakeholders, in advance about the CPE and interviews, and obtained a time for the interviews and no CO staff accompanied ET for interviews. ET obtained interviewee consent by explaining the objectives and the purpose of the evaluation and the interviews and that they have the right not to respond to any particular question if they did not wish to offer information. ET ensured protecting their privacy, confidentiality, and anonymity. If interviews were recorded, ET obtained the interviewees' permission, giving them assurance that information stays within the team and that anonymity will be safeguarded. ET maintained a shared storage space (google space) and others did not have access to the information. ET shared interview notes within the team members and information was aggregated when reporting, to avoid any identification. ET followed "do no harm" policy and respected the time duration for interviews and appreciated and acknowledged the respondents for their input. More on ethical consideration explained in Annex 3.

The team also successfully completed the "Fraud and Corruption Awareness and Prevention" modules and "Prevention of Sexual Exploitation and Abuse (PSEA)" modules prior to undertaking the evaluation.

Retrospective and Prospective Analysis and the Evaluation Criteria

ET assessed the sustainability of results, examining whether expected outcomes have been achieved and the likelihood that the effects of UNFPA interventions will persist after funding ends. Questions were designed to elicit this information, primarily based on respondents' perceptions. Similarly, effectiveness was evaluated by determining the extent to which objectives have been achieved or are likely to be met. The ET combined insights from previous evaluations, programme documents, country office monitoring data, and field observations with interview data to substantiate findings.

1.3.3 Stakeholder Selection and Sites Visited

Sampling Strategy

The evaluation team developed a final stakeholder list (Annex 3) based on the initial map (Annex 6) provided by the country office, document reviews, CO programme presentations, and discussions with CO staff. The team also used the *snowball sampling* technique, asking interviewees to identify additional key informants who could provide valuable insights. The stakeholder list, provided by the country office, was refined based on interventions, geographic location, and the roles in CP4, ensuring representation from all participating UN agencies, ministries, donors and beneficiaries.

Similarly, a purposive sample of field sites was identified for data collection, based on similar criteria. Given numerous reviews and evaluations already conducted by the CO, and other agencies, site visits aimed to collect new information beneficial for CP5 planning and decision-making. To maintain objectivity, the selection of stakeholders and sites was discussed with the CO staff and the ERG for feedback before finalising.

UNFPA's interventions span all 14 municipalities, with varying degrees of focus. The team selected a purposive sample of six municipalities for data collection, reflecting three types of municipalities based on logistical considerations and the following criteria.

- Combination of UNFPA interventions implemented
- Maturity of the interventions (duration of UNFPA support)
- Targeting of less developed areas with limited resources to assess coverage for marginalized populations

- Areas with successful UNFPA-supported interventions and those facing challenges
- Presence of multiple implementing partners across different output areas
- Highest and lowest investment levels
- Availability of integrated, multi-stakeholder programming (e.g. UN Joint Programmes like the Spotlight Initiative)
- Opportunities to observe innovative approaches with scaling-up potential
- Logistical feasibility regarding travel time and distance, given the data collection timeline
- Areas most effected by Corona Virus Disease (COVID-19) and floods in 2021

Based on these criteria and discussions with CO staff, the CPE team selected six municipalities: Baucau, Bobonaro, Ermera, Liquiça, Dili, and Viqueque. Changes were expected if logistical issues arose and as such the initial plan to visit Covalima was replaced by Bobonaro as explained below. Field visits were planned in a logical geographic sequence to maximise efficiency, considering travel time and road conditions.

CPE team initially planned to visit Covalima municipality due to its focus on key population interventions and integrated sexual and reproductive health activities, but several factors prompted a change in plans. Privacy concerns arose during consultations with key stakeholders, including civil society organisations (CSOs) like Estrella+ and Associação Comunidade Progresso, which indicated that interviewing representatives of CSOs or communities living with HIV in Suai could compromise their confidentiality. Additionally, the team faced significant time and logistical constraints that made the long journey from Dili to Suai impractical due to distance and road conditions. It was also determined that sufficient information could be gathered by speaking with key stakeholders at the national level, eliminating the need for the visit. Instead, the CPE team visited the association representing key populations in Dili to interview a key informant, a former IP worked with UNFPA, to obtain the relevant information. Covalima was replaced by Maliana, Bobonaro municipality and a team member visited a high school and youth centre to collect data on the implementation of the Adolescents and Youth (AY) programme.

Given the timeframe for data collection, analysis, and presentation of preliminary findings, visiting all six municipalities, including Dili, posed challenges. As a result, teams split to cover these sites. The evaluation included visits to two municipalities with Spotlight initiatives, coordinated with the international gender consultant to streamline efforts. The evaluation team utilised, when feasible, recent past reviews and evaluations to avoid duplication, directing questions to fill gaps and validate findings. The sample site selection table is in Annex 5 for reference. Table below shows the sites visited in each of the municipalities selected.

Table 3. Municipalities, Post-Administrative and Institutions Visited

Municipality	Post Administrative	Institutions Visited
Baucau	Baucau Villa	Municipal Health Service, Family Planning (FP) Coordinator
		Regional Hospital of Baucau, Maternity, Neonatal Intensive Care Unit and Safe Space, Antenatal Care (ANC) and FP Unit Baucau Regional Pharmacy and Medical Products Warehouse
		Municipal Health Service Maternal and Child Health (MCH) Department
	Laga	Community Health Centre (CHC) Laga, Maternity
	Bolehá, Laga	Health Post Bolehá, Laga

Bobonaro	Maliana	Bobonaro Youth Center
		Escola Secundária Privado Cristal Filial Maliana
Dili	Cristo Rei	National Hospital of Guido Valadares (HNGV), Maternity Unit , Safe Space, etc.
	Vera Cruz	CHC Inpatient Care Vera Cruz, Maternity and Safe Space
Ermera	Gleno	Municipal Health Service Maternal and Child Department
		BEmONC Gleno Safe Space CHC Inpatient Care Gleno
		Health Post of Lodudu, Ermera
		Ermera Youth Center, two schools
	Railaco	CHC and Maternity Railaco, Gleno
Liquiça	Liquiça	BEmONC Liquiça
		Safe Space, CHC Liquiça
Viqueque	Viqueque Villa	BEmONC Viqueque Villa
		CHC Viqueque Villa (ANC and FP) Pharmacy of Inpatient Care Viqueque Villa Safe Space CHC Viqueque Villa
		Viqueque Youth Center
	Ossú	Health Post Loihunu, Ossú
		CHC Ossú

Table 4. List of Representing Institutions and Number of Stakeholders Met

Respondents and Representing Institution	Male	Female	Total
UNFPA CO Staff	7	10	17
National Government Partners/Staff	15	17	32
Municipal Government Partners/Staff	23	52	75
Other UN Agencies, RCO and Donors	9	9	18
NGOs, CSOs and Other IPs	20	16	36
Women's Groups*	-	*1 (2 members)	2
Adolescents and Youth Representatives	19	9	28
Any other (teachers, schools management, Media, GBV Survivor)	4	3	7
Total	97	118	215

Note: the list of names is available in Annex 3
This number does not include interviews held separately by SI consultant, group interviews of students, and women visiting the clinics for SRH service (refer to Annex 3 for details)

1.3.4 Methodological/Data Limitations, Biases and Mitigation Measures

While the current country's administrative and survey-based information systems provide sex and age disaggregated data, there is a limited data available to identify changes in the development conditions of specific target populations of CP4, such as people with disabilities and the poorest segment of society across all programme sites. Similarly, although several initiatives focus on behaviour change, indicators to measure behaviour change are absent. ET based findings on beneficiaries' and IPs' perceptions.

Data on marginalized groups and their access to services were limited. Given the geographical context and tight timeline for interviews, accessing selected field sites proved challenging. While the evaluation sought to address areas related to HIV and CSE, restrictions prevented engagement with key populations. Consequently, one field site was changed, and the team mitigated this by visiting an association representing key populations in Dili instead.

The absence of an interpreter with a full evaluation team to cover major thematic areas posed additional difficulties which were mitigated by sharing responsibilities within the team and the team leader taking on more than indicated in the TOR. The allocated number of days for the CPE was not adequate and the team mitigated this by providing time voluntarily to accomplish the tasks. Time frame given from June to August was not realistic to complete the CPE hence ET requested for a no cost extension. Given the shortage of human resources, and prior commitments on field missions, CO staff had multiple responsibilities and the data collection process took longer which was not anticipated in the design phase. Despite these challenges, ET did not encounter major limitations that affected the evaluation negatively. CO provided extensive and prompt support when requested.

Given the limited knowledge of programme sites and logistical challenges, institutions visited were chosen by the CO staff and IPs, potentially introducing a selection bias. This limitation was mitigated by triangulating findings of various previous independent evaluations, direct observations, and interviews with stakeholders at multiple levels including policymakers, service providers, and intended service receivers. Dependency on the CO staff for interview interpretation also could introduce some bias. However, in most of the fieldwork, the two international consultants paired up with the two national consultants for help with interpretation and the responses we received for the same questions did not vary.

The evaluation team was not fully aware of the coordination with other CPEs as it was not part of the TOR since the UNFPA CPE TOR was completed much earlier than the in-country visit by other international consultants was finalized. However, it so happened that all three CPEs team leaders (except for UNICEF) were in-country almost at the same time. Though it posed some challenges at the beginning of the fieldwork, to adjust the interview schedules, CO was able to attend to logistics and interpretation support for the teams to work smoothly and collaborate with each other. Meetings organized by the UN Women Regional Office Evaluation Specialist, team leader of the UN Women CPE, led the interagency evaluation team leaders' coordination group which provided the team leaders a platform to share evaluation findings was useful. Although this initiative of interagency coordination meant to reduce overlap, lack of time in planning of this coordination meant spending more time in the process: engaging in meetings, preparing for meetings and coordinating within teams. However, this effort was worth as rich exchange of information that was useful to the CPE was made possible.

Chapter 2: Country Context

Located in South-eastern Asia, the Democratic Republic of Timor-Leste is a small island that gained independence as a state in 2002, following over four centuries of colonial rule by Portugal and a quarter century of Indonesian occupation. The country is divided into 14 Municipalities (districts) with include post-administrative/sub-districts, with a varying degree of development. Table 1 provides demographic, social and economic indicators to give background characteristics of the country.

Despite reaching lower middle-income status mainly due to oil resources, the 2023 Multidimensional Poverty Index by UNDP indicates that 24.4% of the population lives below the national poverty line. Unemployment remains high, with limited formal sector job opportunities and private sector job creation falling short of demand. Most of the populations lack consistent earnings; a significant portion of the population relies on subsistence farming.

To address inherited socioeconomic deficiencies, Timor-Leste approved the National Strategic Development Plan (SDP) 2011-2030 in 2010. This twenty-year vision aims to transform the country into an upper-middle-income nation by 2030, focusing on eradicating extreme poverty and developing a sustainable, diversified economy, not dependent on oil. This strategic plan also emphasizes the importance of young people as future leaders, who will drive social and economic transformation of society.

2.1 Development Challenges and National Strategies

2.1.1 Development Challenges

Timor-Leste has shown progress concerning reducing unmet needs of contraception and Maternal Mortality Ratio (MMR) (TLDHS 2016 and Key Facts Table), though far from reaching national targets. The total fertility rate remains high at 4.2 (DHS, 2016). Similarly, the Neonatal Mortality Rate (NMR) and Infant Mortality Rate (IMR) have shown progress. The data on the adolescent fertility rate is high but has shown a reduction over the years (TLDHS 2016 and Key Facts Table). The HIV prevalence in the general population is still less than 1 per cent though higher in key populations (Key Facts Table).

Timor-Leste allocates 1.4% of its GDP and 5% of total government expenditure to health.[4] The major challenges include inequitable geographical access, poor service quality, cultural and religious barriers regarding contraceptive use, and low awareness levels about available services. Though the Government is investing in Primary Health Care (PHC) to improve access, particularly for Emergency Obstetric and Newborn Care (EmONC), coverage and quality remain below global standards. The inadequate care for mothers during pregnancy and delivery, as well as poor access to health care for newborns and infants, are reflected in the poor progress in MMR and NMR.

Awareness about SRHR – and knowledge of HIV is low among youth aged 15-24 as documented in the Demographic Health Surveys and National Youth Policy[5], exacerbated by restrictive FP – policies that limit adolescents' access to contraceptives. In addition to the low levels of awareness about fertility and FP, harmful gender norms further undermine women's autonomy over their bodies and fertility, contributing to high rates of teenage pregnancies and the rising prevalence of Human Immunodeficiency Viruses/ Acquired Immunodeficiency Syndrome (HIV/AIDS) and Sexually Transmitted Infections (STI)

[4] WHO Timor-Leste. Draft National RMNCAH Strategy 2024-2030.

[5] TL DHS 2016. Comprehensive knowledge about HIV is low among teenage girls is 6% and boys is 13% (overall knowledge among men and women 15-49% is 16 % and 10%. National Youth Policy 2016 and tor for CPE also mentions low level of knowledge related to SRHR. See reference 9 also.

among young women. The rising prevalence of HIV, STIs, and unwanted pregnancies among young people threatens the country's ability to achieve a demographic bonus. Cultural and gender issues contribute to low condom use and limited health-seeking behaviour, further exacerbating the spread of the virus among key populations. Integrating FP and HIV/AIDS services is another critical concern. Stigma and discrimination towards people living with HIV/AIDS (PLWHA) hinders access to testing and treatment, while significant challenges persist in achieving equitable distribution of health resources, particularly midwives, and maternal health supplies as noted in the facility assessment of 2022[6]. The current availability healthcare professionals are inadequate, with only 25 doctors, nurses, and midwives per 10,000 population, compared to the recommended 44.5 per 10,000 population.[7]

Variations in health indicators such as the delivery rate across municipalities highlight inequalities in access to care. Seven out of 14 municipalities in the country lack functional EmONC facilities[8]. The IMR in Timor-Leste was estimated at 56 deaths per 1,000 live births, reflecting insufficient care and poor access to healthcare for mothers during pregnancy and delivery. High fertility rates and low skilled birth attendance contribute to elevated maternal and neonatal mortality rates.

While maternal and newborn health in Timor-Leste has improved since independence, significant work remains to address the high rates of maternal and newborn mortality. The maternal mortality ratio (MMR) stands at 195 per 100,000 live births, the infant mortality rate (IMR) at 30 per 1,000 live births, and neonatal mortality at 19 per 1,000 live births (DHS, 2016). These figures reflect inadequate care for mothers during pregnancy and delivery, as well as poor access to health care for newborns and infants. The total fertility rate remains high at 4.2 (DHS, 2016).

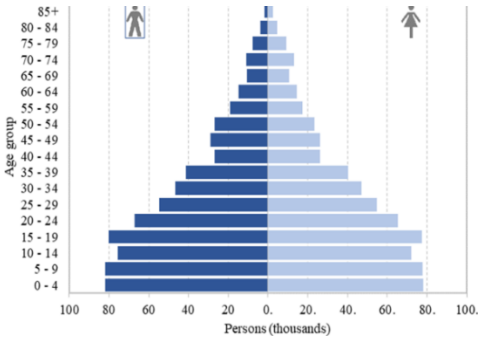
Sexual and Gender-Based Violence (SGBV) is another significant challenge, with 59% of women aged 15-49 experiencing physical or sexual violence from an intimate partner in their lifetime. As stated above, cultural norms, and harmful practices rooted in gender inequality are prevalent, perpetuating a culture of silence around violence against women and girls (VAWG), making discussions about issues like rape taboo. Despite ongoing efforts to address these issues, early and forced marriages persist; the 2016 Demographic Health Survey revealed that 2.6% of women aged 20-24 were married before age 15 and 14.9% before age 18[9]. Violence and discrimination against marginalized groups, including persons with disabilities and those identifying as LGBTIQ, are also commonplace, with weak access to justice despite some advancements in accountability mechanisms.[10]

The challenges in adopting a multi-sectoral approach to address GBV in Timor-Leste included weak institutional coordination, limited access to survivor-centred services, insufficient funding for implementing the National Action Plan on GBV (NAP-GBV), and deeply entrenched patriarchal norms. The first National Action Plan on Gender-Based Violence (NAP-GBV) in Timor-Leste was developed in 2012 and aimed to address GBV through a multisectoral approach. It sought to involve various sectors, including health, justice, social services, and education, in preventing and responding to GBV. Key elements included strengthening institutional frameworks, improving access to support services for survivors, and addressing underlying social norms that perpetuate violence. However, despite its intentions, implementing the multisectoral approach faced significant challenges, as stated above, with weak coordination between sectors, and limited data collection and monitoring capacity. Before

[6] MOH, UNFPA. Report on assessment for reproductive health commodities and services in Timor-Leste 2023.
[7] USAID. Human resources for health retention strategy for Timor-Leste 2022.
[8] TOR for CPE
[9] Country Assessment on Sexual Reproductive Health Rights (SRHR) in Timor-Leste 2017
[10] Ibid

programs like Spotlight and Together for Equality (T4E) were implemented, GBV response systems were fragmented, with only four service providers active nationally and limited awareness among survivors about their rights or available support services. In 2016, 81% of women and 79% of men justified wife-beating under certain circumstances, reflecting a pervasive acceptance of violence. Additionally, data systems for tracking GBV cases were poorly developed, and the capacity for service delivery across health, legal, and social sectors was inadequate.[11]

Figure 2. Timor-Leste's Population Pyramid



Adolescents and youth in Timor-Leste face multiple challenges in education, health, and employment, exacerbated by socio-economic factors and cultural norms. Many lack access to comprehensive SRH services and education, leading to high rates of teenage pregnancies and STIs[12]. Mental health issues are prevalent among youth, worsened by limited access to services and social stigma. Barriers to quality education, including inadequate infrastructure and trained teachers, further limit opportunities for young people, particularly in rural areas[13]. Youth unemployment and underemployment rates are alarmingly high; the Timor-Leste Labour Force Survey 2021 indicated an unemployment rate of 9.6% for young people aged 15-24.[14] The unemployment rate for young people aged 15-24 is 5.0 per cent for males and 5.5 per cent for females.[15] There is a disconnect between education and labour market demand and as such many young individuals resort to informal or subsistence work or seek employment opportunities abroad via the Secretary of State for Training and Employment (SEFOPE). The ongoing demographic transition has created a youth bulge, which presents both challenges and opportunities. As the population grows, the country must harness this demographic dividend rather than allow the next generation to remain trapped in poverty.

Traditional gender roles and discriminatory norms limit opportunities for young women in education and employment. Cultural practices and economic pressures lead to high rates of early marriage, disrupting education and resulting in early childbearing. Despite comprising 57% of the population[16], young people have limited opportunities for political participation due to insufficient support for youth engagement from the government of Timor-Leste.[17]

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.

Moreover, the country is vulnerable to natural disasters such as cyclones, floods, droughts and landslides, which exacerbate issues like food insecurity, malnutrition, and poor health outcomes. During CP4, the country was hit by the COVID-19 pandemic and floods making the humanitarian need high

[11] The Final Cumulative Spotlight Report, 2024 and T4E Endline Survey Report, 2024, and KIIs with stakeholders
[12] Ibid
[13] UNICEF Situation Analysis of Children in Timor-Leste 2014
[14] Timor-Leste Labor Force Survey 2021
[15] Ibid
[16] Timor-Leste Population and Housing Census 2022
[17] UNFPA Project Office Presentation on 4th CP Implementation May 30-31, 2024. UNFPA Timor-Leste

particularly among at-risk populations, including women, pregnant women, newborns, persons with disabilities, and key populations.

The COVID-19 pandemic heavily impacted the health sector, with 22,951 cases and 133 deaths reported by June 2022[18]. The pandemic disrupted health services, particularly primary care, prompting the government to expand integrated PHC, establish intensive care units, and boosting testing capacity, while providing nearly 2 million doses of COVID-19 vaccines.[19]

The floods affected over 25,700 households across 13 municipalities, prompting UNFPA to engage proactively in humanitarian responses to support these communities[20]. The Government is committed to expanding Universal Health Coverage (UHC), but challenges remain, including weak data capacities, limited resources, and coordination issues. Addressing barriers to access for marginalized groups, particularly in remote areas, is crucial for improving health outcomes. Key implications include enhancing health sector resources and digitizing the health system.

2.1.2 National Strategies

Timor-Leste's Strategic Development Plan 2011-30 emphasizes Human Capital development, social inclusion, prevention of domestic violence, gender equality, young people and the environment. The Timor-Leste National Health Sector Strategic Plan 2011-2030 also prioritize human capital through a life course approach, health systems improvement, and ensuring that no one is left behind. Both plans strongly emphasize maternal health, with the health sector plan addressing FP, HIV/AIDS, adolescent health services, and health sector response to GBV. Integration of FP with maternal health and HIV/AIDS is particularly highlighted. It also emphasizes the development of human resources, essential supplies, health financing, health information systems, and infrastructure improvements, particularly for Emergency Obstetric and Newborn Care (EmONC). The Essential Services Package (ESP) of PHC, which includes SRHR and health sector response to GBV, has been updated to support the Health Sector Strategic Plan and decentralization reforms, adapting to epidemiological and demographic transitions while promoting universal health coverage.

The National FP Policy of 2022 promotes various contraceptive methods but bans emergency contraception and restricts adolescents' access, impacting the rights of unmarried and married adolescents. Several strategies and guidelines have been developed to enhance health service quality, including an updated national strategy for reproductive, maternal, newborn, child, and adolescent health, as well as protocols for maternal care, family planning, health sector GBV management, Minimum Initial Services Package (MISP) and maternal and perinatal death reviews.

The Reproductive Health Commodity Security (RHCS) Strategy has improved the supply chain, reduced stock-outs of essential supplies and securing resources for family planning and maternal health and helped facilitate GoTL's contribution to procurement of contraceptives. The National Strategic Plan for HIV and Viral Hepatitis 2022-2026 focuses on prevention, screening, and treatment among key populations, aiming for the elimination of HIV, syphilis, and viral hepatitis among pregnant women. Strategies to address stigma and discrimination towards PLWHA are also being developed.

[18] CO M&E data
[19] CCA, 2023
[20] 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

Adolescents and Youth in Timor-Leste

National Youth Policy defines youth as people aged between 15 to 24 that include married and unmarried young women and men. This age group is further divided into adolescents (15-19 years) and young adults (20-24 years), acknowledging the distinct needs and experiences of each stage.[21] This definition acknowledges that adolescence is a distinct and important stage in youth development, with unique experiences and needs that differ from those of young adults. However, the National Strategy on RMNCAH defines adolescents as 10-19 years, youth as 15-24 years, and young people as 10-24 years.

The country has developed comprehensive national strategies to address the needs and challenges of adolescents and youth, focusing on health, education, empowerment, and socio-economic development. With UNICEF's support, Timor-Leste established the Youth Parliament to engage young people in decision-making processes, develop their leadership skills, and ensure their voices shape the nation's future. These strategies aim to equip young people with the knowledge and opportunities necessary for their well-being and future contributions to the country's development, aligning with global goals such as the SDGs.

Adolescents and youth in Timor-Leste face significant challenges related to SRHR and HIV/AIDS and addressing these challenges is crucial for promoting their health, well-being, and overall development. The national strategies such as the National Youth Policy, the National Health Sector Strategic Plan 2011−2030 and the Timor-Leste National HIV and STI Strategy 2011−2016, advocate for SRHR to ensure access to comprehensive health services and education. However, adolescent and unmarried youth have difficulties accessing SRHR and FP services due to a lack of government policy framework, funding and political commitment.[22] The National Youth Policy, focused on the public health, and CSE that includes Healthy Relationships does not clearly address SRHR.

Legal frameworks for child protection and social impact have been finalized, including laws on decentralization and judicial organization. The revised Criminal Procedure Law prioritizes the protection of survivors of gender-based violence. Additionally, in early 2023, Timor-Leste ratified the Convention on the Rights of Persons with Disabilities, marking a significant step toward inclusivity.

Gender Equality and Empowerment of Women, including GBV

Timor-Leste has made strides in promoting gender equality and addressing GBV. The national strategy for gender equality is backed by a comprehensive legal framework, including the Constitution, the ratification of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 2002[23], with its first report on January 9th, 2008[24]. The government has implemented several national action plans targeting GBV, women's economic empowerment, and their participation in decision-making processes. The government continues to integrate gender considerations into all programs, projects, and plans to achieve gender equality.

The Law Against Domestic Violence (LADV), enacted in 2010, provides legal protection for survivors and outlines government responsibilities in addressing GBV.[25] The National Action Plan (NAP) on GBV includes strategies for prevention, protection, and support services for survivors.[26]

[21] National Youth Policy. Timor-Leste 2016
[22] UNFPA CP Presentation May 30-31, 2024. UNFPA Timor-Leste 2024
[23] National Action Plan Against Gender Based Violence 2022-2032
[24] https://www.mj.gov.tl/files/CEDAW20StateReportPressRelease_5.pdf
[25] Law Against Domestic Violence. Timor-Leste 2010

NAP Against GBV 2022-2030, a comprehensive strategy developed to address and reduce incidents of GBV, support survivors, and promote gender equality,[27] builds on previous efforts, integrating international standards to enhance prevention and response mechanisms. The action plan represents a significant step toward comprehensively addressing GBV. It focuses on prevention, protection, legal frameworks, and multi-sectoral coordination to create a safer and more equitable society for all.[28]

Despite these advancements, persistent socio-cultural norms and beliefs hinder progress toward women's equality and social inclusion. NAP aims to increase women's participation in peace processes, while the National Mediation Network enhances access to justice for women and vulnerable groups. Key policy messages stress a Human Rights-Based Approach for inclusive development and the importance of data-driven strategies for migrant rights. Decentralization remains a priority for future progress.

Timor-Leste is also improving services for GBV survivors through initiatives that strengthen referral pathways and case management system, enhance legal frameworks, and improve healthcare and social services. Safe spaces, providing psychosocial support, and raising awareness about GBV[29] are key components of these efforts, supported by national policies, international partnerships, and UNFPA.

Population Dynamics (PD)

Timor-Leste's strategies for managing population dynamics are focused on addressing the rapid population growth, high fertility rates, and youthful demographic profile.

Under the decree law number 4/2023, article 7, the National Institute of statistics (INETL) Office under the Ministry of Finance (MoF) is responsible for demographic data collection, analysing and using the data for policy decision making. These strategies are designed to promote sustainable development, improve health outcomes, and enhance the overall quality of life for the population[30]. UNFPA ensures that Census data analysed and disseminated down to the lowest geographical level will enable these data to be used for public policy planning including the National Strategic Development Plan (NSDP) 2011-2030. The country's national strategy for population dynamics, which includes Demographic Health Survey (DHS) and Census as the main national surveys for the next decade or so, is grounded in NSDP 2011-2030 and emphasizes sustainable development, inclusive growth, and the improvement of living standards for all citizens.[31]

2.2 The Role of External Assistance

The latest data published by OECD/DAC (Figure 2) shows that ODA in Timor-Leste has been on the rise since 2019. The sectors that receive the largest share of funding are social infrastructure and services (19%), health and population (16%) and education (15%). The Humanitarian sector was allocated 5%. Australia, the United States, EU institutions, Japan, Portugal, New Zealand, Korea, the Asian Development Bank (ADB), Germany, and Global Fund are among the top 10 donors (2020 – 2021 average).

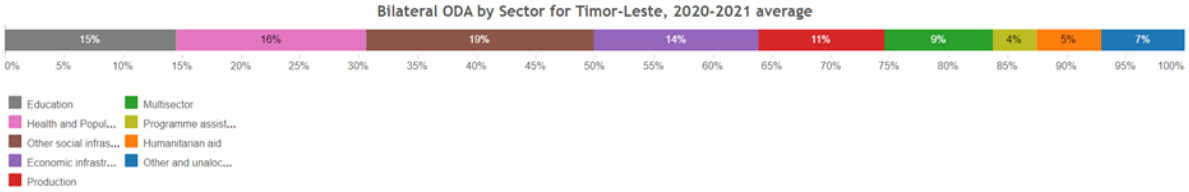
Since the adoption of the SDP, Timor-Leste has undertaken several steps in ensuring transparency and accountability towards donors, development partners and the public at large. The Government Portal

[26] National Action Plan on Gender Based Violence 2017-2021
[27] National Action Plan Against Gender Based Violence 2022-2032. Secretary of State for Equality and Inclusion. 2022
[28] Ibid
[29] Ibid
[30] Timor-Leste National Strategic Development Plan 2011-2030
[31] Ibid

for Transparency was set up, which includes the Aid Transparency Portal; a central repository for all aid information in Timor-Leste has become available in aimed to improve aid transparency, accuracy and predictability and to ensure assistance provided is efficient and effective.

Figure 3. ODA for Timor-Leste USD million (2021-2023)

Figure 4. Bilateral ODA by Sector for Timor-Leste, 2020-2021 Average



In 2020-21, averages indicated an allocation of 31% on Health and population, and Education sectors; and 19% on other social infrastructure and services. Humanitarian aid allocation was 5%.

Chapter 3: UNFPA Response and Programme Strategies

3.1 UNFPA Strategic Response

The UNFPA strategic plans 2018–2021 and SP 2022-2025 outline a global corporate strategy that contributes to the achievement of the SDGs through transformative results defined in the ICPD. By aligning its strategic plan with the SDGs particularly Goals 3 (Ensure healthy lives and promote well-being for all), 5 (Achieve gender equality and empower all women and girls), 10 (Reduce income inequality), 16 (Promote peaceful societies and access to justice), and 17 (Strengthen global partnerships), UNFPA plays a unique role and emphasizes the importance of sexual and reproductive health (SRH), reproductive rights (RR), and gender equality (GE) within the framework of the ICPD Programme of Action and the SDGs, especially Goals 3 and 5.

Focused on three transformative, people-centred results leading up to 2030: (a) an end to preventable maternal deaths; (b) an end to the unmet need for FP; and (c) an end to gender-based violence and all harmful practices, UNFPA strategic plans 2018–2021 and SP 2022-2025, prioritize those furthest from achieving these transformative results, which are essential for reaching the SDGs. The country programme (2021-2025) spans across these two SP cycles.

The SP 2022-2025 identifies six outputs; *policy and accountability, quality of care and services, gender and social norms, population change and data, humanitarian action, adolescents and youth integrating sexual and reproductive health* – including gender-based violence prevention – into national policies, development frameworks and universal health coverage. As stated earlier (under the TOC discussion), the achievement of results will be supported by six accelerators. This approach aims to ensure that no one is left behind, prioritizing those who are furthest behind. The implementation process is enabled by evidence and population expertise, with a special focus on empowering women and young people, especially adolescent girls, in both humanitarian and development settings.

The UNFPA Global Gender Strategy 2018-2021 adopted a two-pronged approach that mainstreams gender and sets specific outcomes for gender equality and reproductive rights (UNFPA, 2019). Key priority areas for promoting gender equality include: strengthening legal, policy and accountability frameworks for gender equality and reproductive rights; enhancing civil society and community action against discriminatory practices and norms against women and girls (including working with men and boys), improving multi-sectoral approaches to prevent and address gender-based violence; eliminating harmful practices affecting women and girls; and building capacities to develop gender-responsive data and statistics for monitoring SDG progress, advocacy and dialogues as relevant to UNFPA's mandate.

UNFPA's third 'Gender Equality Strategy' titled "Agency, Choice and Access: Strategy for Promoting Gender Equality and The Rights of Women and Adolescent Girls" is grounded in the principles of the 1994 (ICPD). It contributes to achieving the three transformational results outlined in the UNFPA strategic plan for 2022–2025. This strategy guides the integration of gender equality and human rights into UNFPA's planning and programming, with a strong emphasis on advancing the rights of women of all ages.

Figure 5. The "Bullseye" with the Strategic Vision and Alignment to SDGs

Source: UNFPA Strategy Plan (2022-2025)

UNFPA's global strategy on adolescents and youth titled "My Body, My Life, My World!", supports the implementation of Youth 2030. It centres on adolescents and youth and is key to UNFPA's efforts to achieve three transformative results by 2030 through the leadership and innovation of young people in development, humanitarian action, and peacebuilding. With an aim to empower every young person with the knowledge and resources to make informed choices about their bodies and lives, it emphasizes using sound evidence to design comprehensive strategies that promote rights and choices, fostering shared leadership and responsibility among government, non- government agencies, and youth led and youth serving organizations.

UNFPA has prioritized humanitarian programming, and its Global Response Plan is fully aligned to and part of the UN Secretary General's three-step plan to respond to the devastating socio-economic impacts of COVID-19. This plan complements the WHO COVID-19 Strategic Preparedness and Response Plan. At both the global and regional levels, UNFPA is part of the coordinated UN response under the Inter- Agency Standing Committee (IASC) COVID- 19 Global Humanitarian Response Plan.

The current strategic plan (2022-25) has been formulated using the latest available evidence, including insights from recent evaluations of UNFPA programmes. It aligns with the principles of the 2030 Agenda for Sustainable Development, emphasizing human rights, gender equality, the principle of "leaving no one behind," and fostering partnerships.

The following section discusses the specific programme of UNFPA Timor-Leste.

3.2 UNFPA Response through the Country Programme

The CP4 (2021-2025) was developed, following the 2201-2021 SP, in consultation with government of Timor-Leste (GoTL) and partners based on the then business model of working in lower middle-income countries, such as Timor-Leste, focusing on advocacy and policy dialogue/advice, capacity development, knowledge management and service delivery on some specific projects. However, although CP4 was not intentionally aligned with the current SP, partnerships and SSTC are part of the country programme as depicted in the current business model. CP4 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), National Health Strategic Plan 2011-30, Sustainable Development Goals (SDGs), and the 2021-2025 United Nations Strategic Development Cooperation Framework (UNSDCF) for the country.

Drawing on the experience of previous programmes, current CP4 supports the UNSDCF 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 CP4 is to support national efforts to achieve universal access to sexual and reproductive health and reproductive rights, contributing to the UNFPA three transformative results as mentioned above. CP4 responds to the principle of leaving no one behind, focusing on women, adolescents and youth, particularly those living in rural areas, marginalized groups such as people with disabilities, LQBTQI and key population groups. Outcomes 2, 4 and 5 of the UNSDCF are directly related to UNFPA's mandate and the ICPD agenda. All three UNFPA transformative results – reduction in maternal mortality, end of unmet need for family planning, elimination of gender-based violence are included among the indicators, however, the emphasis is on two of the three transformative results – elimination of gender-based violence, reduction in maternal mortality.

3.2.1 Brief Description of the UNFPA previous Cycle Strategy, Goals and Achievements

The previous country programme focused on: equitable access to quality reproductive health services; comprehensive responses to gender-based violence; awareness raising for young people to make informed choices for a healthy, productive life; and strengthened institutional capacity of the national statistics office and the Government on knowledge and evidence generation.
The CP3 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 continued strengthening of integrated sexual and reproductive health systems, including the logistics management capacity of the Ministry of Health (MoH), 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, CP4 planned to support UNSCDF strategic priorities 3 (Early Childhood Development and Life-long Learning Outcomes and Skills) and 4 (High-quality Healthcare and well-being), the UNSCDF priorities that are linked to the SDGs 3 and 4.

3.2.2 The Current UNFPA Country Programme and an Analysis of its Theory of Change

As explained under 3.2 above, CP4 was developed in consultation with the government and partners focusing on advocacy and policy dialogue/advice, capacity development, knowledge management, service delivery, coordination, partnerships and SSTCs. Spanning across two strategic plan periods (SP 2018-2021 and 2022-2025), UNFPA Timor-Leste's country programme implemented for the period 2021 to 2025 consists of targeting universal access to SRHR and the three transformative results - ending preventable maternal deaths, ending the unmet need for family planning, ending gender-based violence and all harmful practices. To achieve this, CP4 continued with the four outcomes and five outputs (see Table 5 below). As key interventions CP4 was designed at the tail end of SP 2018-2021, focusing on the

priority actions to reduce maternal and perinatal mortality and morbidity strengthening maternal care including EmONC, through strengthening the primary health care system to deliver a high-quality integrated services and information for FP, maternal health, STIs/HIV and health response to survivors of GBV in development and humanitarian situations; reducing the unmet need of FP through capacity development and strengthening the reproductive health commodity system to minimize stock-outs; focusing on the empowerment of women and violence against women and girls and prevention of GBV; strengthening the national capacity to implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality, and reducing HIV and STI prevalence including reducing stigma and discrimination towards PLWHA (see table 5 below).

All three UNFPA transformative results – reduction in maternal mortality, end of unmet need for family planning, and elimination of gender-based violence are included among the indicators, however, the CP4 emphasis is on two of the three transformative results – elimination of gender-based violence and reduction in maternal mortality.

Promoting human rights and gender equality and by strengthening laws against gender-based violence and the implementation of comprehensive sexuality education (CSE), CO implemented interventions in partnership with other development actors in the field to reduce the unmet need for family planning, ensuring the safety and dignity of all women, girls, adolescents, youth and key populations.

CP4 aligns with Timor-Leste's national strategies and has supported the GoTL in conducting regular population and housing censuses, gathering accurate demographic data. The most recent census in 2022 was the first digitalized census, which aimed to provide detailed insights into population distribution, fertility rates, and migration patterns.[32] This data is crucial for effective policymaking and planning. The 2022 TLPHC is a major source of data for monitoring and evaluating the achievement of the TL SDP, MDG agenda and the SDGs. Furthermore, UNFPA also provided technical support for capacity building of INETL.[33]

Advocating for the availability, quality, timeliness and accuracy of thematic and statistical data that serve policy and decision-makers in addressing population and development issues, CP4 included interventions to strengthen the national capacity for the production and dissemination of quality databases, carry out studies and investment cases in demographic disparities, socio-economic inequalities, health economics analytics, adolescents and youth and gender-based violence. CP4 has attempted to integrate these into the four outputs at the CPD preparation time to achieve the three transformative results. The achievement of results is to be supported by the said six accelerators. Refer to the discussion on the TOCs under section 1.3.1, contribution analysis and theory of change.

Table 5. UNFPA Timor-Leste CP4 Programme (2021-2025)

UNSDCF: Outcomes 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.
Outcome 4: By 2025, the people of TL increasingly demand and have access to gender-responsive, equitable, high-quality, resilient and inclusive PHC and strengthen social protection including in times of emergencies
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.

[32] Timor-Leste Population and Housing Census 2022.
[33] Source: UNFPA Country Programme 2021-2025 document.

CP4 Programme (2021-2025)			
UNFPA Strategic Plan Outcomes (3)			
1. By 2025, the reduction in the unmet need for family planning has accelerated (Ending the unmet need for family planning)	2. By 2025, the reduction of preventable maternal deaths has accelerated (Ending preventable maternal deaths)	3. By 2025, the reduction in gender-based violence and harmful practices has accelerated (Ending gender-based violence and all harmful practices)	
Country Programme Outcomes (4)			
1. Sexual and Reproductive Health Every woman, adolescent and youth in Timor-Leste, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.	*2. Adolescents and Youths* Every adolescent and youth, in particular adolescent girls, is empowered to have access to SRH and Reproductive Rights in all contexts	*3. Gender and Women's Empowerment* Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.	*4. Population Dynamics* Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.

Country Programme Outputs (5)

Under the SRHR Outcome, there are three outputs:

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 the 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 of 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, and contributing to reduced stigma and discrimination towards people living with HIV.

Under the Adolescents and Youths Outcome, there is one output: Output 2.1: The national capacity to implement community and school-based comprehensive sexuality education programmes that promote human rights and gender equality is strengthened

Under the Gender and Women's Empowerment Outcome there is one Output:3.1 The capacity of relevant government institutions and non-government organizations to implement the National Action Plan on GBV is strengthened.

This output is also closely linked with outputs 1 and 2 under outcome 1 (SRHR) and output under outcome 4 (PD) where UNFPA will closely work with the General Directorate of Statistics to strengthen their capacity to collect and analyse data related to GBV, including domestic violence and intimate partner violence, in line with international and regional standards to inform laws, policies and programmes.

The output will be partially achieved though the joint programme with four other United Nations agencies through the Spotlight Initiative.

Under the Population Dynamics Outcome there is one Output 4.1: National capacity for production and dissemination of high-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.

3.2.3 Geographical Coverage of CP4 Interventions

UNFPA's programmatic interventions in Timor-Leste encompass all four outcome areas and extend across all 14 municipalities, including the Oecusse (RAEOA) special administrative region. The capital city of Dili, as the most populous urban centre, maintains the highest density of UNFPA programming, with 20-30 recorded interventions Figure 6. This elevated coverage in Dili can be attributed to the city's large and growing population, as well as the centralization of many essential services within the national capital, which has resulted in significant rural-to-urban migration.

Other municipalities exhibiting relatively high UNFPA intervention densities, ranging from 15-19 recorded activities, include Bobonaro and Covalima, which border Indonesia's East Nusa Tenggara province, as well as Ermera, one of Timor-Leste's most economically disadvantaged municipalities. The eastern municipalities of Baucau and Viqueque also fall within this higher intervention bracket (Figure 6). In terms of the thematic focus of UNFPA's programmatic interventions in Timor-Leste, it reveals that SRH activities maintain the broadest presence across all municipalities (Figure 7). This is followed by GEWE initiatives, which are implemented in selected target locations.

The adolescent and youth (AY) and population and development (PD) programme components also extend across all municipalities, though with a lower overall number of discrete interventions or activities compared to the sexual and reproductive health and GEWE focus areas (which are often integrated).

Figure 6. UNFPA CPD 4th Intervention Map by Coverage across Municipalities

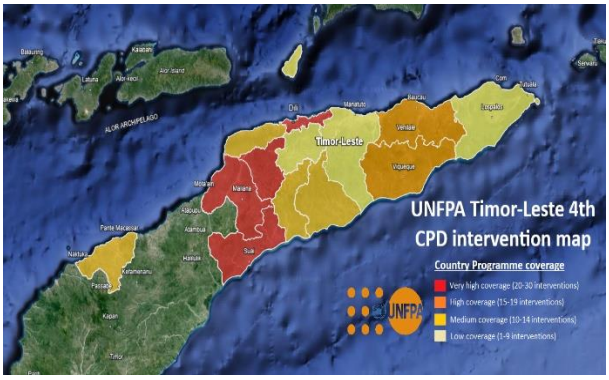
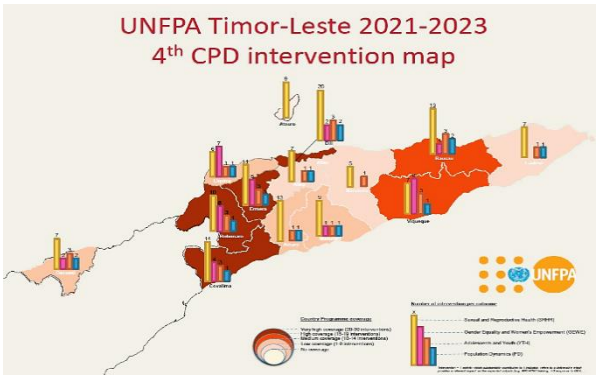


Figure 7. UNFPA TL CP 4th Intervention Map by Outcome Areas across Municipalities



3.2.4 The Country Programme Financial Structure

At the time of the CPD development, CP4 had an indicative allocation (planned resources) of USD 6.4 million from regular (core) resources and USD 10.2 million from other (non-core) resources, totalling USD 16.6 million for the programme (Table 6). While this was only an indicative figure, actual budget allocation and utilization up to the end of June 2024 is shown in table 7 below.

Table 6. Overview of the Budget (Indicative Allocation in millions) for the Programmatic Areas of CP4: 2021-2025

Strategic Plan Outcome Area/ Programme Outcome Areas	Regular Resources	Other Resources	Total
Outcome 1: Sexual & Reproductive Health	3.0	5.5	8.5
Outcome 2: Adolescent and Youth	1.0	0.9	1.9
Outcome 3: Gender Equality & Women's Empowerment	0.6	3.5	4.1
Outcome 4: Population Dynamics	1.2	0.3	1.5
Programme coordination & assistance (PCA	0.6	-	0.6
Total	6.4	10.2	16.6

Source: Timor-Leste Country Office CPD

Table 7. Overview of the Resource Allocation and Expenditure (Regular Resources and Other Resources) for the Programmatic Areas of CP4, Jan 2021-Jun 2024 (By June 30)

	2021	2022	2023	2024 (30th June)	TOTAL
Regular Resources (RR)					
Outcome 1: Sexual Reproductive Health					
Allocations	$411,021.54	$484,075.75	$697,309.90	$870,049.42	$2,462,456.61
Expenditures	$349,721.45	$482,991.00	$677,848.28	$524,529.62	$2,035,090.35
Imp. Rate	85%	100%	97%	60%	83%
Outcome 2: Youth & Adolescent					
Allocations	$45,902.88	$42,968.20	$152,809.24	$126,525.42	$368,205.74
Expenditures	$30,170.87	$40,462.19	$157,566.63	$22,199.79	$250,399.48
Imp. Rate	66%	94%	103%	18%	68%
Outcome 3: Gender and Women's Empowerment					
Allocations	$186,583.02	$78,784.57	$116,673.23	$46,183.48	$428,224.30
Expenditures	$93,087.95	$73,880.64	$103,500.09	$1,760.36	$272,229.04
Imp. Rate	50%	94%	89%	4%	64%
Outcome 4: Population Dynamics					
Allocations	$607,397.11	$664,909.48	$539,047.00	$593,458.00	$2,404,811.59
Expenditures	$361,796.40	$592,517.87	$528,904.34	$463,864.80	$1,947,083.41
Imp. Rate	60%	89%	98%	78%	81%
Programme Coordination & Assistance (PCA)					
Allocations	$106,867.00	$165,955.00	$200,000.00	$-	$472,822.00
Expenditures	$88,395.27	$152,610.70	$201,232.03	$1,386.74	$443,624.74
Imp. Rate	83%	92%	101%		94%
TOTAL Allocations	$1,357,771.55	$1,436,693.00	$1,705,839.37	$1,636,216.32	$6,136,520.24
TOTAL Expenditures	$923,171.94	$1,342,462.40	$1,669,051.37	$1,013,741.31	$4,948,427.02
Other Resources (OR)					
Outcome 1: Sexual Reproductive Health					
Allocations	$1,284,245.71	$1,976,334.30	$1,425,219.57	$2,577,567.98	$7,263,367.56
Expenditures	$912,914.12	$1,667,880.37	$1,143,190.02	$997,158.56	$4,721,143.07
Imp. Rate	71%	84%	80%	39%	65%
Outcome 2: Youth & Adolescent					

Allocations	$7,880.00	$15,367.00	$72,349.00	$69,022.34	$164,618.34
Expenditures	$-	$13,768.96	$8,120.06	$41,888.48	$63,777.50
Imp. Rate	0%	90%	11%	61%	39%
Outcome 3: Gender and Women's Empowerment					
Allocations	$1,213,739.90	$511,298.24	$2,182,849.04	$126,115.31	$4,034,002.49
Expenditures	$566,779.85	$299,494.54	$1,669,641.18	$121,261.59	$2,657,177.16
Imp. Rate	47%	59%	76%	96%	66%
Outcome 4: Population Dynamics					
Allocations	$-	$20,035.94	$38,500.00	$190,898.00	$249,433.94
Expenditures	$-	$19,415.50	$5,029.64	$27,102.23	$51,547.37
Imp. Rate	0%	97%	13%	14%	21%
Total Allocations	$2,505,865.61	$2,523,035.48	$3,718,917.61	$2,963,603.63	$11,711,422.33
Total Expenditures	$1,479,693.97	$2,000,559.37	$2,825,980.90	$1,187,410.86	$7,493,645.10

Source: Country office UNFPA Timor-Leste (Updated by the 30th of June)

In 2021, the UNFPA Country Office in Timor-Leste faced significant challenges in budget execution, particularly with Other Resources (OR) funding. The implementation rate was lower due to the impact of the COVID-19 pandemic, which disrupted many planned activities. For instance, the Comprehensive Sexuality Education (CSE) initiative under the Adolescent and Youth programme could not be implemented as planned due to movement restrictions, such as school closures. Additionally, no OR funding was allocated for the Population and Development (PD) programme that year. Compounding these issues, Timor-Leste experienced a severe humanitarian crisis in April 2021 when floods displaced many people, especially in the capital, Dili. In response, UNFPA coordinated with other agencies to support the government's humanitarian efforts.

In 2022, the budget execution situation significantly improved, with an execution rate exceeding 80% across all areas. However, the Gender and Women's Empowerment programme continued to experience lower budget execution, a challenge that persisted from 2021 through the 2021-2023 period.

In 2023, new challenges emerged following a change in government. The transition, which lasted nearly a semester, resulted in disruptions to staff and management. This affected the implementation of activities, particularly those involving the Ministry of Health, as many staff lacked the capacity to execute the required tasks. These delays led to lower execution of the allocated funds during the year.

As of June 2024, the latest budget is presented. Despite the significant budget execution challenges faced in previous years, including in 2021 and 2023, improvements were made in 2022.

Chapter 4: Findings - Answers to the Evaluation Questions

Note: This chapter answers the 10 evaluation questions (EQs) and related assumptions that were considered during the evaluation design phase (in Annex 1). Although the Evaluation Handbook suggests 6-8 questions, after discussing with the CO, ET decided to keep to 10 questions to make the report useful to the CO. In instances where responses overlap or are repeated across individual programme outputs, ET refers to the corresponding number of the finding to guide the reader. Responses to some EQs are combined as based on the applicability, while those specific to individual outputs, particularly the EQs on effectiveness of CP4 interventions are described separately. For detailed background information to the findings, please see the evaluation matrix in Annex 1. As stated under the methodology, the findings below are based mainly on document review, interview feedback and observations. Key Lessons learned and positive and negative intended and unintended results and challenges are embedded in the findings and conclusions and are not illustrated under any separate heading.

4.1 Answer to Evaluation Questions on 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, LGBTQI, people at risk of and living with HIV, and other marginalised groups, needs of government and civil society organisations 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?

(EQ1 and EQ2 are addressed together as relevant to all four outcome areas SRHR, AY, GE and PD)

4.1.1 Relevance

Summary findings:

CP4 consists of four interconnected outcomes that align closely with the UNFPA Strategic Plan 2022-2025 and directly relate to the three transformative results relevant to the SDGs. CP4 population and development output aligns with Timor-Leste's national strategies and has supported the GoTL to conduct regular population and housing censuses, which aimed to provide detailed insights into population distribution[34]. While essential for effective policymaking and planning, the 2022 TLPHC is a major source of data for monitoring and evaluating the achievement of the TL SDP, and the SDGs.

The CP4 is well aligned with most of the SRH-related SDGs such as 3.1.1,3.1.2,3.2.2 and 3.7.1[35]. The alignment of CP4 with the SDGs is clear except for the adolescent and youth output where the interventions aimed at reducing adolescent fertility and early marriages are absent from the program, specifically those addressing SDGs 3.7.2 and 5.3.1. Notably, while adolescent fertility is included as one of the UNSDCF outcome indicators, relevant data or references to adolescent fertility are lacking in national SDG documents.

The incorporation of key accelerators mentioned in the strategic plan is evident in CP4 interventions, which adopt

[34] Timor-Leste Population and Housing Census 2022.

[35] MMR, 3.1.2- skilled birth attendants, 3.2.2- neonatal mortality, 3.7.1 women of reproductive age who have their need for FP satisfied with modern methods of contraception.

a human rights-based and gender-transformative approach that emphasizes the principle of leaving no one behind.

Overall, CP4 effectively addresses diverse needs through a comprehensive approach that spans four programmatic areas: SRHR including the health sector's response to GBV, gender equality and women's empowerment (GEWE), AY, and PD. The country office actively responds to shifts in national needs and priorities, particularly those affecting vulnerable populations. The Program emphasizes strengthening data collection and analysis to better identify the specific needs of women and girls, incorporating gender-sensitive approaches and engaging CSOs to reach underserved populations. However, there remains a limited focus on an intersectionality approach to identify the needs of women and girls with disabilities and members of the LGBTQI community, etc., based on how multiple categories of social identity may interact with each other. The restrictions under the National FP Policy limit the access of adolescents and unmarried to contraceptives. Currently ASRH services are not provided in health facilities. SRH education is covered under CSE. Strategies to address stigma and discrimination towards PLWHA) are also being developed and the National Strategic Plan for HIV and Viral Hepatitis 2022-2026 focuses on prevention, screening, and treatment among key populations.

Finding #1: CP4 is aligned with the three transformative results and the six accelerators and with the relevant national SDG targets.

The four CP4 outcomes and interventions under five outputs contribute directly to the three transformative results outlined in the 2022-2025 UNFPA Strategy Plan (see table 5 for clarity on linkages to UNSDCF and SP) and support relevant SDGs, specifically 3 and 5. In designing CP4, interventions are aligned with key accelerators. For example, the outputs on HIV/AIDS, maternal *health, GEWE have* used human rights-based and gender sensitive approaches targeting key populations and striving to reduce stigma and discrimination against PLWHA. Partnership established with WHO and CSOs focusing on HIV prevention further enhance these efforts.[36] Human rights-based and gender sensitive approaches are evident in the provision of quality maternal health services, such as BEmONC. Efforts to leaving no one behind are exemplified through BEmONC facilities established in hard-to-reach areas, alongside collaborations with WHO, UNICEF and donors like the Government of Japan for BEmONC Improvement and Maternal and Perinatal Death Surveillance and Review (MPDSR). UNFPA's support for midwifery education has effectively used SSTC mechanisms to achieve its objectives.[37] Examples of innovation can be found under the finding 7 related to HIV and also finding 28; evidence of digitalization through e-LMIS and m-Supply and digitalization of Census, and resilience/adaptation/nexus under the humanitarian findings, keeping in line with the accelerators.

The full alignment of CP4 with SDGs is unclear, as interventions aimed at reducing adolescent fertility and early marriages[38] are missing (specifically SDGs 3.7.2 on adolescent fertility rates for ages 10-14 and 15-19, and 5.3.1 on the proportion of women aged 20-24 married or in union before ages 15 or 18). Adolescent fertility remains one of the UNSDCF outcome indicators; however, relevant data or references are absent from national SDG documents. No data target mentioned for adolescent fertility except a statement to reduce adolescent pregnancy. Additionally, some policies do not align with the needs of the adolescents and key populations as discussed in the findings on SRHR, AY effectiveness and elsewhere.[39]

[36] CPD, Discussions with Programme staff on TOC and Programme Presentations by CO staff, document review
[37] Ibid
[38] CSE training modules include prevention of early marriage; however, there is limited evidence of the implementation of the CSE programme nationwide.
[39] ibid

Finding #2: The objectives and strategies of the CP4 programme components are consistent with* UN frameworks, relevant *national and sectoral policies, including in the development and humanitarian contexts.

CP4 demonstrates strong alignment with various UN frameworks and integrates the core principles of the ICPD, focusing on reproductive health and rights, gender equality, and population issues. This integration ensures that efforts towards gender equality are not isolated but are part of a broader approach to human development and rights. The programme significantly contributes to SDG 3 (Good Health and Well-being, particularly SRHR related indicators) and SDG 5 (Gender Equality) by addressing GBV and promoting women's empowerment, directly supporting the achievement of these global goals within the context of Timor-Leste (as evident from M&E reports, annual reports).

In TOC presented by CO, output 3 reflects national priorities as outlined in the (TLNSDP 2011-2030) and the objectives of National Action Plan for Gender-based Violence (NAP-GBV), both the 2017-2021 versions and its revision for 2022-2032. CP4 also prioritizes enhancing GEWE while focusing on preventing GBV and improving the health sector's response to it, in accordance with its global mandate. Gender concerns are mainstreamed throughout the design and implementation of CP4 treated as a cross- cutting issue, including in humanitarian responses. CP4 provides targeted support to the NAP-GBV 2 for 2022-2023 building on the technical support provided during the revision of the initial NAP-GBV. GBV remains a priority under the Ninth Constitutional Government, and CP4, particularly its outcome area focused on GEWE, aligns closely with national development strategies, the UNFPA Strategic Plan 2022-2025, and other UN frameworks in addressing GBV and promoting women's empowerment in Timor-Leste.[40]

National FP policy 2022 promotes various family planning methods; however, law restricts FP access to unmarried adolescents. SRHR is in line with the country's National Health Sector Strategic Plan 2011-2030 (with few exceptions such as ASRH services, pre-conception care, cervical cancer screening and management), National HIV and STI strategy, and Reproductive Health Commodity Strategy (details discussed key populations in section 2.1.2).

UNFPA plays a key role in supporting censuses, demographic and health surveys, and other large-scale data-gathering exercises, and provides technical support for the analysis and dissemination of the information generated. Population development output in CP4 is line with the NSDP 2011-2030 and the main national surveys such as census, DHS come under this national strategy for population dynamics.[41]

In the humanitarian context, capacity-building initiatives, particularly MISP and essential services, are integrated into CP4 programming (annual reports, humanitarian response reports), with further details outlined in evaluation questions 3, 9 and 10. However, it should be noted that the national policies do not reflect MISP (also see Finding 9).

UNFPA's support for specific interventions in CP4 aligns with government needs, adhering to its mandate and strategic priorities. Work plans are guided by these priorities, incorporating recommendations from the previous cycle, government agreements, national policies and strategies, emerging needs, and available funding.

[40] Document review, CO staff debriefing presentations and interviews

[41] Timor Leste National Strategic Development Plan 2011-2030, Annual Reports, CO staff presentations and interviews.

Finding #3: The CP4 initiatives for adolescents and youth align with national priorities and effectively contribute to the country's development goals but are inadequate in addressing adolescents and youth's sexual and reproductive health services that could affect their development and productivity in the long-run.

UNFPA CP4 initiatives for adolescents and youth[42] align with the Timor-Leste's National Youth Policy[43] and relevant government strategies, ensuring coherence with national priorities and effectively contributing to the country's development goals. The programme emphasizes CSE and has developed resources such as the Healthy Relationship Manual for out-of-school youth and the Boys and Girls Circle manual for in-school youth, addressing the specific needs of vulnerable populations[44]. Despite challenges such as limited resources and community resistance, UNFPA partners and collaborates with the government and local organizations to improve youth awareness and understanding of CSE. However, access to SRH services for adolescents remains insufficient under CP4, despite the inclusion of adolescent and youth health in the national health strategic plan (2011-2030). Given the prevalence of HIV, STI[45]this could affect health conditions of youth affecting their development, missing school due to teenage pregnancy etc. As table 8 below indicates, HIV/AIDS prevention, testing and treatment services had covered a good number of adolescent and youth, however the contribution from UNFPA was discontinued due to lack of funding.

Finding #4: The needs of the targeted populations[46] and the capacities of IPs to deliver the specific services to targeted populations (both government and non-governmental development partners) have been identified in the CP4 planning, implementation, and monitoring of interventions under the Country Programme Action Plan. While progress has been made, challenges remain in addressing the sexual and reproductive health and rights of adolescents and youth.

CP4 was developed in consultation with government implementing partners and collaboration with local civil society partners. CP4 overall design provides strong emphasis on reaching vulnerable and marginalized populations to improve their access to services. The inclusion of LGBTQI and those with disabilities is also stated in the project design; however, their participation has not been adequately reported or visible in the programme implementation.[47] CSOs representing the PWDs and LGBTQI were not visible at the time of the evaluation. Under the HIV programme, there had been an active programme implementation to work with PLWHA, and had been inclusive, covering LGBTQI and other marginalized populations, however due to resource constraint this programme has been discontinued. The programme focused on women and girls, adolescents and youth, survivors of gender-based violence, and key populations.

CSOs like the Alola Foundation, Belun, FOKUPERS, and HAMNASA KP+ play key roles in supporting the national government and development partners, including UN agencies by delivering services and outreach programmes to the beneficiaries. The country office expressed satisfaction with these CSOs' contributions; especially in implementing joint UN projects as addressing GBV prevention and responses and CSE (see Findings 9 and10). UNFPA selects implementing partners, particularly CSOs, based on their

[42] UNFPA Country Programme Document 2021-2025
[43] Document of National Youth Policy 2016.
[44] UNFPA Timor-Leste "Healthy Relationship Manual". 2023
[45] Timor Leste Population and Housing Census 2022- Main Report
[46]Vulnerable and marginalized groups, including women and girls, PWDs, adolescents and youth, survivors of gender-based violence, and people living with HIV
[47] workshop report, CO staff feedback (interview), KP+ interview.

ability to reach vulnerable and marginalized populations, ensuring technical expertise and alignment with programme needs. Regular assessments and reviews help identify their roles, monitor progress, and address challenges to enhance programme implementation.[48]

For example, HAMNASA, a CSO, is acknowledged for its expertise in health sector responses to GBV and its significant role in building the capacity of health workers. Within CP4, HAMNASA led a major GBV awareness campaign across four municipalities, leveraging its grassroots networks and community trust to effectively reach vulnerable populations.[49] However, CSOs, including HAMNASA, emphasized the need for further strengthening long-term partnerships through capacity-building and consistent financial support capacity to better advocate for and implement the National Action Plan on GBV, ensuring they can provide essential services to GBV survivors and other at-risk groups (see Findings 11).[50]

While progress has been made, challenges remain in addressing the sexual and reproductive health and rights of adolescents and Youth. The current Programme (CP4) focuses primarily on CSE for in- and out-of-school youth, alongside community awareness efforts to end GBV, implemented through CSO partners like FOKUPERS, Alola Foundation, and HAMNASA. Only in 2023, the programme has taken some progress (see table 8 below). However, beyond raising awareness, essential youth-friendly services such as family planning, contraceptives, and SRHR counselling remain largely absent, limiting young people's access to comprehensive care.[51]

Interviews with midwives revealed that young individuals may seek help for menstrual issues, but there are no incentives or campaigns promoting counselling and guidance. Young people typically only seek advice related to SRH when planning to conceive or during pregnancy with a partner. Prevailing taboos around single youth seeking SRHR support in public facilities exacerbate the problem, showing that CSE alone is insufficient to address these deep-seated norms. A more interconnected approach, combining CSE with accessible, youth-friendly SRHR services and proactive campaigns, is essential, but currently lacking, to effectively meet the needs of young people and challenge societal barriers. UNFPA has also implemented various initiatives in partnership with CSOs, focusing on improving maternal health, expanding FP, addressing GBV, and empowering women and girls. An online survey of CSOs (N=13) conducted by UN Women, as input for both the UNFPA and UN Women CPEs, revealed 80% of the CSO who responded identified women and girls as a disadvantaged/marginalized group, around 60% mentioned PWDs and people in rural areas, and over 30% highlighted children and sexual minorities as marginalized groups. The root causes identified were a lack of job opportunities (42%), a patriarchal system (33%), and limited knowledge and access to information (25%). This corresponds with the focus given to disadvantaged women and marginalized groups in the CP4 interventions, however, inclusion of PWDs and remote rural area population could get more attention by the UNFPA country programme. The respondents to the survey also agreed that Timor-Leste has a strong and active civil society advocating for the rights of disadvantaged groups and this is an opportunity that UNFPA can explore to include PWDs in the programme in a meaningful way.

As highlighted in Finding 7, UNFPA CO's partnership with three CSOs that support vulnerable and at-risk populations at the national level and in selected regions has garnered significant recognition and

[48] CSO review reports, Feedback from CSOs and CO staff

[49] HAMNASA. (2023). Communities Ending Gender-Based Violence Activity: Quarterly Report Sept-Dec 2023. Dili, Timor-Leste: UNFPA.

[50] UNFPA CP4 Evaluation Team. Key informant interviews with FOKUPERS, Belun, Alola, HAMNASA. Conducted between July 1 and July 26, 2024

[51] CP4 programme documents, CSO interviews and CO staff presentations

achieved notable results. However, the discontinuation of contractual agreements with some CSOs due to funding shortages and the absence of a dedicated officer raise concerns and reflect poor practice. Furthermore, no assessment has been conducted on the SRH needs of people with disabilities, despite being mentioned in the essential service package. As indicated in the above survey, around 60% of CSOs identified PWDs and people in rural areas as marginalized groups, underscoring the need for targeted interventions. Capacity-building programs for SRH services lack tailored components for people with disabilities, and there is no evidence of prioritizing this group during humanitarian crises. While training materials for the health sector's response to GBV include provisions for the care of people with disabilities, aligning with the National Action Plan against GBV and the National Guidance on Health Sector Response to GBV, gaps remain in practice. Field visits also revealed a lack of services specifically for people with disabilities, although awareness among rights holders about their special needs has improved due to previous awareness-raising and capacity-building initiatives.

Table 8. 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.

4.2 Answer to Evaluation Questions on Effectiveness

This section on effectiveness criteria addresses specific questions EQ3 and EQ4 and in general, the extent to which the CP4 interventions achieved, or is expected to achieve, its objectives and results. Outputs related to each of the four CP outcomes are discussed under SRHR (4.2.1), AY (4.2.2), GEWE (4.2.3), PD (4.2.4) and 4.2.5 Humanitarian Response. Since Coverage and Connectedness address most of the related issues on humanitarian response, cross referencing is done to avoid repetition.

Answer to EQ 3 on Effectiveness:

EQ 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?

EQ 3 is directly linked to the interventions supported by UNFPA across three key outputs under SRHR as shown on the table 5:

The first two outputs (refer to table 6 on CP4 outcomes and outputs) contribute directly to the Strategic Plan 2022-2025 outcomes aimed at addressing unmet family planning needs, preventing maternal deaths, and eliminating GBV and harmful practices.

The findings presented in this section is based on a comprehensive document review, including CO materials such as Monitoring and Evaluation (M&E) reports, implementing partner reports, technical reports, and insights gathered from stakeholder interviews and focus group discussions, as detailed in Annex 5 notes and Annex 1 Evaluation Matrix.

4.2.1 Sexual and Reproductive Health: Effectiveness

Summary Findings:

- Of the total nine CP output 1.1-1.3 indicators, three output indicators have achieved the targets (MPDSR implementation, support to midwifery schools and support to CSOs for improving comprehensive knowledge about HIV). Progress is noted in five indicators (CHCs offering comprehensive SRHR services, and services for survivors of GBV, facilities with no stockout of modern methods of contraception, facilities offering BEmONC services and people tested for HIV with results known). On one of the indicators related to stigma and discrimination towards PLWHA is not available.
- Advocacy efforts towards universal access to FP services under the National FP Policy have been insufficient. However, the contributions to increasing the coverage of services and quality have increased the use of modern methods of contraception (though no recent data on Contraceptive Prevalence Rate (CPR) is available).
- UNFPA's leadership in managing the supply chain for reproductive health commodities and the e-Logistics Management Information System (e-LMIS) is well recognized by the MOH and donors. The signing of the Supplies Compact by the MOH and the establishment of the Third-Party Procurement (TPP) mechanism for procuring contraceptives and other reproductive health commodities are significant achievements and demonstrate the government's commitment to funding family planning services. However, there are concerns about stockouts of certain commodities at the facility level.

The capacity building for provision of FP services, strengthening supply systems and establishment of TPP significantly contribute to achieving the CP Outcome related to increase in CPR and SP outcome of reducing unmet need for FP.

- UNFPA plays leadership role in the health sector's response to GBV by enhancing the capacity of doctors and midwives to manage survivors, gaining support from municipal administrators, and expanding services in CHCs. Notable contributions include incorporating GBV case management into pre-service midwifery training and advocacy to include in medical and nursing curricula. However, there are concerns about sustaining the support for the operationalization of safe spaces for GBV survivors and the training needed for managing sexual assault cases.

The investments contribute to achieving the CP outcome related to the care seeking by those affected by GBV and SP Outcome related to GBV.

- The ongoing initiatives to build capacity for implementation of MISP during humanitarian crisis and to improve the integration of SRHR services needs further strengthening. The CP has missed few of the critical SRHR services under the ESP such as the ASRH services, pre-conception care and screening and management of cervical cancer.
- As the sole agency supporting MOH in improving access to functional BEmONC centres and supporting midwifery education to meet international standards, UNFPA's contributions to increasing deliveries by skilled birth attendants and potential decrease in maternal and perinatal mortality is significant. UNFPA's contribution to MPDSR along with WHO and UNICEF is significant especially in establishing the system at municipal level. However, more needs to be done in improving the quality of MPDSR in terms of timeliness, analysis and responses, the quality of ANC and PNC services and strengthening midwifery to further contribute to improving maternal health.

The support for maternal health and midwifery contribute to the CP Outcomes of increased deliveries by skilled birth attendants and reducing MMR and to the SP Outcome of reducing preventable maternal deaths.

- UNFPA's support for the HIV/AIDS program has garnered recognition but led to disappointment among implementing partners this year due to the lack of continued funding. As a sub-recipient of the Global Fund, UNFPA collaborated with a CSO working with key populations to provide basic package of services. UNFPA also supported CSOs to reduce stigma and discrimination towards PLWHA through outreach programmes. The above support contributes to CP Outcome indicator related to increasing knowledge of HIV. Unfortunately, due to funding issues and lack of a dedicated officer for the programme, the activities could not be carried out.
- UNFPA's contributions during the COVID-19 pandemic, including support for the MOH in maintaining SRH services and assisting GBV survivors, have been appreciated by all partners. Key efforts included capacity building for managing COVID-positive pregnant women, establishing a maternity isolation centre, and providing on-line support to BEmONC-trained providers. The materials developed during this period laid the foundation for national guidelines on ANC and PNC. During floods, both fixed and mobile clinics offered support to pregnant and postnatal mothers, along with assistance for GBV survivors.

Findings #5: Significant progress has been made in building the capacity of the national health system to provide quality and rights-based SRH services, but significant gaps remain in integration of SRH services and accessibility of vulnerable populations, including adolescents and persons with disabilities. This finding points to the need for continued advocacy and support from UNFPA.

The areas of focus under CP Output 1 include high-quality, rights-based integrated SRH and HIV services, specifically targeting family planning services, supply system management, health sector responses to GBV, and SRH services during humanitarian crises through the delivery of MISP.

The current National Family Planning Policy 2022, while promoting quality FP services for married couples and for spacing births, is restrictive in terms of access of adolescents and couples who want to limit their families and bans the availability of emergency contraceptive pills (details are provided in Annex 1 under SRHR field notes). The restrictions impinge on the rights of adolescents and married couples wanting to limit their family size and significantly restrict the choice for preventing unwanted pregnancy from sexual assault. The restrictions also are a setback to UNFPA's mission of reducing unmet need for FP. UNFPA's past advocacy efforts had helped to overcome the political and religious barriers to universal access to FP and its inclusion in the ESP under the National Health Strategic Plan. Despite the policy gaps, due to continued advocacy by UNFPA, the MOH remains committed to FP, as evidenced by the signing of the Supplies Compact by MOH (see supplies management section). UNFPA continues to be the primary agency for FP services in the country, focusing on capacity building for delivery of quality services for short-acting and long acting spacing methods and provision of supplies and equipment as evident from annual reports and stakeholder interviews. 6,000 clients from underserved areas were provided FP spacing services through outreach clinics (see Chart 1 in Annex 5 SRHR charts, sourced from UNFPA annual reports). Ninety one doctors and midwives were certified competent in delivering rights-based FP services and their competence was confirmed during facility visits. However, there are gaps in the current training package as FP services for people with disabilities and survivors of GBV are missing and services exclude adolescents and key populations (more information on the training and partnerships is available in Annex 1 on SRHR field notes). During field visits, it was observed that FP is well-integrated with maternal health services but there is a notable lack of integration with HIV/STI services and services for GBV survivors. The current efforts to refine FP indicators, integrating HIV/AIDS services and referral systems, may fill in some of the gaps. As the sole supplier of contraceptives, UNFPA has significantly contributed to improving the use of modern methods of contraception (see Chart 2 in

Annex 5 SRHR Charts) and possibly to CPR which is a CP Outcome indicator (CPR data will be available in 2026 after the DHS is done) and to reducing unmet needs (SP Outcome indicator).

UNFPA is recognized by the MOH and donors for its leadership in Reproductive Health Commodities Supply (RHCS) and access to quality contraceptives. Key achievements include the continued implementation of the RHCS strategy from the previous country program, the institutionalization of the FP Logistics Management Information System (LMIS), and a national assessment of RH commodities conducted in 2022, which evaluated services across numerous health posts, CHCs, and hospitals. Additionally, UNFPA has strengthened the m-Supply electronic logistics management system and established a MoU with MOH for 2022-2027, along with a TPP agreement with the National Institute for Pharmacy and Medical Products of Timor-Leste (INFPM) signed in 2022. The above efforts have led to capacity building in forecasting, timely replenishment of supplies and reduced stockout situations as noted in Annex 5 on CP Outcomes and Outputs. Concerns about the interpretation of this indicator are described Annex 5 CP Outcomes and Outputs. Furthermore, UNFPA's advocacy has led to the signing of the Supplies Compact by MOH, facilitating the procurement of reproductive health commodities—including contraceptives, maternal health supplies, and HIV/Syphilis test kits—using domestic resources since 2022 (evidence-MOU with MOH, proforma invoices, reports).

As noted in Annex 1 SRHR field notes, UNFPA's technical assistance and collaborations assisted with the reactivation and expansion of the m-supply system established by MOH and Partnership for Human Development (PHD), with the revision and implementation of the FP LMIS system and with the efforts to integrate LMIS into the District Health Information Software (DHIS 2). Despite the progress with logistics management, serious gaps in supply systems at the facility levels were observed during field visits, such as, the persistent stockouts oral pills and condoms due to inadequate indents and prioritization of fast-moving contraceptives. Significant shortage of reagents for haemoglobin estimation and urine tests (MOH procurement) and shortage of kits for screening HIV, Syphilis and Hepatitis B in ANC clinics were observed, affecting the quality of services. Though commodities such as condoms and HIV/STI screening kits are included in the programmes managed by the MCH Directorate and National AIDS Control Programme, the forecasting of the needs of these commodities are not done jointly. The gaps listed above and feedback from stakeholders call for continued technical support to MOH and INFPM to ensure a well-functioning supply system which is a critical element of quality improvement.

The MOH's ESP includes support for GBV survivors at all health facility levels. GBV remains a key focus under the Ninth Constitutional Government. UNFPA has taken the lead in the health sector response to GBV, both independently and through joint programs funded by the EU and KOICA through a health systems approach. UNFPA's contributions include improving access to quality, confidential health services and building the capacity of healthcare providers at all levels of the health system to identify, manage, and refer GBV survivors (in-service and preservice). As noted in Annex 5, CP Outcomes and Outputs, few CHCs have been strengthened to provide services for survivors of GBV including safe spaces and are likely to achieve the target of the CP output with inclusion of more CHCs. Some of the key achievements under capacity development include the development of standard operating procedures for managing survivors and referrals, collaboration on adaptation and expansion of the existing training materials to meet WHO standards, standardized training of 352 midwives and doctors and municipal administrators for service implementation across ten municipalities (see Chart 3 in Annex 5, SRHR charts and Annex 1 SRHR field notes for details). During facility visits, high level of awareness about GBV, its management, referral pathways and the need for confidentiality were found among the providers and administrators (observations during field visits as detailed in Annex 1 on SRHR field notes). The support to incorporating GBV in the pre-service midwifery curriculum of midwifery schools (in

collaboration with WHO and La Trobe University) and advocacy to include in nursing and medical education is a sustainable approach. GBV has been incorporated in the midwifery curriculum of National University of Timor-Leste (UNTL) and Instituto Superior Cristal (ISC) and plans to introduce the topic in the curriculum of Instituto Ciência Saude (ICS) (CO reports on GBV and interviews with the staff of midwifery schools and Dean of Faculty of Medical and Health Sciences). The collaborative capacity building support for managing survivors of sexual violence, support for recording cases of GBV (ensuring data confidentiality), inclusion of GBV data in DHIS 2 for monitoring purposes and increasing community awareness through local NGOs and health education efforts are other key achievements (reported in CO reports and implementing partner reports). Most of the investments were put to good use during floods as discussed under Finding 8. The above investments significantly contribute to CP outcome and SP outcomes related to GBV. While many of the initiatives are sustainable, the functionality of safe spaces, investments in medico-legal aspects of sexual violence and integration of GBV into SRH services and training are concerns.

In support of the policy on integrated health programs and ESP, UNFPA developed operational guidelines for integrated SRH services within the primary healthcare context (details are in Annex 1 on SRHR field notes). However, based on the review of the guidelines and stakeholder interviews, it is evident that clarity on the process of integration of various services through common delivery platforms supported by enabling policies, skilled providers and other health system elements is needed.-With the frequent occurrence of floods and other natural calamities in the country and recognizing the need to ensure continuity of SRHR services, support was provided to build capacity of health service providers in the implementation of MISP and advocating for its inclusion in the national response and preparedness plans (reported in annual reports and in Annex 1 SRHR filed notes). This support came into use during the floods (see under Finding 8).

Three of the important components of the ESP, relevant for UNFPA as an Agency, that supports the reproductive rights of adolescents and women, are missing. These include ASHR services, cervical cancer screening and management and preconception care. These services are critical for achieving high degree of reproductive health and are elements of the RMNCAH strategy, currently being developed by MOH.[52]

The output has leveraged several accelerators in its interventions, including human rights-based, gender-sensitive and inclusive approaches in FP and digitalization through e-LMIS and m-Supply. Key partnerships with WHO, PHD, Marie Stopes Timor-Leste, and local NGOs, along with collaborations in the GBV program, have been developed to strengthen the delivery of interventions.

Finding 6: UNFPA's efforts in maternal health have led to improved access to quality BEmONC services as per national standards, improvements in care through development of ANC and PNC standards and guidelines, yet significant gaps remain, including the newborn care component of BEmONC, inadequate screening during pregnancy, antenatal contacts, gaps in postnatal care. Though significant progress has been made in establishing MPDSR committees in all the municipalities (achieving the output targets), concerns persist about the quality of MPDSR reviews. UNFPA's initiative to strengthen midwifery education through curriculum alignment with ICM standards and partnerships has made progress, yet challenges remain in ensuring uniformity in the curriculum of the schools and its implementation, employment opportunities, and the establishment of a regulatory framework.

[52] MOH: Draft RMNCAH Strategy 2024.

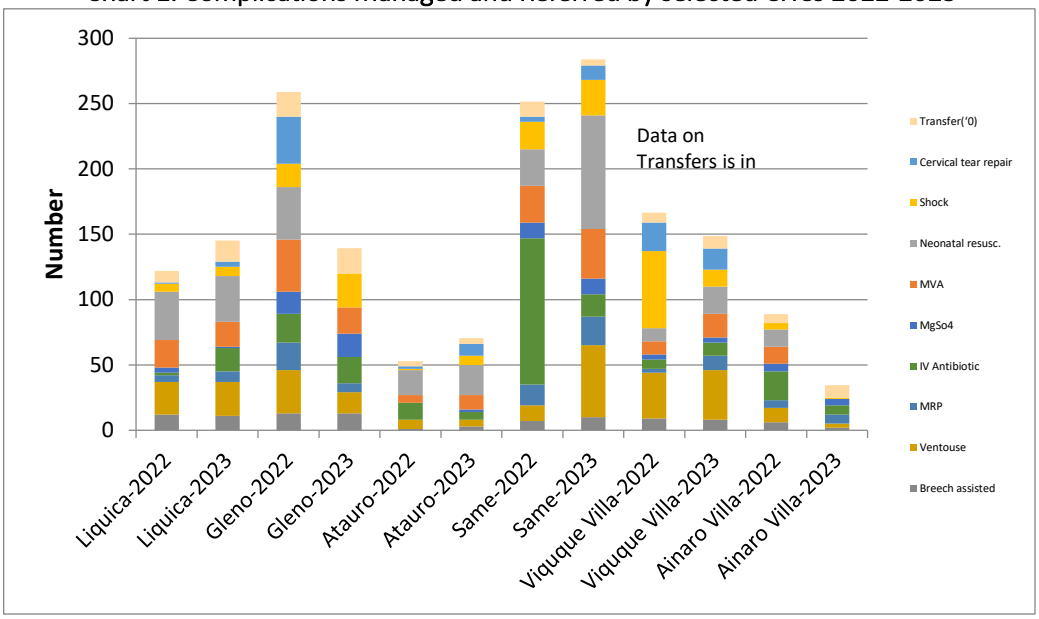
The areas of focus under Output 2 are improved access to quality BEmONC services, implementation of MPDSR and development of midwifery education as per ICM standards.

UNFPA's contributions to maternal health especially strengthening BEmoNC are recognized by the MOH, donors, and UN partners. Efforts to increase access to BEmONC facilities began in the last CP and have been further strengthened under the current CP. The reports on EmONC training and follow up indicate that 154 midwives and doctors (68% midwives), from all 14 municipalities, referral hospitals, and HNGV have been trained with nearly 80% of those trained actively providing BEmONC services (See Chart 4 Annex 5 SRHR charts). Good practices under this intervention include certification, creation of an active WhatsApp group of those trained for case discussions (continued during the pandemic), provision of essential equipments to manage complications such as manual vacuum aspiration syringes and Ventouse, regular monthly reporting of complications managed and mortality among mothers and newborns and stillbirths and regular monitoring visits by senior trainers (details are in Annex 1 of SRHR field notes).

Analytical findings of the reports are shared with the MOH and CHCs for further action (see Chart 1 for analysis of complications reported from 6 CHCs that are fully functional, along with Annex 5 SRHR charts 5, 6). The analysis of data from fully functional BEmONC centres indicates improved case management for most of the complications with reduction in transfers to referral facilities; however, it is too early to draw definitive conclusions including contributions to reducing MMR. The analysis also pointed to the need for further investigations in the cases of neonatal resuscitation, cervical tears, and the provision of IV antibiotics. During visits to BEmONC facilities, the evaluation team observed competent handling of childbirth complications (cervical tear repair and management of cord around the neck of the baby), with staff adhering to protocols for equipment maintenance and record-keeping. Mothers and newborns are kept in the facility for 24 hours as per WHO guidelines.

Feedback from CHC administrators, municipal authorities, and women who recently delivered was positive, highlighting the respectful and compassionate care received. One of the CP output targets is related to functional BEmONC centres and only six CHCs have been certified due to the stringent criteria followed (See Annex 5 Outcome and Output indicators). Besides the stringent certification process, another good practice followed is the selection of CHCs that are strategically located and accessible within two hours of travel time. The systems approach in strengthening BEmONC has attracted funding from the Australian Government and also significant support from the Japanese Government for establishing 20 BEmONC centres in 12 municipalities. Concerns were expressed by MOH and partners about the adequacy of newborn care provided in the facilities as well as the contents of newborn care in the protocols and training guides. (Details of the above findings are in Annex 1 SRHR field notes). Another concern is the missing practice of maternal and newborn “Near Miss” case reviews (a tool for improving quality).

Chart 1. Complications Managed and Referred by selected CHCs 2022-2023



During the pandemic lockdown, ANC, intrapartum and PNC guidelines for care of pregnant women positive for COVID in 2020 were developed (see also under Finding 8). Recognizing the need to enhance the quality of ANC and PNC, national ANC and PNC guidelines were developed (building on the guidelines developed during the pandemic). Capacity building for midwives and doctors has commenced. From the reviews of the manuals, few gaps were observed such as recommendations related to online ANC contacts in the third trimester of pregnancy (not aligned to WHO guidelines), recommendations on newborn care and its compliance to WHO guidelines and lack of clarity of management of HIV positive pregnant mothers that affects the prevention of mother-child transmission (given the prevalence of 0.3% among pregnant as reported in HIV Surveillance reports). During facility visits, it was noted that the services largely adhered to ANC guidelines including advice on FP; however, gaps were noted in screening for HIV, syphilis, and hepatitis B, as well as checking haemoglobin and urine, due to reagent shortages (as explained under the section on supplies under Finding 5) and management of decreased foetal movements (antenatal stillbirths are reported to be significant as discussed under the section on MPDSR). The current support to UNFPA's initiatives by the Japanese Government and its local NGO "Front Line", in building the capacity of doctors in ultrasound scan (in Ermera and Bobonaro) and its plans to expand the support to the BEmONC centres, should contribute to early management of antenatal foetal distress. No assessments on the impact of the capacity building initiatives have been done as the training and follow-up are continuing. The CP has certainly contributed to ANC and PNC coverage during 2022-2023 (Chart 7 of Annex 5 SRHR charts). More details can be found in Annex 1 on SRHR field notes.

Support for MOH regarding MPDSR is a collaborative effort involving WHO, UNICEF, and UNFPA, exemplifying joint support for the MOH. UNFPA's contributions include establishment of MPDSR committees in all the municipalities, updating national guidelines and training staff at HNGV and referral hospitals with the help of international experts. These contributed to achieving the CP output indicator target related to MPDSR (Annex 5 CP Outcomes and Outputs). However, concerns remain about the quality of the MPDSR process, particularly at the municipal level. From the review of MPDSR reports,

positive findings are the notification of deaths within 24 hours of deaths and increase in number of deaths reported (See Chart 8 in Annex 5 SRHR charts). However, there are delays in analysing and assigning causes of death, as well as in addressing associated factors; it is reported that only 12-15% of reported deaths (2021-23) have been reviewed and submitted to the MOH for further action. Such gaps in coverage and response are indicators of poor quality of MPDSR and waste of resources. The poor functioning of the national-level MPDSR committee and MPDSR committees in referral hospitals and HNGV who are expected to improve the system of MPDSR are concerns. Further details are provided in the Annex 1 SRHR field notes. The MPDSR reports point to an alarmingly high number of stillbirths with significant numbers macerated and 43% occurring during the antenatal period. UNFPA has initiated the process of conducting an in-depth review of the stillbirths (as reported by CO). From MPDSR reports, Ermera has reported the highest number of both maternal and perinatal deaths (see Annex 1 SRHR field notes).

Review of HMIS/DHIS 2 data 2022-23 on deliveries shows that while institutional deliveries seem to have increased, nearly 20% of deliveries still take place at home (HMIS annual reports- see also Chart 7 Annex 5 SRHR charts). UNFPA's interventions to improve maternal health would have certainly contributed to increase in institutional deliveries. However, the proportion of home deliveries is a concern, and the CO has contracted the University of Tasmania to study the health-seeking behaviours among pregnant mothers. This research aims to develop messages for pregnant women, families, and communities, as well as to raise awareness among journalists about maternal health and gender-based violence issues.

UNFPA's interventions in midwifery aims to enhance the capacity of midwifery schools to deliver an updated curriculum that aligns with ICM standards, supporting a four-year Bachelor course at UNTL, ISC, and ICS, thus achieving the output indicator target while contributing to the Outcome indicator (as reported in the annual reports and Annex 5 CP Outcome and Outputs). In 2020, UNFPA established a SSTC with Khon Kaen University in Thailand through Thai International Cooperation Agency (TICA) to support the development of the midwifery course. UNFPA has also developed skill labs at the three institutions and facilitated midwifery educators' participation in a Faculty Development Programme and the Alliance for Improved Midwifery Education (as reported in Annual Reports and by CO staff). UNFPA's initiative to strengthen midwifery education in the country is commendable and presents an opportunity to integrate the ongoing inputs to build capacity in GBV management, FP, BEmONC, etc. From the review of documents and stakeholder interviews, the key concerns with the midwifery-initiative include the alignment of the current curriculum with ICM standards in the three schools, the adequacy of skill development in complication management, and issues regarding the selection of training sites and student-preceptor ratios during clinical training. Lack of estimation of midwives needed and opportunities for employment is a gap in the support to midwifery as a significant number of midwives are unemployed (based on the reports of Midwifery Association of Timor Leste and stake holder interviews) - details in Annex 1 on SRHR field notes). From the discussions with stakeholders, the other gaps in support to midwifery are related to the lack of support for Midwifery Association and creation of a regulatory authority for midwifery which are core elements of the ICM profession framework for midwifery.

The maternal health output has effectively employed several accelerators in its interventions, utilising human rights-based and gender-sensitive approaches, focusing on "hard to reach areas–and fostering partnerships with WHO, UNICEF, and donors like the Japanese Government. The support for midwifery education has successfully leveraged SSTC mechanisms to develop the midwifery course.

Finding # 7: UNFPA's collaborations with CSO have effectively improved key population's knowledge about HIV and its prevention as well as access to preventive services and testing. In addition, the

collaborations have made progress in evidence-based advocacy and education through gatekeepers in the community, health providers, law enforcement agencies and young people to minimize stigma and discrimination against PLWHA. However, the cessation of financial and technical assistance due to ending of donor support and no dedicated officer in the CO, have impacted the scale and depth of the interventions. Despite the above setback, the CSO working with key populations have used the skills acquired through the collaboration with UNFPA to acquire short-term funding to continue its preventive activities.

The output focuses on creating awareness on prevention, transmission and treatment of HIV and other STIs, and uptake of HIV testing, especially among key populations, young people and pregnant women and reducing stigma and discrimination towards PLWHA.

UNFPA's contributions to HIV prevention, increased testing and facilitation of treatment of key populations have been highly acknowledged by the Global Fund, the National AIDS Control Programme Manager, and the CSO KP+. Working alongside the National AIDS Control Programme, UNFPA played a significant role in collaborating with KP+ to reach key populations, including men who have sex with men (MSM), transgender, and female and male sex workers in five priority municipalities and providing basic package of services – condoms, lubricants, health education and testing – and facilitating treatment (numbers who were provided services are shown in Chart 9 in Annex 5 SRHR charts and as per reports to donors, the coverage has exceeded the targets). Additionally, UNFPA supplied female condoms to KP+, which were then distributed to female sex workers.

It was noted during visit to the CSO, the skills in supply chain management are weak leading to overstock of condoms and wastage due to expiry of the products. Beyond technical assistance, KP+ valued UNFPA's support in enhancing their skills in proposal writing and fundraising, which helped them secure a Global Fund grant. With the cessation of Global Fund assistance in 2023, collaborative activities with KP+ have halted with no funding or technical assistance from UNFPA, as reported by KP+ during interviews. This situation is particularly concerning given the recent report on an increase in hotspots among key populations (WHO mapping hot spots), underscoring the need for enhanced preventive services. As highlighted in Findings 5, the collaboration between the National AIDS Control Programme and the MCH Directorate appears weak, negatively affecting the efforts to eliminate mother-to-child transmission of HIV and potentially could have prevented stockouts of HIV/STI test kits in ANC clinics as the National AIDS Control Programme reported adequate supplies of kits. The collaboration also could have facilitated the access of key populations to FP services (access of key populations is restricted due to their marital status as reported by the CSO).

During the pandemic, key populations also faced challenges in accessing preventive care as reported by KP+ (see also Finding 8). Based on UNFPA annual report and later validated by KP+ KII, the introduction of self-testing kits through the Pre-Exposure Prophylaxis project, secured by UNFPA and WHO for a 2-year pilot under the funding from the Unified Budget Results and Accountability Framework (UBRAF), not only reached 200 key populations in Dili, but also introduced the potential to expand testing of key populations (innovation). UNFPA's collaboration with KP+ played a major role in the success of the project as echoed by WHO and the CSO. UNFPA's support to HIV/AIDS Programme focused on addressing stigma and discrimination towards PLWHA, recognizing these issues as human rights violations that hinder access to services, testing, and treatment. These collaborations have contributed to CP Outcomes related to increased knowledge of HIV. UNFPA's annual reports and agreements with the CSOs and their reports are the sources of information for the findings listed below. Through the collaboration with Estrela+, a civil society organization dedicated to reducing stigma, key community figures including leaders, health providers, and young people aged 15-29 were provided information on

HIV transmission, prevention, and the effects of stigma. From 2021 to 2023, the initiative reached 699 community leaders, 433 health personnel, 100 uniformed personnel, 744 young individuals, and 393 PLWHA across various municipalities (Reports of Estrela and Annex 1 SRHR field notes). With no dedicated officer for HIV in the CO, no support was provided to continue the activities except the recent support for the publication of the second report on Stigma Index- an advocacy tool to reduce stigma and discrimination towards PLWHA (this support was provided recently, as the CPE report is being finalized, after the evaluation findings were shared). Recognizing the vulnerability of uniformed personnel to HIV and STIs, UNFPA partnered with National Police of Timor Leste (PNTL) which resulted in awareness creation on HIV/AIDS, reproductive health, maternal health, family planning, and GBV, while also working to reduce stigma towards PLWHA. 20 peer educators from Dili and provinces bordering with Indonesia were trained on prevention of HIV and reducing stigma and discrimination towards PLWHA. No formal assessments have been done but PNTL reported improved knowledge and reduced stigma towards PLWHIV. Support to a prominent CSO working on multi-sectoral approach to prevention of HIV for development of a National Strategic Plan and the development of a national Strategy and Action Plan could not be continued due to lack of funding support. The vacant post of programme officer for HIV/AIDS in 2024 has contributed majorly to discontinuation of the significant support to various organizations.

The HIV/AIDS output has effectively utilized various accelerators in its implementation, including human rights-based and gender-sensitive approaches to reach key populations and combat stigma and discrimination towards PLWHA, as well as fostering partnerships with WHO and civil society organizations focused on HIV prevention.

Finding #8: UNFPA's response to the COVID-19 pandemic demonstrated effective intervention in mitigating disruptions to MNCH services and addressing increased GBV through the reactivation of the MNCH technical working group and the establishment of mobile and fixed SRH services; however, persistent gaps in STI and HIV services for adolescents and youth indicate a need for enhanced targeting of marginalized youth.

COVID-19 response reports indicated significant disruption of RMNCH services and increase in survivors of GBV seeking help in health facilities. As noted earlier, key populations had difficulty in accessing preventive services. UNFPA leads the RH sub-cluster (see Finding 6) within the UNCT Emergency Health Cluster and, alongside WHO, helped the MOH reactivate the dormant MNCH technical working group to monitor disruptions in RMNCAH services and take appropriate actions in collaboration with municipal health staff. Through coordination with the RH and gender clusters, UNFPA facilitated discussions on maintaining SRH services and addressing GBV. Key contributions during the pandemic included developing guidelines for the care of COVID-positive pregnant mothers (ANC, intrapartum and PNC), capacity building for maternal health and GBV prevention and care, supporting the establishment of a maternity isolation centre at Vera Cruz CHC and monitoring EmONC activities through WhatsApp communications (see Finding 7). Additionally, IEC materials produced by UNFPA APRO were adapted, printed, and distributed in collaboration with the MOH's Health Promotion Department. More details under Coverage criteria.

In 2023, following severe floods that affected 12 municipalities, the response reports indicated needs assessments in three areas that showed significant disruptions of SRHR services and services for GBV survivors as well as lack of preparedness by the municipal health system. UNFPA set up mobile and fixed SRHR services in tents with focus on remote areas, deployed trained health providers to care for survivors of GBV and collaborated PRADET to manage cases of sexual assault (as also noted in Finding 6). Referral pathways for EmONC and GBV were established. Messages on SRH care and GBV prevention

were distributed to women and communities. In total, 855 women of reproductive age received maternity and hygiene kits; however, significant gaps remain in STI and HIV services for adolescents, as outlined in the MISP guideline (related discussion under findings on coverage and connectedness *Finding # 29, 30, 31)*

UNFPA has employed various accelerators in its humanitarian response, including human rights-based and gender-transformative approaches, innovations such as mobile clinics and online training, partnerships with NGOs, and a commitment to leaving no one behind by establishing camps and clinics in remote areas.

4.2.2 Adolescents and Youth: Effectiveness

Summary Findings:
Based on the indicators set to measure the progress of the interventions, according to the results framework, AY programme has achieved its planned outputs (Table in Annex 5, AY outputs). However, if the programme has made a meaningful change in the expected target groups have some concerns. National CSE guidelines (Healthy Relationship Curriculum and Boys and Girls Circle) were officially approved and disseminated to selected primary and secondary schools in selected municipalities.

Key issues like child marriage and school dropouts are addressed within the CSE modules, but only a few have benefitted from it as CSE is not available in all schools. Urban areas have benefited from these interventions with improved safety and awareness among women and girls. However, rural regions continue to face significant challenges due to the entrenched cultural norms and limited infrastructure which hinder both the delivery of services and outreach to vulnerable groups. In general, the programme suffered due to school closure during the pandemic as well as without a dedicated person responsible for the AY programme.

UNFPA's collaboration with government ministries and local NGOs like FOKUPERS and Alola Foundation has extended CSE programs beyond formal education settings, reaching rural and out-of-school youth. Nevertheless, challenges such as low participation, facilitator turnover, and cultural resistance persist. Despite these barriers, the CSE Programme has been instrumental in advancing gender-equitable education and building institutional capacity in Timor-Leste, with continued community engagement.

CSE Programme has made some progress, particularly in addressing gender-based violence (GBV). Efforts such as community-based interventions, legal aid, and psychosocial support have increased GBV reporting and service access, empowering women and girls. Engaging men and boys as allies has also helped reduce GBV incidents. Despite these successes, marginalized groups—especially those in extreme poverty, with disabilities, or in remote areas—remain underserved, largely due to geographic isolation and inadequate infrastructure. Additionally, exclusion of persons with disabilities from mainstream programs further limits progress.

Finding #9: CP4 has strengthened the institutional capacity of key government ministries, particularly the Ministry of Education, to promote and institutionalize CSE (in-school), resulting in enhanced educator training and curriculum development that empower teachers to advocate for sexual and reproductive health rights, although ongoing revisions of the curriculum demonstrate the need for continued technical support and collaboration.

CP4 objectives of the AY interventions are to empower every adolescent and youth, in particular adolescent girls to have access to SRH and Reproductive Rights in all contexts. This is to be achieved by strengthening the national capacity to implement community and school based comprehensive sexuality education programmes (topics covered under this education programme is in Evaluation matrix – Annex

1) that promote human rights and gender equality via Policy and Programme Development, Capacity Building in Youth Organisations and School Based Interventions.

UNFPA has provided technical support to strengthen the institutional capacity of key government ministries, especially the Ministry of Education (MoE) in the past CP3 and the Ministry of Youth Sport Art and Culture (MoYSAC) in the current CP4 to integrate CSE into the national education framework. This includes integrating CSE as part of the extracurricular curriculum for both primary and secondary school levels, ensuring that the content includes topics on sexual and reproductive health (SRH), gender equality, and human rights.[53] However, currently these programmes are only in a few schools, supported by UNFPA and implemented by CSOs due to the absence of direct partnerships with the Ministry of Education (MoE).[54] CSE was integrated into extracurricular activities in secondary schools to expose students to critical topics outside the regular curriculum (see additional information under AY Annex 5 for details). Teachers were trained to deliver CSE, with support from community leaders to ensure cultural acceptance and relevance.[55]

CSE formed a major component of knowledge transfer. With the approval from the MoE, the program was extended and with the support of two NGO partners over 25 trainers covered 47 schools across seven municipalities reaching 3,862 adolescents and youth across Timor-Leste, out of whom 2,329 were girls. Forty teachers also participated in the training, with the support of the Spotlight Initiative and FOKUPERS in Ermera, Bobonaro and Viqueque; while with KOICA, under the Together for Equality (T4E) initiative and in partnership with Alola Foundation, CSE was implemented in Dili, Baucau, Oecusse and Covalima providing them with essential knowledge on topics such as healthy relationships, gender equality, and prevention of GBV, SRH, and human rights. The pre-training and post-training assessments of the young students showed significant (over 60%) increase in knowledge on sexuality, reproductive health and responsible behaviour.[56]

Support to MoYSAC, MoE, and MoH has advanced SRH, CSE and especially youth-friendly services[57] in the past CP cycle. While progress has been made in CP4, rural adolescents and youth still struggle with access. Special programs target vulnerable girls and those with disabilities, but data on these groups remains limited.[58] While the LNOB principle is integrated in designing programmes, capacity development plans did not show evidence of inclusive learning. CP4 advocacy and visibility for these vulnerable groups require significant improvement. Interview with stakeholders during the CPE revealed that limited inter-ministerial coordination and insufficient resource mobilisation have hindered programmatic scalability and policy influence.[59] However, on a positive note, UNFPA has expanded its work, beyond CSE, to youth empowerment and employment. UNFPA leads the Youth Results Group as its chair, and was able to measure the UN agencies' commitment against the NAP for Youth, with a plan for supporting the achievement of the NAP in the coming years. More importantly, due to UNFPA's advocacy, youth empowerment was made a priority of the Vice Prime Minister for Coordination of Social Affairs, which positioned UNFPA at a high level, to co-lead discussions and programming on youth empowerment and employment in the country.[60]

[53] Interview with primary and secondary school teacher July 2024
[54] Key Informant Interview. Timor-Leste July 2024.
[55] ibid
[56] SI draft evaluation report, 2024, T4E evaluation report,2024
[57] UNFPA, "Timor-Leste Country Programme Document," 2020.
[58] Discussion with local NGOs implementing partner and Key Information Interview July 2024
[59] Country Programme Evaluation (CPE, 2023). Stakeholder interviews regarding advocacy challenges and resource gaps
[60] UNFPA Timor-Leste Annual Report 2023 and Programme Briefing to the evaluation team

The programmes demonstrated some progress in improving SRH knowledge, attitudes, and behaviours among adolescents and youth. Additionally, focus group discussions with students indicated that students and young people gained confidence and felt more empowered to advocate for their SRH rights within their communities, peers, and family which also promoted safety and awareness, particularly for girls, by addressing gender equality and GBV prevention[61].

Finding #10: CP4 has made an effort to improve SRH knowledge and GBV prevention among out-of-school youth through CSE programmes and UNFPA's collaborations with local organizations have expanded CSE into communities. However, challenges like participant disengagement, teacher resistance, and entrenched cultural norms hinder programme effectiveness, underscoring the necessity for ongoing community involvement. In addition, data gaps and monitoring issues hinder measurement of programme effectiveness.

The out-of-school CSE programme was implemented through partnership with CSOs including FOKUPERS, Alola Foundation, and other local NGOs. These partners contributed to the development of CSE modules better aligned with cultural norms and international standards on SRH, human rights, and gender equality. The collaboration with MoYSAC helped ensure that CSE is included in broader youth development programs[62]. Key projects supporting these efforts included the Spotlight Initiative and T4E[63] which were instrumental in delivering CSE programme in schools and communities. While community-based sessions targeted out-of-school youth and involved training facilitators, educators, parents, and youth leaders, these sessions also encouraged men and boys' participation to challenge harmful gender norms. However, their participation was minimal. [64]

Fourteen (14) Youth Organizations conducted CSE training for out of school adolescents and youth. The out-of-school programme content covered SRH and sexually transmitted infections (STIs), life skills focused on critical thinking, decision-making, and resilience; human rights and gender equality, GBV; and awareness campaigns and strategies to prevent GBV, child marriage, and promote healthy relationships. Additional programmes are there to focus on engaging men and boys to shift societal norms.[65] One Youth Center also had tried to address harmful practices and GBV (see Annex 5 AY table for details), however, youth centre representative acknowledged that data gaps and inconsistent monitoring have limited the ability to measure programme impact comprehensively[66].

The out of school CSE programme has shown some increases in SRH knowledge across targeted municipalities. For example, in Bobonaro, participant knowledge and attitude regarding SRH post-test scores increased from 59% to 81%, while in Ermera, scores rose from 66% to 88%[67]. In RAEOA, participants 'knowledge increased from 64% to 90% after training, and in Baucau, from 74% to 97%[68]. Youth has become more confident discussing SRH issues with peers and healthcare providers. For example, CSO partner data from Spotlight Initiative Phase II Quarterly Report by NGO Belun shows that 75% of programme participants demonstrated improved confidence in accessing SRH services after

[61] Key Informant Interview and School Focus Group Discussion during CP4 Evaluation period. Timor-Leste. 2024
[62] Secretary of State for Youth and Sport. Timor-Leste. National Youth Policy 2016
[63] UNFPA Timor-Leste Annual Report 2023 and Programme Briefing to the evaluation team (June 2024)
[64] UNFPA Timor Annual Reports, 2022, 2023
[65] Key Informant Interview and discussion with Focus groups and Youth Center Representative. July 2024.
[66] Discussion and interview with youth centre representative. Timor-Leste. July 2024
[67] Roll out Healthy Relationship Analysis Report. UNFPA Timor-Leste 2022
[68] Ibid

completing community-based sessions.[69] Participants reported improved attitudes toward addressing harmful practices like child marriage and GBV.

While the programmes achieved some positive results in increased awareness, several challenges were observed particularly related to age diversity among participants. Training sessions included individuals ranging from 15 to 35 years, which was more prominent in rural areas. For instance, field observations noted that some students as old as 23 were still attending secondary school in these areas. Additionally, the centralized nature of the training conducted only in municipalities and post-administrative centres limited outreach to vulnerable girls in more remote communities.

Despite cultural resistance, the community-based CSE Programme demonstrated positive outcomes, as evidenced by programme monitoring reports and stakeholder interviews. These included enhanced ability of the youth to make informed decisions about SRH and personal well-being, increased confidence in discussing SRH-related issues with peers, and improved communication and problem-solving skills. However, entrenched cultural norms and resistance in the community and at the highest level of government remain significant obstacles to the program's success[70], compounded by data gaps that limit a comprehensive assessment of the program's impact. To ensure lasting progress, future programming will need to prioritize robust reporting mechanisms and better integration of partner contributions to provide clear, measurable outcomes. Similarly, the absence of formal integration of the in-school Programme into the national curriculum resulted in heavy reliance on external support, limiting its sustainability.

4.2.3 Gender Equality: Effectiveness

Summary findings:

UNFPA has made substantial progress in enhancing the capacity of key partners, including healthcare providers, CSOs, and government institutions, to implement the National Action Plan for GBV (NAP-GBV) by strengthening the capacity of key implementing partners to GBV in Timor-Leste through initiatives like the UN-EU Spotlight Initiative and the KOICA-UN Together for Equality (T4E) program. Capacity-building has focused on advocacy, case management, and legal awareness, leading to improved referral networks and community engagement. The implementation of NAP GBV under CP4 has led to substantial improvements in multi-sectoral coordination and referral mechanisms to address GBV. The improved referral mechanisms resulted in a 30% increase in survivors accessing services in health facilities, highlighting the effectiveness of these coordinated efforts.[71]

Despite these advancements, ongoing training and sustained resources are essential for long-term impact. Additionally, effective monitoring and data literacy are urgently needed to ensure accountability and successful execution of the NAP GBV. UNFPA also prioritized the integration of GBV-specific indicators into the Health Management Information System (HMIS) to improve data-driven decision-making.

While UNFPA-supported programs have increased community awareness and help-seeking behaviour regarding GBV, challenges remain, particularly in integrating these services with sexual and reproductive health efforts and supporting vulnerable populations, including persons with disabilities. Awareness sessions have led to a rise in GBV reports, indicating greater empowerment among community members. However, many cases can still go unreported due to entrenched patriarchal norms and a lack of consistent messaging across organizations. To foster long-term behavioural change and promote gender equity, there is a need for harmonization of interventions and sustained, evidence-based strategies. The Ministry of Social Inclusion also

[69] Spotlight Initiative Phase II Quarterly Final Report. Belun 2022-2023
[70] Key Informant Interview and Discussion with Government Institutions Representative. Timor-Leste. July 2024.
[71] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative

aims to address resource limitations by enhancing human resources for GBV management at local levels.

Finding #11: UNFPA has effectively strengthened key partners' capacity to implement the National Action Plan for GBV, improving knowledge and skills in CP4, but ongoing training and resources remain crucial for sustained impact.

Under this outcome, the expected output is to strengthen the capacity of relevant government institutions and NGOs to implement the NAP-GBV, mainly through a multi-sectoral approach.

UNFPA has made substantial progress in enhancing the capacity of key partners including healthcare providers, CSOs, and government institutions, to implement the NAP-GBV. This effort was underpinned by comprehensive technical and capacity-building support, coupled with strategic advocacy for systemic reforms.[72] Between 2021 and 2023, 759 healthcare providers in eight municipalities were trained using an in-service training package developed with La Trobe University. These trainings emphasized survivor-centred care, case management, forensic examination techniques, and safe space management.[73] Post-training supervision revealed improved practices, particularly in forensic examination management for sexual violence survivors.[74] However, challenges such as high staff turnover and entrenched norms were identified as ongoing barriers to sustaining these gains.[75]

In addition to healthcare providers, CSOs such as FOKUPERS, PRADET, and the Alola Foundation were capacitated through tailored training on case management, survivor-centred service delivery, and participatory monitoring.[76] Reports indicate a 45% increase in their understanding of GBV response mechanisms, enabling more effective community-based interventions.[77] T4E initiative further enhanced CSOs' knowledge of government policies and GBV budgeting, increasing their capacity from 46.2% at baseline to 100% at the program's conclusion.[78] Institutional strengthening efforts included financial management and proposal-writing workshops, enabling CSOs to secure additional funding. The formation of a 23-member CSO consortium also enhanced collective advocacy and networking capabilities.[79]

At the policy level, UNFPA provided technical assistance to the Secretariat of State for Equality and Inclusion (SEI) for the finalization and launch of the NAP GBV 2022–2032. This process included advocacy for the adoption of laws and policies addressing workplace harassment and domestic violence. UNFPA further supported the development and dissemination of over 73 knowledge products, including technical manuals, policy briefs, and strategic frameworks.[80]

Efforts to strengthen monitoring and data collection were another critical component. Training programs targeted government stakeholders and CSOs, equipping them with tools to analyse and

[72] UNFPA Timor-Leste. 2021, 2022, and 2023 Annual Report - Timor Leste. Finalized Official Reports.
[73] Ibid
[74] UNFPA Timor-Leste. 2023 Annual Report - Timor Leste.
[75] 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)
[76] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative
[77] Ibid
[78] 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)
[79] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative
[80] Ibid

disseminate violence against women and girls (VAWG) data.[81] These initiatives fostered national ownership of GBV monitoring systems and enabled at least four quarterly and two annual reviews of NAP GBV implementation by 2023.[82] Standard Operating Procedures (SOPs) for survivor-centred care and integrated SRH and GBV services were continued to be implemented following Spotlight Initiative across 34 health facilities in four municipalities under the T4E initiative, further embedding these approaches into local health systems.[83]

Despite these achievements, stakeholders emphasized the need for continuous training (refreshers) and capacity building for both health care providers and non-health sectors duty bearers in institutional strengthening and advocacy, with well-equipped safe spaces, and sustained resource allocation to address systemic challenges and ensure the sustainability of these efforts. [84]

Finding #12: The implementation of the NAP GBV has significantly strengthened the multi-sectoral response to GBV in CP4, enhancing coordination and referral pathways. However, effective monitoring and improved GVB data literacy are needed to ensure accountability and successful multi-sectoral execution of the plan.

The implementation of NAP GBV under CP4 has led to substantial improvements in multi-sectoral coordination and referral mechanisms to address GBV. Between 2021 and 2023, UNFPA facilitated the establishment of seven safe spaces across municipalities, including Viqueque, Ermera, Bobonaro, Gleno, Atabae, and Dili (Comoro and Vera Cruz), Liquica through initiatives such as the Spotlight Initiative, Together for Equality, and Zonta programs. These safe spaces provided integrated medical, psychosocial, and legal services, serving as critical hubs for survivor support.[85] The referral network expanded from four to 14 service providers, including healthcare facilities, police units, and social services, creating a robust, coordinated response system (also refer to Finding 6 under SRHR for details). This multi-sectoral approach integrated health-sector pathways with non-health sector services, such as law enforcement, legal aid, and community-based reintegration programs.[86] The improved referral mechanisms resulted in a 30% increase in survivors accessing services in health facilities, highlighting the effectiveness of these coordinated efforts.[87]

At the governance level, UNFPA supported the establishment of coordination platforms such as the National Steering Committee and the Civil Society Reference Group (CSRG). These structures enabled regular strategic discussions and reviews of NAP GBV implementation, fostering collaboration across sectors and ensuring inclusive participation from marginalized groups.[88] The Ministry of Social Solidarity and Inclusion (MSSI) further strengthened this network by establishing GBV focal points at all administrative levels, enhancing the capacity of referral systems to provide comprehensive support to

[81] Ibid
[82] UNFPA Timor-Leste. 2023 Annual Report - Timor Leste. Finalized Official Report
[83] 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)
[84] Rodrigues, U. M. S. (2024). Individual Consultant Report (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
UNFPA CP4 Evaluation Team. Key informant interviews with stakeholders. July 2024
[85] UNFPA Timor-Leste. 2021, 2022, and 2023 Annual Report - Timor Leste. Finalized Official Reports.
[86] 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)
[87] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative
[88] Ibid

survivors.[89] The support and investment in the multi-sectoral approach advanced by UNFPA also included survivor-centred SOPs and collaboration with the Vulnerable Persons Unit (VPU) of the National Police, in monitoring systems, capacity-building for GBV data management has significantly bolstered the implementation of the NAP GBV.[90]

UNFPA also prioritized the integration of GBV-specific indicators into the HMIS to improve data-driven decision-making.[91] By 2023, healthcare managers and GBV focal points were trained in GBV data collection, reporting, and utilization. UNFPA provided technical support to healthcare providers, training 229 personnel in eight municipalities to deliver essential services to GBV survivors. This capacity-building effort improved service readiness and infrastructure, with health facility managers advocating for and implementing significant improvements. Advocacy efforts by UNFPA and local partners led to enhanced multi-sectoral coordination, integrating health, police, social, and justice sectors into a unified GBV response system. This capacity-building effort improved monitoring practices, yet persistent challenges and existing gaps to sustaining the progress achieved such as limited data literacy, gaps in geographic coverage, and resource constraints continue to hinder effective accountability and comprehensive tracking of GBV services, to ensure consistent implementation of NAP-GBV in the future. [92]

Finding #13: UNFPA-supported programmes under CP4 have significantly improved GBV prevention and service access in targeted municipalities in Timor-Leste, with achievements including the establishment of safe spaces within health facilities, enhanced community awareness, and positive shifts in attitudes toward GBV. These efforts have contributed to increased help-seeking behaviour among survivors. However, challenges persist in fully integrating GBV services with sexual and reproductive health initiatives, ensuring adequate support and coverage for vulnerable populations, particularly in remote areas and among persons with disabilities (PWDs) and fostering sustained behavioural change and gender equity through long-term interventions. Limitations include inability to measure changes.

Under CP4 Output 3, UNFPA simultaneously implements three key programmes: the UN-EU Spotlight Initiative, the UN-KOICA T4E Programme, and the Zonta International Program, to achieve improved GBV prevention and service access in targeted municipalities in Timor-Leste. Under these-supported programs, CP4 have demonstrated significant progress in advancing GBV prevention and improving service accessibility in Timor-Leste. These initiatives have enhanced community awareness, increased help-seeking behaviour, and expanded the availability of essential GBV services.[93]

The establishment of safe spaces in health facilities and the use of mobile clinics have increased access to GBV services, particularly in targeted municipalities such as Viqueque, Bobonaro, and Ermera. These safe spaces offer medical, psychosocial, and legal support to survivors in a confidential and secure environment. Between 2021 and 2023, the number of survivors accessing these services increased by nearly 300%, reflecting growing trust and utilization of the facilities.[94] Efforts to build inclusive referral

[89] 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) and KII Interview with MSSI Representative
[90] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report.
[91] UNFPA Timor-Leste. 2023 Annual Report - Timor Leste. Finalized Official Report, Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report
[92] ibid
Spotlight Initiative Endline Survey Result Report (Final Version)
[93] UNFPA Timor-Leste. 2023 Annual Report, feedback from CHC staff and CO staff and field observation
[94] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative

networks ensured that services were accessible to marginalized groups, including persons with disabilities (PWDs) and LGBTQ individuals. This included training healthcare providers on inclusivity and survivor-centred care, as well as improving infrastructure to accommodate diverse needs. In Liquiça Municipality, for instance, local authorities have taken an active role in GBV referral pathways and case management systems, significantly promoting gender equality, and violence prevention, and supporting survivors' access to necessary services.[95]

Community awareness campaigns and outreach activities have significantly improved understanding of available GBV services. By the end of 2023, over 23,713 women and girls had reported increased awareness of essential GBV services, including recovery and SRH support.[96] Dissemination of referral information and sensitization activities was critical in equipping communities with the knowledge to access these services. Training healthcare providers further contributed to raising awareness indirectly.[97] Over 400 healthcare professionals were trained under programmes like the Spotlight Initiative to deliver integrated SRH-GBV services, creating a ripple effect where informed providers shared critical information with community members.[98]

Community-level interventions have fostered significant shifts in attitudes toward GBV, with success in engaging male participants. Programmes like "Connect with Respect," implemented in schools, and broader community sensitization campaigns through social media, radio, and community events reached 1,979 male participants across 60 remote villages.[99] These efforts involving organizations such as '*Mane ho Vizaun Foun*' (Men with a New Vision) focused on challenging harmful norms, promoting healthy relationships, and amplifying men's roles in GBV prevention. Testimonies from participants reflected a growing recognition of the unacceptability of GBV and increased support for survivors.[100]

The initiatives have also resulted in a significant increase in help-seeking behaviour among survivors. In 2023, safe spaces and health facilities recorded a substantial rise in survivors accessing services and GBV cases being identified and managed driven by referrals from the VPU, shelters, and other partners. Over the duration of the Spotlight Initiative, the number of survivors accessing multi-sectoral GBV services increased steadily, according to the CO reporting, highlighting the success of integrated referral networks and targeted outreach efforts.[101] *(*There was no reference to the previous years in the reports to make a comparison of the trend (increased by how many % and the ET did not see any users of the services or occupying the safe spaces at the time of our field visits though we were able to interview survivors who previously benefited by the services.

The T4E programme (one of the three mentioned above) 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.[102] Outreach initiatives targeted remote and underserved areas, ensuring broader access to psycho-social and referral

[95] UNFPA Timor-Leste Annual Report 2022, 2023, stakeholder Interview feedback
[96] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative
UNFPA Timor-Leste. 2023 Annual Report - Timor Leste. Finalized Official Report
[97] Ibid
[98] UNFPA Timor-Leste. 2021, 2022, and 2023 Annual Report - Timor Leste. Finalized Official Reports.
[99] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative
[100] Ibid
[101] UNFPA Timor-Leste. 2023 Annual Report - Timor Leste. Finalized Official Report
[102] 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)

support. Over 10,000 individuals benefitted from educational campaigns, with a focus on integrating SRH and GBV prevention information, particularly in disaster-prone regions.[103] Reporting rates of GBV incidents increased by 182.6%, with survivors receiving multi-sectoral support, reflecting improved community awareness and help-seeking behaviour. Training for service providers and community leaders enhanced survivor-centred care and community reporting systems, fostering confidence among women to seek assistance and report incidents of violence. These interventions highlight the program's success in addressing barriers to access and improving support for vulnerable populations.[104]

Despite significant progress in addressing GBV in Timor-Leste, challenges remain in reaching vulnerable populations and ensuring long-term sustainability. Logistical and infrastructure challenges, particularly in rural and remote areas, have limited the reach of services to some vulnerable populations[105] which was confirmed in our field interviews as well.

Data limitations hinder a full understanding of GBV dynamics among marginalized groups, such as PWDs and LGBTQ individuals, and insufficient metrics to measure long-term behavioural change complicate the evaluation of awareness campaigns.[106] Furthermore, variations in community awareness strategies among implementing partners create inconsistent messaging, highlighting the need for standardized, evidence-based approaches.[107] While UNFPA-supported programmes under CP4 have expanded service access, strengthened inclusive referral networks, and fostered positive shifts in attitudes, particularly among male participants in addressing these systemic challenges remains challenging to sustaining and consolidating these gains.[108]

4.2.4. Population and Development (PD): Effectiveness

Population and development aims to strengthen the national capacity for production and dissemination of quality disaggregated data on PD 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, SRH and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings. PD cuts across all thematic areas providing technical support to censuses, demographic and health surveys, and other large-scale data-gathering exercises generating data and knowledge products for informed policy and decision making.

Summary Findings:

UNFPA leads in supporting the census and the thematic analysis of the census. Providing financial and technical support CP4 extended its assistance to INETL to successfully complete the first digitalized 2022 Census in the country and supported a number of publications that will provide essential data for evidence-based planning by the government and other development partners. Some delays in implementing the Demographic and Health Survey (DHS) were experienced due to COVID-19 which made other studies that

[103] Ibid
[104] Ibid
[105] Ibid
[106] Rodrigues, U. M. S. (2024). Individual Consultant Report (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.
[107] KII with a CSO Representatives
[108] 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)
UNFPA CP4 Evaluation Team. Key informant interviews with stakeholders (CSO), July, 2024

depended on DHS data to be postponed. Hence, CP4 planned outputs were only partially accomplished. INETL and the broader development community highly commend UNFPA's support in enhancing data generation and mapping. Census and DHS data serve, nationally, as credible sources for planning, monitoring, and measuring progress. Data supported by UNFPA has contributed to the formulation of national policies and strategies. The reference to census data from the previous censuses in 2015 and 2022 by ministries and other stakeholders illustrates the role of this data in planning and policy preparation.

Population and Development programme delivered on policy advocacy, data and knowledge creation and sharing, capacity enhancement, and maintained programme coherence by coordinating and supporting country team with policy and strategic oversight on emerging population issues. Capacity-building efforts on data literacy for GBV-related issues have facilitated monitoring of the NAP-GBV. Given the country's demographic profile and the potential for a demographic dividend, UNFPA is engaged in dialogue with the government, making this an opportune moment for UNFPA to lead a multi-sectoral intervention.

Finding #14: UNFPA's support for the National Institute of Statistics (INETL) has effectively enhanced the capacity for the 2022 Census. In CP4, UNFPA has substantially strengthened the data generation capacity of INETL through targeted training and support, resulting in the successful publication of thematic reports and enhanced data collection for evidence-based planning. These efforts have effectively bolstered the utilization of census data in government programs and facilitated informed policy development at the local level. However, delays attributed to COVID-19 have significantly hindered the implementation of key surveys and studies essential for informing national development policies in SRHR, gender equality, and GBV during CP4.

Aligning with CP4 objectives, UNFPA mobilized resources and provided technical support to strengthen the capacity of the National Institute for Statistics (INETL), formerly known as the General Directorate of Statistics (GDS), to conduct the National Population and Housing Census. INETL, in close cooperation with UNFPA, successfully released the 2022 Census report. Crucial for effective policymaking and planning, Census 2022 was the first digitalized census, which aimed to provide detailed insights into population distribution, fertility rates, and migration patterns[109]. The software for Retrieval of Data for Small Areas by Microcomputer (REDATAM) and census dissemination dashboard have been made available on INETL's website since June 2024, enabling the processing of microdata from population and household censuses, surveys, and vital statistics. Although UNFPA intended to bring in a technical consultant to further enhance INETL staff capacity, this opportunity was missed due to limited funding.[110]

The census largely was financed by the Ministry of Finance, additional financial and material support such as tablets, power banks came from UNFPA, UNICEF, UNDP and WFP. Technical support provided by UNFPA throughout the census resulted in a successful completion of the Census under the slogan "Our Census, our future be part of it." UNFPA, taking the lead in supporting the census analysis both technically as well as financially, helped produce and launch monographs on Housing Characteristics and Amenities, Youth, Gender, Disability, Labour Force and Census Atlas (detail table in Annex 5 additional information). A few more publications are still in the process of completion (see Annex 1).

The COVID-19 pandemic impacted the implementation of the DHS and other planned surveys by INETL. The delay in the DHS hindered the completion of SRHR investment case studies and health economics

[109] Timor-Leste Population and Housing Census 2022.
[110] CO Annual Report 2022, 2023, KII with INETL and CO staff, and census data website.

analytics related to family planning and GBV, as well as studies focusing on adolescents and youth. Consequently, the planned exercise to map demographic disparities and socio-economic inequalities could not be carried out. All these studies were part of the CP4 planned outputs that are crucial for informing national development policies and strategies across programmatic areas, including SRHR, gender equality, and GBV, that were intended but could not be completed during CP4.[111]

In 2023, UNFPA continued its capacity development efforts with INETL to address gaps in data generation capacity and availability. UNFPA facilitated training for 15 INETL staff members in administration, finance, human resources, and procurement, thereby enhancing the institute's administrative capabilities. Additionally, 14 staff members were trained to support post-census activities, leading to the successful completion and publication of six thematic reports with UNFPA's technical assistance. The reports, in total 12, which cover topics such as education, fertility, mortality, and population projections, highlight the effectiveness of UNFPA's capacity development and technical support. Ongoing production of thematic reports on children and youth, gender, labour and economics, and the demographic dividend is also in progress (complete list of reports in annex 5). Furthermore, 25 junior professionals and technical staff were trained, in Dili, on key subjects such as tabulation, thematic report writing, data analysis, data editing, and population forecasting. Additional six staff members received training in Bangkok focusing on Census dissemination and Census projection and as a result, these trained individuals were assigned to analyse the thematic report of the Census "*Fó Fila Fali*," *(Give Back)* which was published and disseminated in July 2024. The report launch presided by the Prime Minister applauded UNFPA contribution towards the report and emphasised the attendees (attended by higher officials from the government, non-government, UN agencies and donor communities) the importance of the use of data for evidence-based planning.

The report "*Fó Fila Fali*,"is intended for planning at the sub-municipal level, providing detailed insights into small-area estimations, an approach that allows for a nuanced understanding of local population dynamics and conditions. The primary objective of this analysis is to furnish 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 designed to inform targeted interventions and resource allocation, ensuring that policies and programs are tailored to the unique circumstances of each area. This level of detail is vital for developing responsive and effective strategies that improve living conditions and meet the needs of local population.[112]

In the absence of a robust plan for effective utilization of data for data driven planning, advocating the use of data could foster a culture of evidence-based policy and strategy planning dialogue which could enhance the delivery of the transformative results. While technical and financial support is provided to generate valuable data, a strategy for marketing this data to increase its utility seemed to be missing. UNFPA could advocate utilization of census, DHS and other large survey data in government programmes to facilitate evidence-based planning to help achieve UNFPA's transformative results. In Timor-Leste, the DHS is currently being implemented, and most ministries, UN agencies, and national stakeholders utilize data from the 2016 DHS. This reliance underscores the credibility of the data for planning purposes[113].

[111] UNFPA progress reports, interview with CO staff and INETL KII

[112] document review (Annex 1 with details), CO and INETL staff interviews, Observation of the *"Fo Fila Fali "*launch, data presentations and speeches

[113] Documents citing census, DHS data; reference to data sources in presentations on policies, conference papers, CO documents, interviews etc.

Finding #15: UNFPA's support to INETL has effectively enhanced the capacity for data collection and analysis on violence against women and girls, demonstrating a significant improvement in the quality and consistency of data utilized for evidence-based policymaking and intervention design across multiple municipalities.

In terms of population dynamics and data utilization, CP4 emphasizes the importance of collecting, analysing, and using sex-disaggregated data, which is essential for evidence-based policymaking. The programme also aims to strengthen national capacity for conducting gender analyses of demographic data, thus informing policies that address gender disparities. A specific focus is placed on improving the collection and analysis of GBV data to better understand its scope and nature in Timor-Leste, including pilot initiatives to integrate GBV data collected from health facilities in targeted municipalities. Furthermore, support for gender-responsive budgeting initiatives ensures that national resources are allocated in ways that promote gender equality, facilitated through direct advocacy and collaboration with implementing partners such as FOKUPERS and the Women's Network (REDE FETO).[114]

As part of the Spotlight Initiative, UNFPA has provided significant support to INETL to enhance the range, quality, and consistency of prevalence and administrative data on VAWG. Through the capacity development Programme (CP4), training sessions were conducted to strengthen the ability of both government and non-government institutions to access, utilize, and disseminate data related to ending EVAWG for planning and intervention design. A total of 256 individuals from 27 institutions across four municipalities—Ermera, Bobonaro, Viqueque, and Dili—were trained in data literacy, enabling them to produce reliable prevalence and incidence data on VAWG. Additionally, UNFPA supported an Administrative Data Mapping project aimed at improving the quality of VAWG data. At the municipal level, INETL staff received TOT for the census, which included concurrent training on data literacy GBV, funded by the EU Spotlight Project.[115] CP4 mobilized resources to strengthen the capacity of INETL staff. As part of the Census data collection exercise, UNFPA provided training to municipal statistical staff through a TOT Programme and data literacy initiatives funded by the EU. Although not specifically focused on Civil Registration and Vital Statistics (CRVS), this training has been highly beneficial for municipal chiefs in their routine data collection tasks, including those related to the Census and CRVS. CP4 also supported the collection of sex-disaggregated data for evidence-based planning and policymaking on gender issues.

Moreover, UNFPA's support in collecting and analysing gender-related data enhances evidence-based policy-making and targeted interventions. For instance, UNFPA Timor-Leste is piloting the collection of GBV data through the HMIS in several targeted municipalities. Additionally, efforts to integrate GBV data into supervision tools like the HMIS have begun, starting with five municipalities, where initial data collection has commenced. The development of HMIS indicators for GBV is ongoing, with discussions about key indicators to facilitate better analysis by HMIS officers. This is a new initiative and the feedback from the responsible persons was that this will improve the data availability (in the form that is useful) and utilization by the government and relevant institutions for monitoring the implementation of the NAP GBV enabling a more robust response to GBV that could facilitate monitoring progress toward gender equality goals. Despite these advances, there are limitations in data disaggregation. Currently, GBV data is only disaggregated by sex, with insufficient information about people with disabilities, age categories, and other vulnerable groups, including LGBTQ+ communities and sex workers.[116] While there is an abundance of data from surveys, the utilization of data for planning, especially at sub-national level

[114] CO country programme briefing for ET, CP documents
[115] CO Annual Plans, Monitoring reports, interviews during field visits
[116] Interviews with SEI, CO staff, Municipal level health staff, Co project documents, Annex 1 matrix

and by CSOs seems lacking. Data on marginalized populations were especially difficult to get at, thus making it hard to know the reach and what portion of the population is missing out on the services. [117]

UNFPA, together with UN Women has also assisted the government in utilizing data to monitor efforts related to the NAP-GBV. Key activities include capacity building on data literacy for GBV-related issues in four municipalities, with 125 participants from line ministries, CSOs, and the PNTL. A national workshop focused on strengthening GBV data production has increased knowledge and understanding of the current GBV situation and data production in Timor-Leste.[118]

Finding 16: UNFPA support to data literacy during census has had unintended positive results

UNFPA has provided training to statistical staff in all municipalities as part of the Census data collection exercise through a TOT Programme and data literacy programs funded by the EU. While this training was not specifically focused on CRVS, interviews with several municipal staff mentioned that it was more like a refresher course in sampling and data collection and it greatly benefited their routine data collection tasks, including those related to CRVS. Support for Civil Registration and Vital Statistics (CRVS), though it is not officially the role of UNFPA, is crucial for recording essential information such as births, deaths, and other vital events, which enables individuals to claim their identity and civil status. At the municipal level, INETL staff (with WHO) are responsible for collecting data on births, deaths, marriages, and maternal deaths. 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 which can be linked to LNOB principle. 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 capacity to effectively plan and target essential services can be significantly enhanced.[119]

Population and Development programme delivers on policy advocacy, data and knowledge creation and sharing, capacity enhancement, and maintains programme coherence by coordinating and supporting country team with policy and strategic oversight on emerging population issues. There is more room for PD unit to be engaged as a cross-cutting service provider with technical assistance within the country office. CP4 emphasizes the importance of using data to assess demographic shifts, which will help optimize investments for the demographic dividend.

4.2.5 Humanitarian Response *Effectiveness* is discussed under Findings 5, 8 and under the evaluation criteria *Coverage*.

EQ4. 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?

[117] Discussions with CSOs, progress reports, CO annual reports
[118] ibid
[119] interviews with INETL municipal chiefs of three municipalities, project documents

Summary Findings:

Overall, CP4, in collaboration with civil society and youth organisations, has advanced gender equality and addressed gender-based violence (GBV) through Comprehensive Sexuality Education (CSE), primarily in urban areas. Progress has been made in engaging both in-school and out-of-school youth, with Youth Centers providing young women and girls with information on sexual and reproductive health (SRH), healthy relationships, and GBV awareness. However, significant barriers remain, particularly in rural areas, where traditional norms, logistical difficulties, and extreme poverty hinder participation, especially for marginalised groups such as out-of-school youth and adolescents with disabilities.

While CP4 includes initiatives on maternal health, family planning, GBV prevention, and HIV services (see table 8), rural implementation remains constrained by entrenched cultural norms, inadequate infrastructure, and unreliable transportation. Moreover, the lack of nationwide SRH education and the absence of contraceptive access for adolescents further limit the program's impact. Expanding infrastructure, strengthening engagement with marginalised groups, and addressing socio-economic disparities are critical to ensuring equitable access to CSE and SRH services across Timor-Leste.

Despite the implementation of inclusive policies and targets assessments to inform programming, gaps remain and ASRH service delivery is missing. The absence of contraception for adolescents and limited nationwide SRH education through CSE highlight the need for enhanced strategies. Addressing extreme poverty, expanding infrastructure and strengthening engagements with marginalised groups are critical for ensuring equitable access to SRH service and education across Timor-Leste.

(For more details on responses to EQ 4, please also refer to Findings 3, 4 under Relevance and Finding 5, 6 under SRHR Effectiveness)

Finding #17: ***Poverty significantly impedes the effectiveness of UNFPA CP4 implementation, as programs have struggled to reach vulnerable populations in extreme poverty and remote areas, with unreliable transportation further limiting access to essential educational and health resources.***

Poverty in Timor-Leste poses a substantial challenge to the effective implementation of CSE. Vulnerable young people, especially those in extreme poverty[120], with disabilities, or in remote areas remain underserved due to geographic isolation, lack of infrastructure, and insufficient resources[121]. Moreover, Timor-Leste 2022 National Development Report identified that 45% of rural areas lack reliable roads, further isolating communities from health care and education services[122]. These barriers are particularly pronounced, affecting access to healthcare, education, and social services. Despite international commitments, people with disabilities are often excluded from mainstream development programs[123]. For example, despite Timor-Leste commitments under the on the Rights of Person with Disabilities (CRPD), people with disabilities frequently report exclusion from mainstream development as highlighted by a 2021 Disability and Development Survey conducted by national NGOs.[124] Evident in the CP4 work plans, UNFPA has made a concerted effort to address the needs of PWDs, and other

[120] Rights and choices for all adolescents and youth: a UNFPA global strategy 2021 and World Bank. (2018). Poverty and Shared Prosperity 2018: Piecing Together the Poverty Puzzle. Washington, DC: World Bank

[121] World Health Organization & World Bank. (2017). Tracking Universal Health Coverage: 2017 Global Monitoring Report. Washington, DC: World Bank.

[122] National Development Report (2022). Timor-Leste's infrastructure deficits and their impact on rural populations

[123] United Nations Department of Economic and Social Affairs (UNDESA). (2018). Disability and Development Report. New York: United Nations.

[124] Disability and Development Survey (2021). Findings on exclusion from mainstream programs in Timor-Leste.

marginalized groups; however interviews with CO staff and CSOs show there are challenges in the implementation at the ground level. Regarding youth, UNFPA has conducted targeted assessments, including the 2017 SRHR Assessment, Teenage Pregnancy Study, and the 2018 Nossal Institute Assessment on People with Disabilities. These studies continue to inform inclusive programming in UNFPA, although recent studies are lacking. Barriers remain for women and girls in accessing health services, particularly in relation to SRH education and specialized support for GBV survivors.

Finding #18: ***CP4 interventions have challenges in providing access to SRH services for adolescents and youth. Persistent geographical barriers and insufficient outreach to marginalized groups indicate a need for improved advocacy and targeted strategies. SRHR education through CSE has been implemented by CSOs, but there is no coverage nationwide.***

Adolescents Sexual and Reproductive Health (ASRH) in Timor-Leste faces many challenges shaped by the country's social-cultural, political and infrastructure landscape which led to limited or no access to ASRH services, at both national and municipal levels. Contraceptives are not provided as the law does not permit it (refer to discussion under the Relevance criteria as well as Finding 5 under SRHR). In and out of school CSE programme focuses on ASRH information, but services are not available. Despite these efforts, challenges remain in reaching marginalised groups, such as adolescents with disabilities, out-of-school youth, and rural students. Youth representative have reported difficulties engaging all targeted groups due to inaccessible geographical location[125]. In rural areas like Ermera, unreliable transport and long commutes, hindering participation in CSE programs and extracurricular activities, reflect broader infrastructural deficits in Timor-Leste. During a focus group discussion in Ermera young beneficiaries of the in-school CSE Programme highlighted ongoing challenges, especially for rural students, which limit access to education and essential services for rural beneficiaries.

CP4 has implemented programs and inclusive policies to increase SRH information access for marginalized communities.[126] However, challenges persist due to geographical barriers and limited infrastructure in rural areas, hindering service delivery.[127] Poverty also remains a major barrier to inclusion in development initiatives. ET noted that while there are efforts to reach marginalized groups, they often fall short.

UNFPA has made efforts to address the diverse needs of young people by incorporating age, gender, and geographical considerations into its interventions, particularly in CSE and SRH initiatives through Youth Center Groups, promoting CSE for vulnerable girls at the community level especially in rural area in targeted municipalities[128]. Thanks to MoYSAC for supporting the CSE Programme for out of school youth through youth organisations which have effortlessly promoted CSE in target municipalities. For example, in 2022, UNFPA trained 40 young leaders who, by 2023, these trained youth leaders have reached 2,367 women and girls in targeted municipalities, to disseminate information on SRH, healthy relationships, and gender-based violence (GBV).[129]

[125] KI, July 2024.
[126] UNFPA Timor-Leste. (2020). Country Programme Evaluation Report. Dili: UNFPA Timor-Leste and The Journey towards comprehensive Sexuality Education. Global Status Report. UNESCO 2021
[127] Human Rights Ombudsman and Justice (Provedoria dos Direitos Humanos e Justiça (PDHJ), UNFPA Timor-Leste. 2017 Country Assessment on Sexual Reproductive Health Rights in Timor-Leste
[128] UNFPA Timor-Leste 2021 annual report. Finalized in January 2022
[129] UNFPA Timor-Leste Annual Report 2023. Finalized in January 2024

Finding #19: There is lack of information on disaggregated data to indicate if UNFPA planning and implementation of all UNFPA-supported interventions related to young people (including adolescents) have been inclusive. However, some interventions related to key populations have been inclusive (discussed under the finding 4 as well).

UNFPA in partnership with civil society organisations (CSOs) and youth organisations have facilitated public awareness raising the need to focus on inclusive planning. CSE is the main channel to deliver the messages pertaining to the wellbeing of the young adults which go beyond the formal education system. CSE programme is designed to reach and cater to out-of-school youth and adolescent groups to deal with societal issues like child marriage, school dropouts, and GBV via community-level interventions. Initiatives such as Engaging Men and Boys as Allies are more commonly found in out-of-school programs, targeting broader societal normsActually there are no specific interventions aimed at reducing adolescent fertility or early marriage, but those topics are tackled in the CSE interventions. Although in the UNSDCF outcome indicator (SDG indicator 3.7.2) is the reduction of adolescent birth rate (ABR 10-14 and 15-19 ages), UNFPA SP outcome indicator under that is related to knowledge about prevention of sexual transmission of HIV. However, UNFPA supported interventions related to HIV and STI have been inclusive (refer to Finding 4). Feedback from Youth Centres and Beneficiaries suggests out-of-school programs as primary platforms for delivering these interventions. While the program's objectives align with goals relevant to both school and community environments, the output indicators to measure UNFPA SP outcome has been used as the national capacity to design and implement CSE for in and out-of-school. However, it was not possible to learn how many have been reached based on the sexual orientation, ability, employment and marital status, related to in and out-of-school programmes. Disaggregated data is lacking to comment on this.

4.3 Answers to Evaluation Questions on Efficiency

EQ5. Did UNFPA get the value for money for its intervention vis-à-vis the results achieved?

(Discussion under Efficiency is common to all thematic areas)

Summary Findings:

Despite limited staff and budget, UNFPA has successfully implemented sustainable development initiatives, as outlined throughout this report. Through established partnerships with government and non-governmental organizations, UNFPA has achieved cost-effective results. Advocacy and capacity development at both institutional and individual levels, upstream policy support, and joint programming have demonstrated value for money. However, challenges are also apparent. Capacity development forms a large part of CP4, but lacks a comprehensive and a systematic approach given the cross-cutting nature of the country programme.

The Country Office faces efficiency challenges due to staffing constraints, with a limited number of permanent and fixed-term staff, relying heavily on consultants and contractual agreements. This issue is particularly evident in the Adolescent and Youth programme.

Given UNFPA's crucial role in the UN Country Team, particularly in adolescent and youth health, women's health, and population issues, the absence of a committed long-term representative is a missed opportunity for synergy and coordination within the broader UN framework. Additionally, considering Timor-Leste's complex political and cultural landscape, having a dedicated long-term representative is essential for accumulating valuable institutional knowledge and developing a deep understanding of the local context, which is vital for building strong, lasting partnerships and effectively navigating the country's unique challenges.

CP4 has partnered with other UN agencies, along with the government and civil society organizations, in joint

programming, which is expected to increase efficiency and reduce costs. To some extent, the results have been positive, as several agencies have pooled their expertise to work simultaneously toward the same objectives. However, this approach also incurs high costs.

Finding #20: The UNFPA Timor-Leste Country Office (CO) operates efficiently across 14 municipalities, but staffing challenges and short-term contractual arrangements hinder long-term planning and partnership stability, underscoring the need for a dedicated Youth Programme team and sustainable funding commitments.

CO operates with a small number of staff in collaboration with government and non-governmental partners and supports and implements a comprehensive Programme covering all 14 municipalities (refer to Figures 10 and 11) with satisfactory achievements. However, the staff is overstretched, with some positions vacant and team members sharing additional responsibilities. This issue is particularly evident in the Adolescent and Youth program, where the Youth Programme Officer position has remained vacant for an extended period and is currently overseen by the M&E Officer managing multiple responsibilities. While this arrangement may be cost-effective, it risks inefficiencies during high-workload periods, potentially compromising programme quality and reach. The office requires a dedicated Youth Programme team with experience and specialized knowledge to effectively advance UNFPA's youth agenda, especially considering the country's predominantly young population. UNFPA could take the opportunity to strengthen its impact on youth initiatives and solidify its leadership role among UN agencies, specifically in areas like SRH for adolescents and youth.[130]

Frequent leadership changes and prolonged vacancies in the representative position at the UNFPA Timor-Leste Country Office significantly impact the organization's effectiveness and relationships. Temporary placements often fill these gaps, undermining the country office's visibility at higher levels, stability, and partnerships. The lack of a long-term representative can result in inconsistent decision-making, weakened oversight and accountability, and potential disruptions to ongoing programs and initiatives. Additionally, this situation can strain existing relationships and impede the development of new partnerships with key stakeholders, including government bodies, donors, civil society organizations, and local communities.[131]

CO has allocated nearly 40% of its budget during 2021-2023 on capacity building initiatives[132]. While the UNFPA Country Office has made significant progress in strengthening relationships with local CSOs through capacity-building initiatives that leverage their local knowledge and grassroots expertise, the short-term nature of contractual agreements poses challenges. This approach may prove to be cost-ineffective in the long run and creates uncertainty regarding funding security for the CSOs, leading to difficulties in staff retention and potentially disrupting activity implementation. Although the investment in local partnerships is commendable, the current contracting model may inadvertently undermine the benefits of these collaborations, highlighting the need for more sustainable, long-term partnership arrangements to fully utilize the CSOs' capabilities and ensure consistent programme delivery. The main challenge identified by almost all IPs is the short-term validity of contractual arrangements, which hampers IPs' long-term planning and staff retention. UNFPA's inability to commit funding beyond one-year limits partners' opportunities for multiyear engagement with a dedicated budget.[133]

[130] UNFPA CO Organogram, Annual Report 2023, Monitoring Reports, and interviews with CO staff
[131] KII with UN and CO staff
[132] Annex1 Matrix under Efficiency Criteria 9Assumptions 21 and 22)
[133] Interviews with CO staff, CSOs (IPs), IP Annual Review Meeting minutes

Feedback from stakeholders suggests that one-off training is not enough to build the capacity (some were referring to one day awareness-raising big events and others for one-off training) without following up on the issues to make an impact and is inefficient cost wise as well. While more than one third of the CP4 budget is spent on capacity building,[134] lack of a comprehensive capacity building plan and systematic approach may limit the effectiveness and efficiency of these initiatives. While avoiding duplication, results achieved could be made more robust and sustainable.[135]

The establishment of SSTC with Khon Kaen University, Thailand, to enhance midwifery education through TICA is commendable, with benefits that outweigh the costs. However, UNFPA also faces lost opportunities from the abrupt discontinuation of projects (as discussed under Finding 7) due to funding shortages and the absence of proper exit strategies which prevents the demonstration of results from prior investments. Nonetheless, the country office staff works diligently, providing valuable technical support to the government and other implementing partners.[136]

Finding #21: The CO has effectively managed limited resources during CP4, leveraging additional support from development partners, but lacks systematic risk assessment documentation and faces questions about the cost-effectiveness of joint programming with multiple UN agencies.

CO has effectively managed its limited financial and human resources, as evidenced by the numerous achievements during CP4. The flexibility shown in accommodating programme demands with a small staff has been commendable.[137] UNFPA has actively mobilized sizeable resources to enhance the country's response to GBV and support the implementation of the National NAP-GBV through Spotlight Initiative and T4E, Together for Equality Programme with the EU and KOICA, respectively.[138] Additionally, the resources provided by UNFPA have had a leveraging effect, prompting additional support from other development partners. Additional resources were also mobilized and secured from Zonta International for the "Her Health and Dignity, Our Priority" programme focusing on strengthening the referral system within the healthcare and expanding psychosocial GBV responses in Liquica municipality.[139] CO also leveraged UNFPA APRO's technical support to develop a national GBV curriculum, enhance case management systems, create evidence-based guidelines, and mobilize additional resources, demonstrating its capacity to maximize partnerships.[140]

While the CO has managed and mitigated risks identified during the CP4 programme cycle, systematic documentation for Risk and Assumptions analysis was not available for assessment. Despite the lack of a formal risk assessment and mitigation plan, the CO has successfully adapted the programme to a changing environment without compromising its objectives.[141]

Although joint programming is intended to reduce costs, there are concerns about whether projects like SI have incurred higher expenses by engaging multiple UN agencies.[142] A detailed analysis of this issue can be found in the Spotlight Initiative case study report, which is attached to this report. However, this

[134] UNFPA CO 2023 MEL report, June 2024
[135] Stakeholder feedback
[136] UNFPA programme documents, Progress monitoring reports, UNFPA CO Annual Reports and CO staff interview feedback
[137] UNFPA Timor-Leste Annual Report 2023, Finalized in January 2024 and CO staff interview feedback and ET observation.
[138] Ibid
[139] Ibid, Zonta International. (2023). Her Health and Dignity, Our Priority: 2022-2024 Project Description - Timor-Leste and Papua New Guinea.
[140] Airoldi, G., & Rejinders, M. (2022). Mission Report of APRO GBV Specialist - Q4 (13-17 November 2022). UNFPA APRO, Timor-Leste.
[141] Discussions with CO staff
[142] Key Interview with Stakeholders and Donors, SI Final Report, 2024.

initiative aimed to meet organisational mandates while minimising the burden on stakeholders and identifying opportunities for collaborative analyses within the CPE processes. This collaboration would assess how participating agencies address ending violence against women and girls (EVAWG) in Timor-Leste, ensuring coherence and effective use of resources. Similarly, the joint supervision missions also minimized vehicle usage contributing to environmental benefits. [143]

A culture of environmentally friendly practices was observed in the country office. A conscious effort to reduce paper wastage by going paperless or reducing the amount of printing was adhered to. Making a point to switch off unnecessary lights when not in use, for example during the lunch break, was followed by every staff member in the country office. Pooling vehicles, when possible, also contributed to a cleaner environment.[144]

Finding #22: UNFPA strategies and interventions in SRHR, AY, GEWE and PD add value to the work of other development partners, especially the UN system. UNFPA plays a crucial role in advancing sexual and reproductive health and rights, youth issues, and gender equality, contributing significantly to the efforts of other development partners through data generation and capacity building.

UNFPA is a key agency addressing SRHR, youth and adolescent issues, gender equality and women's empowerment, and health responses to GBV and VAWG, with a particular focus on awareness on ASRH and HIV interventions. UNFPA's strategies and interventions in SRHR and adolescent health add significant value to the work of other development partners, especially within the UN system, largely due to the agency's mandate. A notable area of collaboration is UNFPA's support for data generation through partnership with INETL, which enhances the efforts of other partners. Additionally, UNFPA's investments in CSOs on the ground further contribute to the collective impact of development initiatives. In terms of capacity building for midwifery schools, UNFPA is the sole agency providing support.[145]

4.4 Answers to Evaluation Questions on Sustainability

(Common to all four programmatic areas)

4.4.1. Sustainability

EQ6. *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?*

Summary Findings

The capacity-building initiatives in family planning, GBV response, and maternal health have significantly enhanced the skills of IPs and key populations at national and municipal levels. These efforts, including training midwifery schools and community educators, have empowered healthcare providers and key populations in areas like HIV prevention and maternal care. However, challenges such as dependency on external support and concerns about programme sustainability hinder long-term effectiveness. The absence of robust exit strategies has led to incomplete handovers, threatening continuity once programme funding ends. Despite these challenges, projects

[143] Spotlight Initiative Timor-Leste – Case Study Report, *For UN Women and UNFPA Timor-Leste Country Programme Evaluations 2024*, Report, August 2024
[144] Observation, and discussions with CO staff
[145] Feedback from key stakeholders and CO staff

like the UN Spotlight Initiative have successfully integrated sustainability through clear exit strategies, strengthened government mechanisms, enhancing the durability of effects across – SRHR, GEWE, GBV, and AY. Implementation of CP4 through existing government system provides an environment to ensure sustainability of the interventions.

Finding #23: The capacity-building initiatives in family planning, GBV response, and maternal health have significantly enhanced the capabilities of implementing partners and key populations, yet challenges such as dependency on external support, limited data literacy, sustainability concerns, and inadequate exit strategy planning hinder long-term effectiveness and Programme continuity.

In general, capacity building efforts have produced satisfactory results evident from interview feedback and CO reports.

The capacity-building initiatives in FP, health sector response to GBV, MISP, BEmONC; and ANC and PNC have significantly enhanced the capabilities of implementing partners at both the national and municipal levels (discussed in Findings 5,6,7). The intervention focused on building the capacity of midwifery schools in competencies prescribed by the ICM, including health sector response to GBV, is sustainable and likely to reduce the need for in-service training. In maternal health, education on the importance of institutional deliveries and birth preparedness has empowered pregnant women and their families to utilize healthcare facilities for delivery, as discussed in Finding 6. Due to the involvement of the health system at all levels, these interventions are expected to continue as noted in Findings 5 and 6.

Under the HIV program, the capacity of CSOs was strengthened not only in report writing but also in proposal development for resource mobilization which has helped the CSO to continue some of the preventive activities (discussed in Finding 7).

Additionally, the capacity building of community and religious leaders to advocate against stigma and discrimination towards PLWHA should contribute to further reducing the stigma and discrimination. However, there was no exit strategy or plan for a smooth handover of activities to implementing partners concerning HIV-related activities. The capacities of key populations were enhanced through the training of community educators in basic package of services for the prevention of HIV and STIs as detailed under Finding 7 should contribute to more preventive measures, testing and treatment.

The health sector's response to GBV includes a comprehensive component focused on mobilizing communities for the prevention of GBV and for reporting cases. Capacity development efforts for implementing partners in integrating gender equality and providing GBV services, as well as services for adolescents and youth and interventions under population dynamics, reveal both progress and challenges. Improvements in capacity development for healthcare providers, particularly in integrating GBV screening into comprehensive SRH services includes the implementation of guidelines and standard operating procedures have created cadre of service providers in the national system which can be a sustainable model. However, there is still a dependency of external funds to operate the programme. With funds on these initiatives coming to an end, the government will have to take over the operational cost of the GPB prevention work, and on a positive note, MSSI is supporting the operational costs.[146]

CSOs involved in gender equality and GBV work face challenges due to limited data literacy, hindering their capacity to collect high-quality and reliable data on VAWG, especially in emergency situations. Both government stakeholders and local CSOs are concerned about the sustainability of programs when

[146] CO presentation on CP4 progress, Field observation and interviews with stakeholders

funding is uncertain or comes to an end. While the structures and mechanisms set in place will be there, unless the government commits funding, sustainability of the effective functioning remains a concern, as many initiatives are project-based and may find difficulty to continue after initial funding ends, underscoring the need for both short-term and long-term planning.[147] Although exit strategies are increasingly being discussed in projects, many previous initiatives lacked effective exit planning, leading to unfinished activities due to funding limitations and staff changes.[148] Findings of CF evaluation stated that in general out of 85 projects implemented by UN agencies 69 of them did not have any reference to exit strategy. Two joint projects, including SI project had included exit strategies.[149] The joint UN SI project and T4E sustainability is ensured through a strategy that was integrated into the project design, focusing on strengthening government mechanisms. More supporting details can be found in the Spotlight Initiative case study findings.[150]

Additionally, interventions from previous country programme cycles have reinforced this capacity-building focus. For instance, the reduction in dependency on international consultants within government offices signals sustainability in investments made by UNFPA, as evidenced by successful initiatives like censuses, publications, and policy development. A notable example is PRADET; a civil society organization supported by UNFPA two cycles ago, which now operates independently and provides nationwide services while generating its own funding. UNFPA utilised existing national systems to implement the CP4 without establishing parallel systems to ensure sustainability of the interventions.

EQ7. To what extent did UNFPA achieve government ownership of various interventions (BEmONC, Safe Spaces, ANC-PNC, Family Planning, HIV, CSE, and Census)?

Summary Findings:

UNFPA has made significant strides in strengthening logistics and capacity-building initiatives; however, there is still reliance on external funding. UNFPA strengthened the logistics management information system for FP and the m-Supply system for many commodities needed by health services, thus avoiding creating parallel structures. The plans for expanding BEmONC facilities and certification are jointly developed by the MOH and UNFPA making it part of the government system from the beginning. The MISP is still not included in national disaster preparedness plans, although there are plans to advocate for its inclusion and requires continued advocacy.

With regard to safe spaces, observations and interviews with key informants reveal that safe spaces continue to operate even after EU funding has ceased. The MOH continues to provide services, while MSSI contributes to sustaining the centres. This is an indication that these are within the government ownership, however, a lack of resources was noted, raising concerns about long-term sustainability.

MSSI, including SEI, have enhanced the capabilities of its officers in implementing NAP-GBV and case management through sustainability plans. UNFPA has strengthened implementing partner capacities and operational mechanisms for continued resource commitments and ownership of interventions; however, reliance on annual

[148] KII feedback, CSO feedback
[149] UNSDCF 2021 – 2025 Final Evaluation"Timor Leste, November 2024
[150] SI evaluation report, 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)

funding contracts for CSOs and ongoing training needs hinder long-term programme effectiveness.

In addition, capacity-building initiatives in FP, the health sector response to GBV, MISP, BEmONC, and ANC and PNC have significantly strengthened the capacities of implementing partners at both the national and municipal levels. Given the involvement of the health system at all levels, these interventions are likely to continue. UNFPA has contributed to strengthening institutional capacities for data production and utilization. The census was successfully completed, and several publications were produced with UNFPA support, resulting in 100% government ownership, allowing INETL to continue this work independently.

Finding #24: While UNFPA has made significant strides in strengthening logistics and capacity-building initiatives, in all areas, concerns about government ownership and sustainability arise from reliance on external funding, unclear integration strategies, and the need for ongoing government support to large surveys such as census, maintain infrastructure (such as safe spaces) and essential services.

UNFPA has strengthened the logistics management information system for FP and the m-Supply system for many commodities needed by health services. While there are areas that require improvement, the successful implementation of these systems at the national INFPM, regional INFPM, HNGV, regional hospitals, and CHCs demonstrates the government's commitment to this intervention (see Finding 6). However, there was no exit strategy or plans for a smooth handover of activities to implementing partners concerning HIV-related initiatives (Ref. Findings 7). While the structures and mechanisms set in place will be there, unless the government commits funding, sustainability of the effective functioning remains a concern, as many initiatives are project-based and may find difficulty to continue after initial funding ends, underscoring the need for both short-term and long-term planning[151].

There is evidence of a committed budget under the TPP mechanism for procuring contraceptives and other reproductive health supplies, amounting to USD 342,745 and USD 240,648 in 2022 and 2023, respectively. The ICM curriculum for midwifery training has been implemented in three midwifery schools; however, issues related to curriculum uniformity among these institutions remain (reference Finding 6). The intervention related to the capacity-building of midwifery schools in competencies prescribed by the ICM, including health sector responses to GBV, is sustainable and likely to minimize the need for in-service training.

The plans for expanding BEmONC facilities and certification are being jointly developed by the MOH and UNFPA. A primary concern is the repair and replacement of equipment and instruments once funding ceases. The concept of integration regarding the provision of services within the essential service package is unclear, particularly whether it refers to the integration of services at various health service levels.

The MISP is still not included in national disaster preparedness plans, although there are plans to advocate for its inclusion and requires continued advocacy. With the contextualization of MISP guidelines and the capacity building of providers, it should be feasible to implement MISP in emergencies. As noted in Finding 6, advocacy for developing rights-based family planning services has been inadequate and needs continued efforts. Given the involvement of the health system at all levels, these interventions are likely to continue. Another sustainable initiative being planned is the inclusion of health sector responses to GBV in the pre-service curriculum for midwives, nurses, and doctors, in collaboration with the Office of the Dean of the Faculty of Medicine and Health Sciences[152].

[151] KII at municipality staff, Annex 1 Matrix, Annual Plans, SI and T4E evaluation reports
[152] CO planning documents, CO staff interviews and CP4 presentation by CO

As stated earlier, capacity-building initiatives in FP, the health sector response to GBV, MISP, BEmONC, ANC and PNC, CSE and implementing large surveys such as census have significantly strengthened the capacities of IPs at both the national and municipal levels (see Findings 5, 6, 14 and 23).

To ensure sustainability, UNFPA has contributed to strengthening institutional capacities for data production and utilization. For example, the census was successfully completed, and several publications were produced with UNFPA support, resulting in 100% government ownership, allowing INETL to continue this work independently. However, a key informant requested UNFPA's technical support for large surveys such as the Census and DHS and in capacity building for data analysis (see also findings under Effectiveness criteria on PD).

Finding #25: MSSI, including SEI have enhanced the capabilities of its officers in implementing NAP-GBV and case management through sustainability plans, while UNFPA has strengthened implementing partner capacities and operational mechanisms for continued resource commitments and ownership of interventions; however, reliance on annual funding contracts for civil society organizations and ongoing training needs hinder long-term programme effectiveness.

The Director of Municipality Social Services oversees all coordination related to social assistance, with municipal coordination meetings held quarterly to update and gather feedback on referral pathways and other relevant issues. Programme sustainability is bolstered by established systems, including the enactment of a law addressing domestic violence, which provides a legal framework for these interventions. During emergencies, MSSI officers collaborate with municipal authorities to conduct real-time surveys to identify individuals requiring social assistance.[153] This comprehensive approach ensures a coordinated response to GBV cases, from initial reporting to the provision of necessary support and services. Capacity development efforts include training staff and disaggregating data by sex and age, reinforcing community and national ownership, including commitments of financial resources. Partner organizations have created sustainability plans, with MSSI continually enhancing the capabilities of its field officers in GBV case management through support from various partners.[154]

Observations and interviews with key informants reveal that safe spaces continue to operate even after EU funding has ceased. The MOH continues to provide services, while MSSI contributes to sustaining the centres. However, a lack of resources was noted, raising concerns about long-term sustainability. With the donor funding, such as T4E and Zonta, set to end in late 2024, some functions may struggle to remain operational unless government allocates funding. Financial issues have already been observed in the Spotlight Initiative (SI) project, where funding ended in December 2023, affecting the operation of safe spaces—particularly the cost of food for survivors, who often do not come alone. While there have been no reported safety incidents affecting survivors or staff thus far, safety remains a concern. Transportation and communication facilities are essential for providing services, and currently, personal mobile phones of the staff are being used for communication.[155]

However, as mentioned under Efficiency criteria, UNFPA’s provision of annual contracts, dependent on funding availability poses challenges for CSOs, as they face uncertainty regarding funding beyond the first year(contractual period). This unpredictability can hinder staff retention and affect service efficiency, making it difficult to maintain trained personnel within the organization. Furthermore, the

[153] Key Informant Interview with Director General of Social Protection, Ministry of Social Solidarity, conducted on July 15, 2024

[154] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative; 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)*

[155] key informant interview feedback, SI evaluation report 2024

ongoing need for recurring training presents additional challenges. [156] However, the experiences and findings from various projects related to GBV referrals have significantly influenced the development of policies and interventions, particularly through the five-year Strategy for Social Protection. This comprehensive approach has led to key advancements, including the approval and enactment of the domestic violence law, the implementation of an action plan for GBV led by the SEI, and the specification of MSSI's mandate to oversee the implementation of all social policies and assistance programs for GBV survivors.[157]

4.5 Answer to Evaluation Questions on Coherence/Coordination

***EQ8**. To what extent has 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?*

Summary findings:

UNFPA CO, actively engaging in various technical groups, results groups and management teams, benefitted from UNCT coordination mechanisms to yield positive outcomes. UN joint programme is an example where the effective and enhanced coordination within the UN system benefitted UNFPA by ensuring a clear division of labour that avoids overlap and duplication.

Despite effective partnerships with other UN agencies and donors, coordination challenges persist, highlighting the need for improved communication and standardization in joint monitoring where needed. Joint programming has successfully reduced overlaps in GBV prevention initiatives by promoting coordinated efforts among UN agencies.

UNEDAP, inter-agency network promoted an evaluation culture contributing to coordination of the CPEs that were implemented simultaneously and UNFPA was able to take advantage of the evaluation findings of other CPEs avoiding overlap.

UNFPA effectively established coherent partnerships and coordinated efforts with local organizations and government agencies to implement the National Action Plan on Gender-Based Violence, and direct collaboration with marginalized groups. Similarly, UNFPA benefitted from working with UN groups in the humanitarian context as well. 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 the disaster during the pandemic and the nationwide floods at the same time.

Finding #26: UNFPA CO's active participation in UNCT working groups and joint initiatives has strengthened coordination and delivered positive outcomes in health response to GBV, gender equality, AY, and humanitarian responses. Clear division of labour and shared objectives within the UN system have minimized overlap, enhanced partnerships, and promoted synergies, especially in gender equality and GBV efforts.

UNFPA CO actively participates in the UNCT coordination mechanism through various technical groups, results groups, and management and operations teams, thereby supporting the RCO and contributing to UNSDCF planning and implementation. CO has further strengthened coordination by engaging in UN joint programming, sector coordination, monitoring and evaluation teams, data sharing, and humanitarian preparedness and response. UNFPA's long-established coordination with government and donor agencies has yielded positive results, as demonstrated in the discussions under the effectiveness

[156] Key Informant Interview with CSOs, conducted between 03 and 18 July 2024
[157] Spotlight Initiative. (2024). Spotlight Initiative Timor-Leste Final Cumulative Report. Spotlight Initiative

criteria in the programmatic areas of SRHR, GEWE, GBV, AY, and PD, including in humanitarian responses (ref findings under the Effectiveness criteria of all four programme areas).[158]

UN Joint programming has significantly contributed to reducing overlaps in gender-based violence (GBV) prevention and awareness initiatives in Timor-Leste by facilitating the collective implementation of the NAP-GBV as a unified UN Agency. This reduction in duplication is primarily achieved through several key mechanisms. First, UN agencies concentrate on their respective areas of expertise, ensuring that each agency adds unique value to GBV initiatives while supporting the overall effort. Additionally, for major joint programmes like the UN-EU Spotlight Initiative and UN-KOICA T4E, UN agencies coordinate their proposals based on specific mandates and responsibilities, resulting in clearly defined roles, with UNFPA and UN Women often taking lead positions. Collaborative implementation is also evident in initiatives such as the SI and T4E, which include joint monitoring and consolidated progress reports submitted to donors, adhering to their specific reporting formats. Furthermore, UNFPA plays a pivotal role in key areas such as youth and adolescent programming of CSE, health sector responses to GBV, and integrated SRHR services.[159]

UNEDAP, an inter-agency network, that promotes an evaluation culture contributing to UN coherence on evaluation, promoted the coordination of the CPEs that are on the ground simultaneously. This is to take advantage of the evaluation findings that could be useful to each other, avoiding overlap and ensuring that evaluation is addressed as a strategic function by UN agencies and their partners that share the same goals and vision of promoting human development.[160]

UNFPA has maintained a strong presence in policy-making and key decision-making functions related to its mandate, as evidenced by its involvement in active working groups. Current engagements include Joint UN Partnership projects with UNICEF, UNDP, UN Women, ILO, and IOM, where UNFPA coordinates efforts on gender equality and gender-based violence.[161] The coordination among the UN agencies works positively avoiding duplication and contributing to the results based on each agency expertise. The UN Gender Technical Working Group (GTG) is co-chaired by UNFPA and UN Women, highlighting its leadership role in this critical area. Youth Group, which is active and meets regularly, is co-chaired by UNFPA and UNICEF with the aim to advance youth engagement and integration; however, the results group on youth does not implement NAP Youth.[162]

Finding #27: UNFPA Timor-Leste has effectively established coherent partnerships and coordinated efforts with local organizations and government agencies to implement the National Action Plan on Gender-Based Violence, and direct collaboration with marginalized groups.

Partnerships with other development agencies as well as government and non-government institutions working toward the same objectives, UNFPA have been able to positively leverage achieving government commitments in implementing NAP GBV as well as to some extent NAP Youth. This collaboration supports the provision of specific technical expertise in relevant areas under the premise of multi-sectoral coordination. By establishing rapport and long-term partnerships with CSOs, UNFPA has identified organizational expertise that facilitates successful implementation without duplicating

[158] UNCT meeting minutes, EF326 Narrative Humanitarian Report, KII
[159] ibid
[160] CPE team leader meetings and communication with APRO
[161] Spotlight Initiative Timor-Leste – Case Study Report, *For UN Women and UNFPA Timor-Leste Country Programme Evaluations 2024*, Report, August 2024
[162] Ibid; UNCT meeting minutes, KII, document review,

efforts. Additionally, a functional inter-ministerial coordination mechanism has contributed to avoiding overlap[163].

Despite these coordinated efforts, several challenges and areas for improvement have been identified. 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. UNFPA IP review reports mention the lack of participation from members of vulnerable groups (e.g. people with disability and LGBTQI) although they were invited for the review meetings. The evaluation team did not get the opportunity to meet these groups to delve into the reasons. The Common Country Assessment 2023 also highlights a "lack of coordination between the Government and development partners working in the youth sector" and barriers to participation and representation for rural youth, young women, and youth with disabilities.

Finding #28: UNFPA effectively leveraged its partnerships with other UN agencies and aid organizations to enhance support for gender-specific mandates of CP4, demonstrating leadership in gender equality initiatives through coordinated efforts and technical expertise.

Leveraging Partnerships and Additional Resources: CO has leveraged its impact to enhance GBV response and prevention through strategic partnerships, innovative approaches, and resource mobilization. Collaboration with multiple development partners through projects such as SI, T4E and Zonta to support the implementation of the NAP-GBV (2022-2032) has helped strengthen health services for GBV survivors, improve infrastructure, and conduct community awareness campaigns. Through these projects, UNFPA mobilized resources for advocacy, CSE, and capacity building in response to GBV, extending their reach across multiple municipalities in Timor-Leste.[164]

However, concerns about coordination among UN agencies persist. Differing mandates and procedures can hinder the achievement of desired outcomes. Donors have raised issues on inconsistent joint monitoring practices involving donors, and implementing partners while the EU has expressed concerns about the broader impact on beneficiaries in relation to allocated budgets.

Despite some of the advancements, challenges persist. IPs and donors have reported weaknesses in coordination among UN agencies, and there are notable gaps in programming, particularly regarding ASRHR within the current country Programme and joint initiatives (e.g. IPs using their own SOPs, not harmonized to deliver the same output; focus of interventions not well coordinated in the field thus the optimum results cannot be achieved). Based on key informant interviews, there is a sense of competition among different agencies, each with its own interests and procedures. More detailed information supporting this assessment is available in the SI case study report.[165]

Organizations like KOICA, Spotlight Initiative (SI), and Zonta share similar objectives in addressing GBV but differ in their implementation coordination. 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[166], therefore establishing more diverse, and in some cases ongoing, relationships with the UN Agencies.

[163] CCA, 2023

[165] SI repot, KII

[166] Interviews, CSO stakeholders

UNFPA has expanded its work in the area of youth, beyond CSE, and has engaged in the area of youth empowerment and also on employment, initiated coordination with the Secretary of State for Training and Employment (SEFOPE) for future engagement. UNFPA led the Youth Results Group (YRG) as its chair, meeting regularly with about 10 UN agencies, enabling cross-learning between UN agencies with discussion of major programs of the agencies related to youth. A key area was to measure the UN agencies' commitment against the National Action Plan for Youth, with a plan for supporting the achievement of the NAP Youth in the coming years. Similarly, UN joint programmes T4Eand SI working with CSE out-of-school population contributed to UNFPA youth programme.[167]

Additionally, during stakeholder interviews, concerns were raised about the lack of donor visibility in display and publicity materials. It was not clear whether there was a platform to discuss and iron out this kind of misunderstandings and miscommunications. These could easily be addressed through regular meetings and enhanced communication among relevant parties. Feedback from key informants suggested that UN agencies could better utilize their technical expertise to support local partners in advocating for and implementing the NAP-GBV. This interconnected approach aims to ensure that the efforts of UN agencies are cohesive and comprehensive, addressing the needs of Timor-Leste's population throughout all stages of life. Timor-Leste has a high-level coordination mechanism in place, namely the Development Partners Coordination Meeting (TLDPCM), led by the MoF and the MoFA. This meeting occurs annually and quarterly, but it may not have been fully utilized as a platform for information sharing and effectively leveraging the partnerships with other development agencies to enhance support for UNFPA mandated areas including gender, through coordinated efforts and technical expertise.[168]

These observations underscore the critical need for improved coordination among UN agencies, enhanced sustainability of initiatives, and strengthened monitoring and evaluation practices. For example, in interviews with key informants, IPs suggested that UN agencies could better utilize their technical expertise to support local partners in advocating for and implementing the NAP-GBV. This interconnected approach aims to ensure that the efforts of UN agencies are cohesive and comprehensive, addressing the needs of Timor-Leste's population throughout all stages of life. By adopting this holistic strategy, the implementation of the NAP-GBV could become more effective and sustainable, leveraging the combined strengths of various UN agencies to create a more significant impact in preventing and responding to gender-based violence in Timor-Leste.[169]

4.6 Answer to Evaluation Questions on Coverage and Connectedness

4.6.1 Coverage

EQ9. *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"?*

Summary Findings:

During the COVID-19 pandemic and the 2021and 2023 floods in Timor-Leste, UNFPA targeted vulnerable populations, including persons with disabilities, through gender-based violence (GBV) prevention campaigns

[167] Spotlight Initiative Timor-Leste – Case Study Report, *For UN Women and UNFPA Timor-Leste Country Programme Evaluations 2024*, Report, August 2024
[168] KII,
[169] Spotlight Initiative Timor-Leste – Case Study Report, *For UN Women and UNFPA Timor-Leste Country Programme Evaluations 2024*, Report, August 2024

and essential service provision for survivors. Under UNFPA leadership, the Sexual and Reproductive Health sub cluster was reactivated to ensure service continuity, and online capacity-building training for health providers continued. UNFPA distributed dignity kits to needy women and girls, provided psychosocial support, and conducted a mapping exercise to address vulnerable groups' needs. **I**n addition to the flood damages in 2021, the situation became worse by increasing cases of COVID-19. Despite challenges, including the lack of a functioning inter-agency sexual and reproductive health coordination body, UNFPA continued to integrate sexual and reproductive health and rights services into humanitarian efforts, ensuring access to hygienic items and essential services while supporting data collection on SRH and GBV services.

Finding #29: During COVID-19 pandemic and the floods UNFPA reached out to the neediest groups: women, children, and other vulnerable groups. However, there is limited information on women or children with disabilities or those from marginalized sexual orientations. CO established effective management system through the GBV Subgroup while addressing the needs of women and girls in evacuation centres and flood-affected areas.

Under the UNFPA leadership, the SRH sub cluster was reactivated within the Health Cluster of UNCT to monitor the continuity of SRH services and the incidence of GBV. In collaboration with WHO, UNFPA reactivated the dormant MNCH technical working group, which includes representatives from UNICEF, NGOs, and international NGOs (ref. Finding 8). This group regularly assessed service disruptions, morbidities, and mortalities in close coordination with all the municipal health authorities.[170]

In ongoing efforts, UNFPA continued to ensure that SRHR and GBV services were integrated into humanitarian coordination mechanisms, strengthening partnerships among UN agencies. CO reports on the pandemic noted movement restrictions and the healthcare system's focus on COVID-19 vaccine campaigns, which limited GBV service outreach. Public messages on GBV prevention were revised and distributed to address rising GBV during COVID-19 restrictions, and psychosocial support was launched, including in quarantine facilities.[171] Under the Spotlight Initiative, more than 400 healthcare workers were sensitized on GBV identification, response, and referral during COVID-19, but challenges such as movement restrictions and healthcare worker engagement due to COVID-19 vaccine campaigns delayed some GBV interventions. CO trained 4 batches of frontlines healthcare workers from the National Hospital and other Community Healthcare Centres (CHC) in Dili.[172] Prevention of GBV and information on care seeking were also part of the capacity building. Key contribution of UNFPA's response to the COVID-19 pandemic was in capacity building of health workers in maternal care, BEmONC and infection prevention, especially care of COVID positive mothers in isolation camps (ref Finding 8). Protective garments were provided to health providers.

During floods in 2021 and 2023, UNFPA demonstrated significant visibility and responsiveness, particularly targeting vulnerable populations, including PWDs and other hard-to-reach groups. The organization played a pivotal role in supporting communication campaigns focused on GBV prevention and response providing essential services to GBV survivors during these crises. Through the modality of the GBV Sub Group, 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. UNFPA made special efforts to sensitize women, adolescents, families, and communities about GBV prevention and

[170] Socio-Economic Impact Assessment of COVID-19 in Timor-Leste, Round 2, 2021, CO documents related to the response
[171] Spotlight Initiative. Final Narrative Programme Report: Timor-Leste (2020–2023), United Nations and European Union.
[172] Ibid

the available avenues for care. Additionally, it worked to ensure that key populations had access to a basic service package, although this was not always achievable. Collaborating with established implementing partners, UNFPA provided psychosocial support in three evacuation centres (Vera Cruz, Lahane and Tasi Tolu). Additionally, they have collaborated with FOKUPERS to implement psychosocial support activities for women and girls in two evacuation centres.[173]

2021 was a difficult period; in addition to the flood damages the situation became worse by increasing cases of COVID-19. Crowded and poorly ventilated housing, lack of handwashing and sanitation, generally weak health system and high prevalence of underlying conditions had increased Timor-Leste' vulnerability to high transmission rate with only 3 designated isolation centre treatment facilities available at Vera Cruz, Lahane and Tasi Tolu. UNFPA coordinated with national partners through the Health and Protection cluster coordination mechanisms and 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. UNFPA supported to establish and equip a maternity isolation at Vera Cruz isolation centre. Also led the development of the training modules for ANC, intrapartum and postpartum for women with COVID-19 which included a session on sensitization on Gender-Based Violence (GBV). The guideline had been widely used as a guide for mothers with Covid-19 in all isolation centres.[174]

Estimated target for UNFPA beneficiaries were 745[175] and 345 maternity kits containing basic needs for pregnant women and babies were distributed. 437 women of reproductive age were assisted through the Mobile Maternity Clinic across 15 IDP camps. As the pandemic was spreading UNFPA had locally procured Covid-19 prevention supplies for the volunteers who provided services in the IDP camps and to support 14 health facilities in 9 districts who distributed maternity packages to beneficiaries. 16 packages of Covid-19 prevention supplies were also distributed to 14 health facilities during distribution of Maternity Packages. Through Alola foundation, UNFPA distributed 254 maternity kits for 160 pregnant and 85 post-partum packages to 14 health facilities in ten municipalities affected by floods.[176]

The floods in 2021 affected over 25,700 households across 13 municipalities (numbers reported vary based on source, see table presenting the cases in Annex 1 under Coverage criteria, Assumption 34), prompting UNFPA to engage proactively in humanitarian responses to support these communities.[177] For more details, please refer to finding 8. Out of the total affected population there had been 2,982 Women in Reproductive Age (WRA) plus approximately 345 pregnant women. During this period, dignity kits were distributed to support 1,305 women and girls of reproductive age in evacuation and COVID-19 facilities. Activities conducted by implementing partners, such as engaging children in play to allow parents to receive counselling and support for GBV prevention and intervention, highlighted the holistic approach adopted by UNFPA. Psychosocial support was offered in quarantine facilities during COVID-19, and safe spaces to help survivors identify signs of violence and receive the necessary support through a network referral system. Specific interventions also included mental health services for children, positive parenting sessions, and emotional first-line support for GBV survivors. UNFPA also conducted a mapping exercise to ensure a coordinated response that addressed the specific needs of

[173] Spotlight Initiative. Final Narrative Programme Report: Timor-Leste (2020–2023), United Nations and European Union.
[174] Socio-Economic Impact Assessment of COVID-19 in Timor-Leste, Round 2, 2021, EF326 -Narrative Report Humanitarian Fund 2021 (Jan 2022), Feedback from CO relevant staff
[175] Ensuring continuity of essential SRH and GBV response services for nationwide flood response during the COVID-19 pandemic, EF326 Narrative Report Humanitarian Fund 2021 (Jan 2022), Feedback from CO relevant staff
[176] ibid
[177] ibid

women, children, PWD, and other vulnerable groups. However, it is important to note that there is limited information regarding women or children with disabilities or those from marginalized sexual orientations.[178]

In 2023, following severe floods that affected 12 municipalities, the response reports indicated needs assessments in three areas that showed significant disruptions of SRHR services and services for GBV survivors as well as lack of preparedness by the municipal health system. UNFPA set up mobile and fixed SRHR services in tents with focus on remote areas, deployed trained health providers to care for survivors of GBV and collaborated PRADET to manage cases of sexual assault (as also noted in Finding 6). Referral pathways for EmONC and GBV were established. Messages on SRH care and GBV prevention were distributed to women and communities. In total, 855 women of reproductive age received maternity and hygiene kits; however, significant gaps remain in STI and HIV services for adolescents, as outlined in the MISP guideline[179] (related discussion under findings related to coverage and connectedness).

The prepositioning strategy for the maternity and dignity kits has been critical and timely for the country office and when the new localized emergencies (floods) hit Covalima, Manatuto, Baucau, Lautem, Viqueque and Bobonaro municipalities in June 2024, MOH had requested UNFPA to support by distributing 400 Dignity kits (DK) and Maternity Kits (MK) to Covalima. During this period, CO, under the emergency fund (EF476) had prepositioned 1,200 maternity and dignity kits to ensure quick access during emergencies and had been able to hand out maternity and dignity kits to in other municipalities in need (200 to Ainaro, 200 to Bobonaro, 200 to Covalima, 200 to Manufahi and 400 to Viqueque). CO procured 5 comprehensive intervention kits for emergency response teams (MISP-trained health workers) to enhance government preparedness and capability. Those intervention kits are made of medical and non-medical kits, GBV kit and logistic kit that are context-specific. The distribution has been channelled through SNAEM and the District Health Services.[180]

There is also a challenge with the consistency of data, as different numbers are reported in different reports. However, it is evident that given the limited capacity of UNFPA and only a few IPs (CSOs) working with several other development agencies, UNFPA has reached out to cover those in need during these emergencies.[181]

Finding #30: Capacity building in MISP of health service providers, managers at municipal level and selected NGOs working with UNFPA has been done. While there was no evidence of capacity-building initiatives for community leaders and women's groups in emergency preparedness at the municipal level, UNFPA effectively utilized the CSO network to provide psychosocial support to affected women and girls, addressing immediate needs while acknowledging long-term interconnected challenges in emergency response.

UNFPA CO trained 23 health care providers from 5 health facilities on the MISP and introduced the draft SOPs. CO had reached a total of 179 beneficiaries in Bobonaro (Maliana, Balibo, Bobonaro administrative posts) and in Covalima (Suai, Tilomar, Zumalai) through the implementing partner CSO Belun. 93 females and 86 males had been engaged in 29 meetings on maternal health and GBV in

[178] Ensuring continuity of essential SRH and GBV response services for nationwide flood response during the COVID-19 pandemic, EF326 Narrative Report Humanitarian Fund 2021 (Jan 2022), Feedback from CO relevant staffibid
[179] Reports to Humanitarian Fund 2022
[180] UNFPA Annual Report 2021,2022 and 2023, EF 326 Narrative Report Humanitarian, CO staff feedback
[181] ibid

emergencies. The evaluation was not able to find sufficient evidence of capacity-building initiatives for community leaders and women's groups in emergency preparedness, as there are currently no preparedness plans at the municipal level (see Finding 8). Despite this gap, UNFPA leveraged the established CSO network and IPs to provide support in areas affected by floods. FOKUPERS conducted two-day Reflection and Counselling for 30 participants (17 women and 13 girls affected by flooding), 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. 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 time thus addressing immediate psychosocial needs while laying the groundwork for long-term resilience.[182]

Strengthening CSOs and providing necessary resources were key strategies employed by UNFPA to assist the affected populations, aligning with the understanding of the long-term and interconnected nature of challenges in emergency response. While most of the response needs were covered, missing are those related to HIV/STI prevention and ASRH services (see Finding 8) which will have implications for the population that will be left out without services[183]

In 2021, heavy rainfall caused floods and landslides, displacing populations into overcrowded camps, increasing their vulnerability to COVID-19 and other communicable diseases. In addition, Maternity mobile clinics, staffed by three new midwifery graduates supported by UNFPA, visited the camps to offer information on SRH, HIV, family planning, GBV, and COVID-19, identifying pregnant mothers for referral to nearby facilities. A total of 378 women of reproductive age received FP information, including 27 pregnant and 73 postnatal women, leading to 11 continuers and 17 new acceptors of services. MISP orientation conducted with technical support from APRO and RH specialist included 22 participants covering decision makers and programme managers including two UNFPA Program managers on GBV programme.[184]

Throughout the COVID-19 pandemic and floods, UNFPA effectively managed resources, with no reported shortages of supplies. Under its Humanitarian Coordination and Preparedness initiative, UNFPA has taken significant steps to enhance preparedness and coordination in humanitarian settings including developing and regularly updating an Annual Preparedness Action Plan, ensuring staff availability for critical functions during emergencies, and improving the capacity to swiftly provide essential relief supplies to affected populations while maintaining constant communication with humanitarian partners. Additionally, UNFPA supported displaced communities in three evacuation centres (Vera Cruz, Lahane and Tasi Tolu) through the involvement of UN Volunteers. Under the Gender and Protection Working Group (GAPWG), two coordination sub-groups mobilized to provide essential support at evacuation sites for affected communities. Moreover, UNFPA played a crucial role in data provision during crises, ensuring that multi-sectoral assessments included sex and age-disaggregated data, as well as addressing minimum SRH and GBV issues within assessment tools. Four comprehensive assessment tools were developed to thoroughly address SRH and GBV issues, facilitate effective information management, and monitor response efforts.[185]

[182] EF326 Report
[183] Humanitarian response-related documents and CO staff interviews
[184] EF 326 and EF476Narrative final Repot-Humanitarian, and feedback from CO staff
[185] ibid

UNFPA's contributions during the pandemic and floods were acknowledged by the MOH, with initiatives such as the development of national guidelines for ANC and PNC, and specific guidance for managing COVID-positive pregnant mothers in isolation camps. During the floods, UNFPA conducted situation analyses in several municipalities to assess supply needs for maternity kits and hygiene packs and raised resources accordingly.[186]

UNFPA has also supported GBV risk mitigation and response activities specifically targeting women of reproductive age in flood-affected areas and those impacted by COVID-19. Reports on the COVID response and flood response have been made available for 2021 and 2023, with proposals written for resource mobilization. Assessments conducted during the floods led to the development of documents for planning mobile and fixed SRH services and estimates for necessary supplies (refer to Finding 8). UNFPA established fixed and mobile camps to ensure SRH and GBV services for displaced populations, distributing maternity kits to pregnant women and dignity kits to women and adolescents.[187]

Additionally, UNFPA's focus on preventing GBV and supporting survivors was a significant aspect of its emergency response (Ref. finding 5, 6). It is noted that there were no ASRH services available during the COVID-19 and flood situations. The agency's strategic input included social and behavioural communication about care during pregnancy and GBV prevention, as highlighted in previous findings.[188]

4.6.2. Connectedness

(Linked to Sustainability question as well)

EQ10. *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?*

Summary Findings

UNFPA ensured that SRHR and GBV services were integrated into humanitarian coordination mechanisms and strengthened humanitarian partnerships, particularly among UN agencies.
The Emergency Preparedness Plan has been updated accordingly and Action Plan is rolled over into 2024 to build capacity of municipality and CHCs. The ANC and PNC guidelines developed during COVID pandemic were later modified for capacity building and are continuing.

Capacity building in MISP of health service providers, managers at municipal level and selected NGOs working with UNFPA has been done; however, there is no evidence of capacity-building initiatives for community leaders and women's groups in emergency preparedness at the municipal level. UNFPA effectively utilized the CSO network to provide psychosocial support to affected women and girls, addressing immediate needs while acknowledging long-term interconnected challenges in emergency response. Additionally, country office faces the challenges in terms of staff dedicated to emergency response and to be able to allocate time to address long-term interconnected problems is beyond the capacity of the country office. Thus support to building capacity and resiliency of the humanitarian partners and beneficiaries has been minimal given the current capacity of the country office. However, UNFPA, with key partners, has supported laying some groundwork to strengthen the government capacity to respond and manage the emergencies.

[186] EF 326 and EF476Narrative final Repot-Humanitarian, and feedback from CO staff
[187] ibid
[188] Spotlight Initiative. Final Narrative Programme Report: Timor-Leste (2020–2023). United Nations and European Union; UNFPA Annual Report 2021

Finding #31: UNFPA has provided some support to long-term preparedness and coordinated support for GBV-related activities during emergencies.

Timor Leste frequently experiences floods and UNFPA has been at the forefront in providing essential SRH services, including mobile maternal health, FP advice, and GBV prevention education and GBV services including first-line psychosocial support in quarantine facilities and evacuation sites. [189]As the lead agency for SRHR in the UNCT Emergency Health Cluster, UNFPA has initiated capacity building for MISP. Evident from annual reports and review of the MISP manual, UNFPA has contextualized the interagency manual on MISP and trained MOH staff, doctors, and midwives, advocating for its inclusion in National Disaster Plans and for prepositioning reproductive health supplies (more under Finding 8).[190]

After having finalized the contextualized MISP guideline, through a partnership with the National Ambulance and Medical Emergency Service (SNAEM) under the (MOH), five municipalities Covalima, Ainaro, Manufahi, Viqueque and Dili benefited from the establishment of the Emergency Response Team (ERT) and the training of the health care providers on MISP. This is a major steppingstone for UNFPA in its advocacy efforts to ensure that sexual reproductive health needs and gender-based violence are included in the National Emergency Plan of the Civil Protection Authority and the Timor-Leste first National Adaptation Plan (NAP), as none of these two crucial disaster management policies are currently mentioning SRH or GBV.[191]

UNFPA, participating in GBV and Health Clusters (2023 Annual Report) led by the government for humanitarian issues, jointly with other UN agencies, under T4E initiative, developed a joint manual with IOM on GBV response in emergencies. Interview feedback verified that UNFPA also leads and coordinates the RH sub-cluster under the Health cluster. The ANC and PNC guidelines developed during COVID pandemic were later modified for capacity building on response and are continuing. The implementation of the MISP, supply change management, on-line advice, etc. and lessons learned had been useful for developing preparedness plans, but there are no firm plans in place for long-term readiness. Establishing the capacity to manage future emergencies, UNFPA CO, drafted two SOPs on ERT and on GBV in emergencies directed to the government. One SOP for the ERT was handed over to the National Ambulance and Medical Emergency Service under the MOH and the other SOP for GBV in emergencies to MSSI. These SOPs are meant to align with the Minimum Preparedness Actions (MPAs) agreed within the CO and especially the need for integrating SRH and GBV at both the emergency preparedness and response levels. Country office has been able to lay the groundwork to establish the ERT at district health services level and build in cooperation with several key partners such as UNICEF, IOM, WHO and UN Women to design standard operating procedures, which will contribute to strengthening the Government's capacity of emergency national and local response and management.[192]

To strengthen the system, UNFPA Country Office trained 23 health care providers from 5 health facilities on the MISP and introduced the draft SOPs in the first quarter of 2024, in one facility and the work plan has approved to conduct those training for 30 participants. After developing the

[189] Spotlight Initiative. Final Narrative Programme Report: Timor-Leste (2020–2023). United Nations and European Union; UNFPA Annual Report 2021
[190] Ibid
[191] EF476 Final Report, July 2024
[192] ibid

contextualized MISP, UNFPA is waiting for its approval to advocate for the integration of the SRHR services in the humanitarian preparedness and response plans of the government (future plans).[193]

However, most of the preparatory plans were focused on the response and the evaluation team did not find much evidence on strengthening or building capacity of the humanitarian partners or the beneficiaries. CO documents mention the gaps in the humanitarian preparedness plan and the need to ensure that humanitarian coordination mechanisms in SRH and GBV are strengthened. CO is aware of the efforts to strengthen the integration of the SRH and GBViE in the existing mechanism and structure of the government in preparedness and response in emergency. Based on the background documents and interviews, the challenge is the lack of a dedicated humanitarian staff with clearly assigned roles and responsibilities for implementation. While a focal point overseeing the work in the humanitarian context is there, given the other responsibilities to take on strengthening the coping capacities of the affected communities and build other supporting mechanisms and structures after an emergency have seen as a challenge.[194]

There are still gaps observed in the humanitarian preparedness plan in the country office. The SRH and GBV components in emergency should continue to be strengthened. The CO has to ensure that humanitarian coordination mechanisms in sexual reproductive health and gender-based violence are strengthened. It is crucial to strengthen the integration of the SRH and GBViE in the existing mechanism and structure of the government in preparedness and response in emergency. However, CP4 humanitarian short-term emergency response was commendable given the limited capacity, efforts on the longer-term and interconnectedness aspects were less focused and could be stronger – this is perhaps due to lack of staff and competing priorities. Evident from the reports related to the humanitarian situations was that the engagement of CSOs and communities for the long term building capacity and resiliency seemed limited.[195]

[193]UNFPA CO feedback, EF476 Final Report, July 2024
[194] Humanitarian response-related documents and CO staff interviews
[195] UNFPA Co Annual Report 2023, Humanitarian Response Reports (EF326) and CO feedback

Chapter 5: Conclusions

This chapter presents conclusions drawn from the findings grounded in evidence from triangulated data.

5.1 Strategic Level

1. **As the lead agency for family planning, UNFPA has been instrumental in strengthening and expanding quality family planning services since the country's independence, particularly by increasing access to modern contraceptive methods and strengthening supply systems, with a focus on reaching remote areas and ensuring services and supplies during the pandemic and floods.** Despite these achievements, challenges remain in ensuring universal access primarily due to restrictions under the National Family Planning Policy, which limits the access of adolescents, unmarried and key populations and due to issues related to supply management of certain commodities. During the COVID-19 pandemic and humanitarian crisis caused by floods, services and supplies were ensured. Nevertheless, these persistent gaps continue to impede progress toward the Strategic Plan (SP) outcome of reducing unmet needs for family planning and require further investments (Linked to Finding 5, 6, 7, 8).

2. **In maternal health, UNFPA's systematic efforts to enhance access to quality EmONC, coupled with stringent certification measures, has contributed to improved maternal care during pregnancy and improved access to skilled care at birth even during the pandemic and floods; however, more investments are needed in improving the quality of care, especially newborn care as well as quality improvement processes such as MPDSR**. Support for midwifery education is a long-term investment in human resources for RH services; however, meeting and sustaining the international midwifery standards for education and practice, creation of regulatory body for midwifery and ensuring gainful employment are concerns. The use of SSTC approach for technical assistance to midwifery education is innovative and could accelerate progress but needs closer scrutiny. The above initiatives are critical to achieving the SP outcome of reducing preventable maternal deaths and addressing preventable perinatal deaths (Linked to Finding 6).

3. **The absence of ASRH services under the CP is surprising; given the country's significant youth bulge and the critical role these services play in harnessing the demographic dividend**. This gap undermines UNFPA's leadership in youth initiatives within the UNCT and its related outcomes. UNFPA's technical assistance to MoYSAC and MoE has enabled the promotion of comprehensive sexuality education for adolescents in an out-of-school environment. However, the low level of awareness of HIV/STIs and SRH in general, combined with delays in fully integrating CSE into the formal education system and youth training centres, pose serious challenges. Additionally, geographical barriers and inadequate infrastructure further impede service delivery, leaving marginalized groups underserved and highlighting the need for greater visibility and advocacy efforts. These gaps have significant implications for achieving related outcomes under the SP (Linked to Finding 5, 9, 10).

4. **Although national surveys generate substantial data, and some are accessible through websites and other platforms, evidence highlights limited data utilization and availability for effective planning, policymaking, and decision-making, particularly in relation to reaching those furthest left behind**. Challenges remain in reaching vulnerable groups such as people with disabilities and LGBTQI individuals due to the lack of disaggregated data. The lack of an intersectionality approach to analyses further limits gaining a deeper understanding of social inequalities. The absence of a data marketing strategy further hinders efforts to promote enhanced data utilization. UNFPA holds

a unique position and significant potential within the data ecosystem to address these gaps and play a pivotal role in improving data availability, accessibility, and application (utilization) for targeted and inclusive policy actions. Addressing these challenges requires significant efforts to strengthen capacities in both data generation and utilization to ensure inclusive and equitable access to health services (Linked to Findings 14, 15, 17, 18).

5. **Beyond data limitations, physical, cultural, and linguistic barriers continue to impede access to health services for women, girls and adolescent/youth populations, underscoring the urgent need for targeted SRH and ASRH education and GBV support. Effective utilization of available data to target these underserved populations remains weak** (Linked to 7, 9, 10).

6. **A robust Theory of Change (TOC) aligned with the SP 2022-2025 could have provided a stronger foundation for developing S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time-bound) indicators to monitor transformative results effectively**. While CP4 interventions aligned with the SP and core elements were addressed, the use of poorly designed indicators in the results framework, limited the M&E effectiveness. While the outputs are achieved according to the targets, some indicators (choice of indicators) measuring the outputs are not relevant to the expected outcome and linkages to the expected/planned outcome are not clear. Thus the results measured do not necessarily indicate the contribution to the final objective for results achievements. Incorporating S.M.A.R.T indicators would have improved progress monitoring and outcome measurement. In addition, the results measured have not focused adequately on the quality aspect of the outputs. (Origin Relevance and effectiveness criteria and related findings, and linked to Findings 1,2,3)

5.2 Programmatic Level

7. **UNFPA's leadership in the comprehensive health sector response to GBV, leveraging both its own resources and joint programme funding, has significantly expanded service access and significantly contributes to the National Action Plan on GBV.** The joint UN initiatives such as T4E and SI, employing a multi-dimensional approach, successfully brought together key CSOs, government sectors, and UN agencies. Investments have been comprehensive and show promise for sustainability, despite human and financial constraints faced by some of the facilities, the continuation of services even during floods is noteworthy. While this collaboration enhanced awareness of GBV prevention and the elimination of all forms of violence against women and girls, many individuals may still be missing out on essential services and awareness efforts. Integration of GBV data into HMIS is established and Health sector response to GBV, while has some integration with SRHR, ASRH is missing. A deep understanding of the root causes and gender and cultural norms related to GBV as long-term solutions to prevent GBV is still in a premature stage. GBV case management and referral system is established but a good forensic service needs to be in place. All the above inputs are expected to contribute to the SP outcome of reducing gender-based violence (Linked to Finding 5, 23, 24).

8. **The integration of SRH services remains a weak component of the program, particularly the inclusion of HIV/AIDS services. Key missing elements that could have strengthened integrated services include preconception care and cervical cancer screening and management**. Addressing these gaps through partnerships could significantly enhance service delivery and outcomes (Linked to Finding 5, 8).

9. **UNFPA's initiatives to integrate MISP in the national emergency preparedness and response plans, as well as at the municipality levels, require further strengthening to ensure comprehensive and effective implementation.** UNFPA offered strong examples of integrating humanitarian interventions into long-term development efforts, such as the institutionalization of maternal health service guidelines. These efforts significantly advanced the integration of SRH and GBV services. However, major gaps persist, including the lack of ASRH services and the exclusion of HIV/STI services (Linked to Finding 8).

10. **CP4 humanitarian short-term emergency response was commendable given the limited capacity. Longer-term and interconnectedness aspects were less focused in the humanitarian approach and could be stronger** (reason may have been due to lack of staff and competing priorities). CO made contribution to prepare and respond, but still gaps are observed in institutional strengthening mechanisms and in the humanitarian preparedness plans. Given the recurrent nature of floods and the lack of a dedicated staff responsible for humanitarian work, CO has not considered mainstreaming humanitarian work within the country programme, integrating outcome areas covering SRH, ASRH, GBV and Data. To some extent, supporting institutional mechanisms were evident, but engagement of the CSOs and communities on long term capacity building and resiliency were less evident (Linked to Finding 8, 29, 30, 31).

11. **CP4 has dedicated over one third of its budget on capacity building. A coherent strategic plan for capacity building was not evident. While most of the capacity building efforts received high recognition and positive feedback, the efficiency and the sustainability of some of these interventions need consideration**. Given the crosscutting nature of the interventions, it would have been effective and efficient in order to avoid duplication of efforts and practical for the recipient as well. While the LNOB principle is integrated in designing programmes, capacity development plans did not show evidence of inclusive learning. This would need extra resources and allocations and need to be considered for development of materials and delivering the training in catering to those with learning challenges/disabilities. (linked to Findings 20, 21, 23)

Chapter 6: Recommendations

Recommendations stemming from the conclusions have been discussed and validated by ERG members, and CO programme staff and APRO. ET did not have information on CP5 resource allocation and human resource availability when these nine recommendations (strategic and programmatic) were made. The timeline for implementation is based on the resource capacity of the Country Office and the IPs' readiness and availability. Recommendation 1 to be implemented during CP4 before CP5 implementation.

6.1 Strategic Recommendations

Strategic (Design Related) Recommendation 1: ***Development of TOC and Results Framework***
Linked to Conclusion:6,11
Development of TOC to help establish the causal conditions (or causal pathways) to achieve the planned results via meticulous planning and assessing the evaluability of the programme (before implementing the CP5) and identifying potential risks and assumptions.

Establish cross-functional teams avoiding vertical project planning and management to benefit from one overall comprehensive TOC with a clear and shared understanding to provide a framework indicating linkages across parts of the country programme

Responsibility: **Country Office** (with APRO if needed) Priority level: **High**

Operational Implications - Who should do what:

1. Leverage the existing knowledge base to develop the Theory of Change (TOC) in alignment with the Strategic Plan (SP), incorporating lessons learned from the SP 2022-25 Mid-Term Review (MTR) and the formative SP evaluation.
2. Employ a combination of multi-sectoral interventions, by considering, clarifying and improving the programmatic linkages (cross-fertilization) in the planning stage to achieve better and more comprehensive results.
3. Articulate clearly the interventions addressing inequalities, discrimination and needs of the population groups left furthest behind.
4. Conduct a scoping exercise (informal) to assess the activities of other UN agencies and development partners working in the same thematic areas or pursuing similar objectives as UNFPA. This will help avoid overlaps and enhance efficiency and effectiveness.
5. For CP5, align all planned interventions in the TOC with the UNFPA transformative results. Ensure the results pathway is explicitly linked to these objectives to simplify monitoring and evaluation.
6. Establish clear indicators or proxy indicators to measure the integration and impact of the six accelerators, if they stay relevant to the new SP.
7. Include explicit sustainability and exit strategies in the work plan to ensure long-term impact and smooth transitions.
8. Where feasible and appropriate, engage government and non-government implementing partners (IPs) and other stakeholders involved in CP5 in a workshop to co-develop the TOC. . Review TOC and update as programme changes and as relevant, and make the new CO staff and IPs familiar with the TOC.
9. Identify what kind of capacity building is needed, for what and for whom (with areas needing

capacity strengthening – individual, institutional capacity etc. and with clear outcome oriented)

10. Ensure the TOC design clearly articulates the pathway to realizing the benefits of the Demographic Dividend (DD)

Strategic Recommendation 2: ***UNFPA's Role in Data-Driven Development***

Linked to Conclusions: 4,5,10 (and in general across all conclusions)

UNFPA to emphasize its comparative advantage as a data agency and support data for development, data on youth on harnessing the demographic dividend and to create financing opportunities. Maintain the UNFPA role as in the past with more support to advocating for the availability, accessibility and utilization of data for evidence-based policy dialogue, planning, and monitoring.

Responsibility: **Country Office** Priority level: **High**

Operational Implications - Who should do what:

1. Continue to advocate for improved data availability and accessibility to maximize its use in evidence-based planning and implementation of national development policies and strategies across all programmatic areas (SRHR, AY, GE and GBV including the Humanitarian sector).
2. Lead the coordination of studies and findings and dissemination of results relevant to UNFPA's mandated areas; ensuring consistent data are shared with stakeholders.
3. Continue to collaborate with the government to update its data-sharing platform to meet multi-sectoral data demands and continue strengthening institutional capacities with a focus on advanced and rigorous statistical models.
4. Advocate expansion of data disaggregation beyond sex and age to incorporate intersectional factors and to identify the marginalized and vulnerable populations by geographic areas, enabling more targeted and effective planning.
5. Develop a data marketing strategy for increased awareness and utilization of data.
6. Strengthen INETL's collaboration with line ministries to improve their capacity for collecting and analysing GBV data, including domestic and intimate partner violence, in line with international and regional standards. Use this data to inform laws, policies, and programs (e.g., HMIS department, SEI). Provide ongoing support to data producers to enhance their capacity to collect and analyse GBV-related data.
7. Technical support for robust data analysis to design effective development strategies and monitor the performance and impact of programs.
8. Support the generation of data during different stages (specifically relief and recovery) of the crisis in the humanitarian setting to identify and address the evolving needs of affected populations.

Strategic Recommendation 3: ***Integration of human rights-based approaches and the LNOB/RFB principle***

Linked to Conclusions: 1,2,3,5,7,8,10

CP 5 to continue and strengthen its focus on human rights-based approaches to policy and service delivery and supply systems emphasising quality, expanding contraceptive choices and access to meet the needs of the vulnerable, including adolescents, PWD, PLWHA and LGBTQI, and advocating for sustained national investments based on evidence.

Responsibility: **Country Office** Priority level: **High**

Operational Implications - who should do what:

1. Implement the current plans to conduct an investment case study on family planning with emphasis on return of investment.
2. Advocate to parliamentarians and religious organisations to reconsider and revise the existing

family planning (FP) policy to make it more rights-based, drawing on the insights from the investment case study.

3. Expand the supply chain management system to integrate commodities and supplies for HIV/AIDS programme, thus promoting integrated approaches to supply systems that improve efficiency and effectiveness and less wastage of resources.
4. Explore the possibility of reaching integrated SRH services to vulnerable population groups, such as the LGBTQI community, and scale up existing services among PWDs and those individuals in geographically remote or hard-to-reach areas. Based on the outcome of this, capacitate the service providers to provide integrated services for the most vulnerable including LGBTQI, PWDs and PLWHA.
5. Re-evaluate the policies and strategies that prevent youth and adolescents accessing contraceptives, linking to the studies and assessments on girls' school dropout and teenage pregnancies, and related complications. Advocate for strategies that will reduce the barriers youth currently face in the area of ASRH.
6. Resource allocation as all the above will need additional funding and high-level technical assistance. These are critical for Timor-Leste in the context of high fertility, high maternal and perinatal deaths and low contraceptive prevalence rate and for achieving the transformative goals related to reduced unmet needs and preventable maternal mortality.
7. Employ inclusive approaches in learning programmes to ensure LNOB principle.

Strategic Recommendation 4: Integration of ASRH with SRHR in *Health Sector Response to GBV*
Linked to Conclusions: 7

CP 5 should continue to focus on the health sector response to GBV, focusing on integration with SRHR and ASRH services, while developing a deep understanding of the root causes and gender and cultural norms related to GBV and addressing them for long-term solutions to prevent GBV. Support GBV case management and referral system with a good forensic service in place.

Responsibility: **Country Office, APRO, and other donor partners** Priority level: **High**

1. Conduct implementation research on the effectiveness and impact of the health sector response to GBV. This research should be carried out during the remaining period of the Country Programme (CP). Additionally, documenting best practices should be prioritized to inform future strategies and scale-up efforts.
2. Continue supporting the strengthening of the health system to improve the quality and coverage of the health sector response to GBV through capacity building, follow-up, and integration with SRH services. This includes integrating GBV HMIS into DHIS 2 and ensuring adequate technical and resource support for operationalization. Additionally, strengthen community awareness about GBV in health education and referral pathways for a multisectoral response. Initiate efforts to enhance referral pathways for case management, expanding the scope to include vulnerable populations such as adolescents, LGBTQI individuals, persons with disabilities, and other marginalized groups.
3. Strengthen the ongoing support to integrate the health sector response to GBV into the pre-service midwifery curriculum and initiate the process for integration of the health sector response to GBV into medical and nursing curricula to ensure comprehensive training for future healthcare professionals. Develop and implement an advocacy strategy/plan.
4. Serious consideration should be given to continuing support for safe spaces and enhance skills in

conducting forensic examinations of rape cases to improve the quality of care and justice for survivors.

5. Reflecting more on the multi-sectoral service and the GBV, capitalizing on lessons learnt from SI and T4E, integrate GBV prevention efforts with CSE initiatives and ensuring access to adolescent sexual and reproductive health (ASRH) services is a core component of the upcoming CP5.

6.2 Programmatic Recommendations

Programmatic Recommendation 5: ***Multisectoral Approach to addressing GBV***
Linked to Conclusions: 7

CP5 to strengthen a multi-sectoral response to GBV by enhancing referral networks, formalizing inter-agency roles, and standardizing survivor-centred, trauma-informed service provision across key sectors. Focus on addressing harmful norms, empowering CSOs, and establishing a centralized data system to ensure evidence-based, impactful interventions.

Responsibility: **Country Office** Priority level: **High**

Operational Implications - Who should do what:

1. Enhance the functionality of GBV referral networks established under the National Action Plan for Gender-Based Violence (NAP-GBV). Focus on formalizing inter-agency collaborations with clear roles for education, justice, law enforcement, and social protection sectors.
2. Build on the health-sector SOPs to develop comprehensive, multisectoral SOPs that standardize GBV case management and referrals across sectors such as health, education, social services, law enforcement, and community organizations. Convene representatives from key sectors to collaboratively draft, validate, and implement survivor-centred, trauma-informed guidelines, supported by targeted training and robust monitoring mechanisms to ensure accountability and continuous improvement.
3. Conduct targeted research to identify harmful social norms that perpetuate GBV, using findings to design culturally relevant, community-driven interventions. Strengthen initiatives like "Connect with Respect" to engage/'canvas' men and boys as allies in challenging patriarchal norms and promoting positive masculinity. Partner with local influencers and male community leaders to advocate for gender equality and integrate these efforts into education and workplace programs. Establish sustainable funding and campaigns to ensure long-term behaviour change.
4. Continue to empower local CSOs by enhancing their technical and advocacy capacities to scale up community-based responses and hold duty bearers accountable. Collaborate with local governance structures to formalize partnerships, integrate GBV advocacy into municipal development plans, and expand outreach to remote and marginalized communities. Use participatory approaches like community safety audits to ensure local ownership, while increasing funding and technical support to sustain and expand advocacy efforts.
5. Support the Government to establish a government-led centralized monitoring and evaluation system to track and harmonize GBV-related data across sectors, ensuring consistent collection and analysis. Build the capacity of government agencies, such as INETL, and CSOs to generate and use disaggregated data, including on domestic and intimate partner violence, aligned with international standards. Address data gaps by producing evidence on marginalized populations for targeted planning. Strengthen collaboration among line ministries, CSOs, and key

departments (e.g., HMIS, SEI) to institutionalize regular reporting and feedback, ensuring GBV initiatives are evidence-driven and impactful.

Programmatic Recommendation 6: ***Maternal Health***

This Linked to Conclusion~~s~~: 2

CP 5 should continue to support health system strengthening for maternal and newborn health through improved access to BEmONC, quality of maternal care during pregnancy and childbirth and postnatal period, quality of MPDSR reviews and actions and strengthening midwifery services as per ICM standards and human resource needs of the country

Responsibility: **Country Office,APRO,and other (donor and UN) partners** Priority level: **High**

Operational Implications - Who should do what:

(UNFPA should collaborate with donors to address point 1, and partner with WHO and UNICEF to achieve points 2 and 3)

1. Strengthen and expand quality maternal health services, especially lifesaving BEmONC, focusing on hard-to-reach areas and strengthening the neonatal component. Ensure facility readiness, update and expand guidelines to improve quality, and promote respectful and compassionate care, including bereavement support for families experiencing stillbirths and newborn deaths. Document best practices to guide further improvements.
2. Along with WHO and UNICEF, support the quality and timeliness of MPDSR reviews, analysis of maternal deaths and utilise the data from the proposed study on stillbirths (UNFPA) to implement preventive actions. Introduce 'maternal near-miss and newborn case' reviews to identify and address preventable causes of maternal and neonatal deaths.
3. Strengthen midwifery education and services by engaging short-term technical assistance from the International Confederation of Midwives (ICM) to align with ICM standards. Additionally, develop a National Health Account for the Health Workforce, with a focus on midwives, to enable evidence-based policymaking tailored to the country's specific needs.
   UNFPA needs to mobilise resources if MHTF is no longer available.

UNFPA to advocate the government to strengthen infrastructure capacity to ensure institutional deliveries.

Programmatic Recommendation 7: Primary health care system to provide integrated SRH services

Linked to Conclusions: 8, 9, 10

Strengthen the capacity of the primary health care system to provide integrated SRH services through diverse service delivery platforms, ensuring seamless access during both developmental and humanitarian phases.

Responsibility: **Country Office** Priority level: **Medium**

Operational Implications - Who should do what:

1. Review and revise the current operational guide on integrated SRHR services and identify and develop service delivery platforms that have the potential to deliver integrated services (Integration, as relevant, is critical for quality delivery of FP, maternal health, GBV, HIV and STI and ASRH services) so that people receive a continuum of health promotion, disease prevention, treatment and follow up care as relevant, across the life course.
2. In collaboration with WHO, support the development of the national cervical cancer control programme including the development of strategy, and capacity building of providers and institutions. Once developed, the programme should become part of the integrated package of services.

3. Advocate and facilitate collaboration between the MCH Directorate and the HIV/AIDS programme at policy, service and supply system levels for integrating preventing HIV and STI transmission and Prevention of Mother to Child Transmission.
4. Advocate for inclusion of MISP in the national disaster and pandemic preparedness plans, development of minimum preparedness action and the need for minimum initial rapid assessment during disasters.
5. Design and implement programs that build community resilience by enhancing awareness and access to SRHR and GBV prevention services during crises. Collaborate with the government and other UN agencies to develop coping strategies for minimizing the impacts of disasters, ensuring UNFPA's role focuses on SRHR and GBV components.

Programmatic Recommendation 8*: Life Course Approach to the Demographic Dividend through Adolescent and Youth Empowerment*

Linked to Conclusion: 1,3

In alignment with the National Youth Policy and RMNCAH strategy, revitalise previous efforts to deliver adolescent- and youth-responsive SRH services while continuing to expand CSE programs. These efforts aim to empower adolescents and maximize health and economic benefits.

Responsibility: **Country Office (APRO could bring in regional experience)** Priority level: **High**

Operational Implications - Who should do what:

1. Adopt a life course approach to the demographic dividend through CSE as an investment to maximize the benefits of the demographic dividend. UNFPA is in a unique position to take the lead on youth (already UNFPA is the lead on YRG) to develop a joint UN project on DD.
2. Strengthen UNFPA's technical assistance and visibility on youth empowerment through advocacy and support to the government (MOE and MoYSAC) and CSOs for both in-school and out-of-school CSE programs.
3. Develop a programme for ASRH services in collaboration with the government and NGOs that are actively engaged in ASRHR (for e.g. Marie Stopes and Plan International). Ensure the programme includes family planning, GBV and HIV services that are appropriate, accessible and adequate for young people (including PWD and LGBTI individuals).
4. Design and implement a comprehensive pre-conception care package aligned with the RMNCAH strategy. Define the package's components, identify entry points, establish implementation mechanisms, and assess health system support needs. This initiative is distinct from ASRH services and targets both married and unmarried adolescent girls and boys.
5. Provide technical assistance to relevant ministries and CSOs to develop and implement an advocacy strategy/plan to strengthen the integration of CSE into the national education curriculum. This will empower young people to safeguard their health and rights, well-being and protect themselves from GBV.
6. Support youth centres and CSOs through government structures to strengthen and institutionalize out-of-school youth programs. This includes updating the "Healthy Relationships" manual to better address the needs of young people.
7. Mobilize resources to enable the Country Office (CO) to appoint a dedicated programme officer

to lead and coordinate youth-focused interventions

Programmatic Recommendation 9: Humanitarian- Development Nexus
Linked to Conclusions: 9,10
Apply Humanitarian- Development Nexus approach: Given the recurrent nature of emergencies, mainly floods, CP5 to include a humanitarian preparedness and response work plan integrated within the key programmatic areas (SRH, Gender, AY and Data), coordinating and collaborating with other relevant agencies.

Responsibility: Country Office (APRO to be engaged) (Priority level: Medium)

Operational Implications - Who should do what:

1. Appoint a dedicated staff member to be responsible to oversee the humanitarian response
2. Mainstream humanitarian preparedness and response within the CP5 programme
3. Build awareness and strengthen capacities of CSOs (who would be working in response work) and communities on coping mechanisms
4. Explore a possibility of youth centre staff and youth groups to be capacitated on humanitarian response
5. Develop a plan how to make the response inclusive (ensure that PWDs and other marginalized groups are not missed)
6. Apply humanitarian development nexus approach to address root causes and decrease risks and vulnerabilities.

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